State of Ohio,)
County of Cuyahoga) SS:

IN THE COURT OF COMMON PLEAS

DOC 331

MARY LOU MOTLEY,)
)
Plaintiff,)
vs.) Case No. 250806
) Brian J. Corrigan
KAISER FOUNDATION HOSPITALS,)
et al.,)
)
Defendants.)

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THE DEPOSITION OF STANLEY H. NAHIGIAN, M.D.
WEDNESDAY, MAY 25, 1994

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The deposition of Stanley H. Nahigian, M.D., called by the Plaintiff for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Charles A. Cady, Registered Professional Reporter and Notary Public within and for the State of Ohio, taken at the offices of Stanley H. Nahigian, M.D., 29001 Cedar Road, Cleveland, Ohio, commencing at 4:05 p.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff:

J. Michael Monteleone, Esq.
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On behalf of the Defendant Kaiser Foundation Hospitals:

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On behalf of the Defendant St. Luke's Medical Center and Henry Fabian, M.D.:

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STANLEY H. NAHIGIAN, M.D., DEPOSITION INDEX

STANLEY H. NAHIGIAN, M.D.

of lawful age, called by the Plaintiff for examination pursuant to the Ohio Rules of Civil Procedure, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

MR. MONTELEONE: Your Honor, at this time the plaintiffs will call as their next witness Dr. Stanley Nahigian.

EXAMINATION OF STANLEY H. NAHIGIAN, M.D.

BY MR. MONTELEONE:

Q Good afternoon, Doctor.

A Good afternoon.

Q Would you please introduce yourself to the ladies and gentlemen of our jury?

a Yes. My name is Stanley Nahigian. I'm an orthopedic surgeon with special interest in surgery of the hand.

(And what is your professional address, Doctor?

I'm at 29001 Cedar Road, in Lyndhurst.

(All right. And are we at your offices this afternoon, --

A Yes.

Q -- Wednesday, May 25, 1994?

A Yes.

Q Doctor, is this where you see your patients?
A Yes, sir.
Q Would you be kind enough to please tell us -- you've identified that you are an orthopedic surgeon. And I think in the common parlance that would be known as a bone doctor?
A Yes.
Q You fix fractures. But you also have a specialty in -- what is it, Doctor?
A In surgery of the hand, yes.
Q Surgery of the hand. Can you tell us, are you licensed to practice medicine in the State of Ohio?
A Yes, I am.
Q About how many years?
A Since 1957.
Q Before you tell us about your patient Mary Motley, it would be helpful to the jury to know a little bit about your professional background and your training.

So would you please give us just a brief idea starting with medical school and bring us up-to-date, if you would?

A Yes. Yes. I graduated from Ohio State University College of Medicine 1957, completed

five years of postgraduate training in Cleveland, a rotating internship and four years of orthopedic surgery, and then took a year of postgraduate surgery and surgery of the hand in Gothenburg, Sweden, under Professor Eric Moberg, who at that time had a personal professorship of surgery of the hand from the king of Sweden.

Q All right,

A And then subsequently returned to Cleveland. I have privileges at most of the major hospitals on the East Side and have an academic appointment at the university as associate professor of orthopedic surgery, at Case Western Reserve. I'm a member of the American College of Surgeons, the American Academy of Orthopedic Surgery, the American Society for Surgery of the Hand.

And in 1989, I think, I passed the test for a -- it's the only certificate for postgraduate education that's now sanctioned by all three boards, and it's the certificate for added competence for surgery of the hand. And it's sanctioned by the American Academy of Orthopedic Surgeons, the American College of Surgeons and Plastic Surgery Society. There are

about maybe in Cleveland about four or five who have completed that examination.

Q Out of all the doctors in Cleveland --

A Yes.

Q -- there's only four or five?

A Uh-huh. You have to have, to sit for it -- it was started in 1989. And to be eligible to even sit for the examination you have to have a certain amount of case experience, a stature in the community and have shown that you have had previous experience and contributed scientifically and other ways to even take the examination, all in the field of hand surgery.

Q All right. And you were invited to do this?

A Yes.

Q Dr. Nahigian, would you tell the members of the jury briefly what kind of surgery you do?

A Yes. My practice at this time now is essentially limited to surgery of the hand and related problems to the upper extremity. So that means if there's a problem that the hand is deficient because of something at the elbow or the shoulder or forearm, we take care of the entire upper extremity.

Q Where do you do most of your surgery these days,

Doctor?

A I do surgery both at St. Luke's Hospital, Hillcrest Hospital, occasionally at Marymount Hospital. I have privileges at St. Vincent Charity Hospital but I don't operate there much anymore.

Q Dr. Nahigian, how many days a week are you in surgery, sir?

A Three days a week.

Q All right. And the other days, of course8 you see --

A In the office.

Q In the office.

A I'm in the office Tuesday and Friday the entire day.

Q All right. Dr. Nahigian, are you also involved in the teaching of young doctors your specialty of hand surgery?

A Yes. At the present time I have a resident at St. Luke's Hospital in the orthopedic rotation who is at the PGY-4 level. That means he's had four years of surgical training. And he rotates with me for six months to learn hand surgery. And I also have residents rotating from Brentwood Hospital who are osteopaths who rotate

with me for two months at a time at the PGY-3 level, a little more junior.

Q All right.

A In addition, I teach medical students, nurses and other people.

Q Have you been doing this most of your professional career?

A Yes.

Q All right. You told us about your special certificate and accomplishments in hand surgery,

A Uh-huh.

Q I assume you also have your board certification?

A Yes, I have.

Q And as I understand it, not all doctors are, in fact, board certified; is that true?

A That's true.

Q You need to be approved, so to speak, by your peers and pass an examination, both oral and written exam?

A Yes.

Q All right. Dr. Nahigian, let's talk about your patient Mary Motley. We have your office records. I have given copies of them to attorneys for the defendant. And so that you understand and the jury understands your

function here, --

A Yes.

Q -- both of the defendants, Drs. Anouchi and Fabian have admitted that they were negligent in placing a suture through the ulnar nerve of Mary Motley and that it has caused injury to her arm and her hand.

MR. GOLDWASSER: Objection.

MS. VANCE: objection.

Q So I will not be asking you questions about their conduct or their standard of care.

What I would like to talk to you about and have you explain to the jury has to do with Mary's treatment by you and what you found her condition to be when you first saw her. All right?

A Yes.

Q All right. Please tell us --

MS. VANCE: Objection and move to strike. Go ahead, Mike.

Q Please tell us when you first saw Mary Motley and how she became your patient, Doctor?

A May I refer to my notes?

Q Certainly.

A Yes. I first examined her on July 14, 1992, at

the request of Dr. Yoel Anouchi. I served as a consultant until recently to the Kaiser Hospital insurance system, and I would see the tertiary, or complicated, hand surgery cases. And Yoel contacted me first in the hospital and then subsequently had her see me because of this problem with her ulnar nerve.

Q All right. So Dr. Anouchi himself asked you to take over?

A Oh, yes, Yes.

Q All right. Tell us what you found out, what you learned, when you saw Mary Motley for the first time on July --

A Well, Yoel had told me -- excuse me -- beforehand what the problem was at the time of the surgery.

Q Okay.

A A month or so before.

Q All right.

A And the urgency of it and why I should see her and so forth.

Q Very good. And when --

A So I had sort of an introduction before she came here.

Q All right. When you say Yoel that's Doctor --

A Anouchi. Dr. Anouchi
Q Dr. Anouchi's first name?
A Yes. Yes.
Q All right. What did Dr. Anouchi tell you was the problem, the nature of the problem, that he was asking you to see her for?
A Well, he told me about the problem in surgery in which they had operated on her for an elbow problem for a release of the tendons from her elbow, which is a standard procedure for what we call medial epicondylitis, or golfer's elbow. And it's a standard operation that he performed. It's well documented. There's nothing wrong with the procedure. But someplace in the course of the surgery, and I think he told me during the closure, that the suture was placed around the nerve, and it was not picked up until later on.
Q All right. So during the first operation that was done on June 4 of 1992, either Dr. Anouchi or the resident, Dr. Fabian, --
A Yes.
Q -- put a suture inadvertently -- I should say accidentally --
A Yes.

Q -- through the nerve in her elbow?
A Yes, and tied it.
Q And tied it up?
A Yes.
Q Okay. Go ahead, then. What else did you learn?
A Well, this caused her a severe amount of pain that should be way out of proportion to what would be from a normal release of the muscles. Everybody who has that type of a major operation has some major discomfort, but apparently they were aware suddenly that her nerve was in jeopardy and it wasn't just simple postoperative pain, and they took her back to surgery again to explore the nerve.
Q On June 19?
A On June 19, yes.
Q All right,
A At that time they found out, you know, what had happened.
Q And what did they learn at that time, Doctor?
A Well, that there was a suture -- you'd have to -- did you not refer to his operative note? I think it's in there.
Q It is. And the jury will have those records before them.

A Okay. Well, anyway, you can refer to his note, whatever they did. They released it and they took the suture out. And then she still didn't do well and she was having more trouble. The biggest problem at the time when I saw her was not only that there was damage to the nerve hampering the function of her hand -- she had what we call a claw hand deformity, which the fingers of the -- and we have photographs to document this -- but her biggest problem was she's a coach and she uses her -- this is her dominant hand.

And she could not move her elbow without this severe shooting incapacitating pain which would shoot down into her ring and little fingers whenever she moved her elbow and attempted a straightened position. The nerve was being tethered. It was just like caught on something and there would be excruciating pain. If she stayed still it would be relatively comfortable. But the minute she moved that nerve, that elbow at all she could feel this shooting pain. And she was just distraught. And that was a bigger complaint than the clawing.

Q All right. You mentioned that this was part of the history you received.

And then you got a chance to see her for the first time I believe on July 14, 1992; is that correct?

A Yes.

Q All right. Did you conduct an examination, Doctor?

A Oh, yes. Yes.

Q Tell us, would you please, what you found of significance or important to you as a hand surgeon?

A Yes.. I'll have to -- I'll read from my notes, if you don't mind.

Q That's quite all right.

A As we talked about, I sort of knew what we were going to find because of my discussions with Dr. Anouchi. And she was a healthy, very athletic woman. And she was in severe distress, I mean just at wits end, way out of proportion to someone who has a simple elbow problem. So you know that nerve is being acutely pinched. I mean this is a very serious problem.

And she had -- and I have marked it down. She had very severe discomfort. She still had

clawing and evidence of what we call intrinsic paralysis. That means the small muscles in her hand which are innervated by the ulnar nerve were all paralyzed. And that makes her hand extremely weak, clumsy and out of balance.

She had profundus paralysis, That means these muscles that bend the fingers were paralyzed, particularly to the little and ring finger. And this means that the nerve is also in trouble.

And I took a -- wait a minute. Then the biggest problem was that the elbow, she could only move it from five to -- excuse me, from 15 to 55 degrees. That means she could only go from this position to about this position, and anything beyond that she had a severe amount of pain emanating from the elbow.

I took an x-ray of the elbow just to make sure there was no pathology within the elbow joint itself. I mean you could always find out if there was scmething else going on. And the elbow was clean, the elbow joint itself. So we knew all this trouble was coming because of the scarring and the tethering of the nerve at the elbow site,

Q The ulnar nerve that had --

A Yes.

Q -- had this suture placed into it?

A Yes. The nerve -- I'll show you on this little model here. The nerve -- this is a standard elbow. Are you focused in on it? This is a skeleton of the nerve -- of the elbow. Okay? Can you see it?

Now, the nerve in the elbow, -- people say it's the only mistake mother nature made -- the nerve goes behind this boney prominence and comes down into the forearm. We'll show you some pictures later on if you want it. And what happened was, this is the area that was released. It was operated on originally back in early June. And then when they went back in the second time, they had removed the bone to try to decompress the nerve, but it was still stuck in this mass of scar tissue right at this area.

So anytime that the elbow would move, it would just pull the nerve and it would shoot the pain down the arm. So she had this funny little range of motion in this elbow. And the other side had a full, pain-free range of motion. She had no arthritis or anything. So.

Q You mean the other arm?

A The other arm.

Q Okay.

A The other elbow. I said the other elbow. Okay.

Now, a Tinel's sign, a strongly positive Tinel's sign, which is a signal in which people have had it -- if you hit your funny bone or any other nerve, you feel this shooting pain that goes down or shooting pins and needles that goes over the nerve. That tells you the nerve is embarrassed, it can be cut, it can be crushed, it can be anything, caught in scar. It's all the same sign, It was described about 100 years ago by Dr. Tinel. And it means that there's embarrassment of the nerve.

And with her it was excruciating. You could barely touch it and just electrical shocks would shoot down her hand. So you know there was severe damage. And if I tried to flex the elbow beyond 55 degrees, it went into her fingers. She could feel it.

Q What is the normal range of motion?

A Oh, it should be 135. She should be able -- a limber woman like her, she could put her fingertips on her shoulder. This one, it would

hardly come up any further than that.

Q How about extending the arm?

A Same thing. She kept in this very short range, Anywhere you went beyond that arc, the nerve.

Let me see. She said she had immediate relief of the original exquisite pain when the suture was in after they reexplored the elbow on June 19, but she said there had been no progressive improvement in the elbow symptoms since the 19th and she could not increase her range of motion. I mean even though they had taken this bone away and had taken the suture out, she still had this tethering effect of the nerve hampering her elbow.

Q So when Dr. Anouchi and Dr. Fabian went back in on June 19 of 1992 to see what was causing all this problem and they found this suture that was through the nerve, even though they had removed it, she presented to you and she was still having the problems that you have indicated?

A Oh, yes, with with the elbow. Yes.

Q All right.

A So she was not cut of the woods. She was some better compared to June 4 but she was not well at all.

Q All right.

A And I put her in a splint, and that made her feel better. I put her in a protective splint which just kept the elbow quiet. This was in no way treating her. Now, she is, as I mentioned, in the Kaiser system, so I have to get approval from their physicians before I can take over the case. So I had called Dr. Anouchi and I discussed it with him and he said -- you know, he gave her his approval, he said go ahead and do it.

Q Okay. Now, you mentioned, Dr. Nahigian, that this injury was to the nerve, the ulnar nerve, in her dominant hand?

A Yes.

Q And I'm going to ask you if you would be kind enough, please, first of all, before you show the jury some medical illustrations so they can see exactly where this suture went through the nerve, is it of any significance to you as a hand specialist, a hand surgeon, that the injury was to the hand that she used predominantly, in other words, her dominant hand?

A Yes. She was a coach and she had a very fine woman's volleyball team. And she could not

coach, she couldn't hit the ball, she couldn't partake. Basically, her hand was completely useless, not only because of the weakness and the paralysis, because of the pain from the elbow down. So basically a useless appendage.

Q All right. Do you have with you here a medical drawing or illustration that will show the jury the course of the ulnar nerve that would be of some benefit to them in arriving at their decision here?

A All right.

Q Do you have something in one of your medical --

A I have. I took a very nice atlas here which has very clear pictures. I hope they project well.

This is the Frank Netter's book on the Atlas of the Human Anatomy. These are -- Dr. Netter was a physician and medical artist, who recently died, who had these magnificent pictures. Does this come through?

MR. MONTELEONE: Let's ask the videographer if he can focus on that a little better.

A These are two of the major nerves in the hand. One is the median nerve on the right side. Do you want to hold that back.

Q I'll hold that for you, Doctor. Do you want to use this?

A I've got one.

Q You've got one? Good.

A All right. This is the ulnar nerve. Most everyone knows where their ulnar nerve is because they've hit it on their elbow and have caused pain and numbness to go into the little and ring finger, And this is what I discussed before.

Nature put the nerve behind the bone. It comes under, around this bone that I showed you before, then comes into the muscles in the front and then, of course, down along the heel of the hand and goes to all the little muscles, except for a few, into the palm.

And it is the main motor nerve, or the muscle nerve, that goes into the muscles of the hand. It also controls the flexion, basically, of the ring and little fingers with the long muscles there. It has nothing to do with the index, long or other fingers as far as the long tendons go. But all the small muscles are innervated by this.

And it also has what we call cutaneous

invasion, where the area of numbness is on the border of the hand along the little and half of the ring finger and on the back, or what we call the dorsal surface, of the hand. And this has some variability. This is what we call the typical pattern, but it can have more distribution or less distribution. I mean the good Lord makes a lot of variations, and here's an example of the median nerve which you see on the other which takes care of the other part of the sensation of the hand. But this is what the ulnar nerve typically covers.

Q Okay. Thank you.

A Is that helpful?

Q Yes, I think so.

A Okay- The area of entrapment or the pain, when I was talking about Tinel's, was all right here. There was nothing -- the rest of the nerve was fine. All of her symptoms came from this area where the incision was up near the elbow.

Q Is that where the suture had been placed?

A Yes.

Q All right. You make note in your medical records regarding her that she had an ulnar nerve palsy?

A Yes.
Q What does that mean in layman's language, Dr. Nahigian?
A Well, palsy is another word for paralysis. Basically, the nerve is not functioning at all. Whether it's, as I mentioned, either cut, crushed, damaged by infection or whatever, it is nonoperational from the elbow down.
C All right. As I understand what you have told us, this particular nerve in the arm has a couple of functions. One is to provide electrical impulses so that the muscles can move?
A Yes. Correct.
Q And that's called its motor function?
A Yes.
Q And the other is a sensory, or a feeling, function --
A Yes.
Q -- so that you can detect pain, hot, cold that kind of thing?
A Yes. Yes.
Q So if a suture, or a stitch, is put through a nerve, --
A Yes.

Q -- this obviously is going to cause some, as you describe it, exquisite pain?

A If it's put through and tied, not just -- put through, it's not too bad. I mean you don't want to do it every day. But putting it through and tying it is disaster.

Q All right. Doctor, will you tell us, please, what you recommended to Mary Motley after you saw her on that first visit of July 14, 1992?

A Yes. I put her in a splint, as I mentioned, to see how she would do and to be able to talk to Dr. Anouchi and to see what -- you know, there was always an outside chance that she would be getting some better even by splinting it, because she had had no splint on her arm from the time she had left his office, whenever that was, until I saw her here in July.

And I saw her about a week later to see if there would be some dramatic improvement, hoping that with rest and prevention of bumping and what have you that the elbow would get -- excuse me, the nerve would get sone better. And I saw her on July 21st, July 21.

And I said, "She has no change in her Tinel sign. Did not get any appreciable relief

with the splinting." And she has a second Tinel's, which means another area, essentially in the same area, which means there is no progression of the improvement or healing. Tinel's helps us measure if the nerve is getting better.

Q Now, Tinel was a --

A That's a sign. He's a neurologist that showed this. It's a nonspecific test. You hit it, hit the nerve, either with your finger or a small hammer, and it sends the electrical shock oven: the distribution of the nerve.

Q And you were able to tell by performing this test on her what her problem was?

A Yes. It was not -- if a nerve is going to get better -- for instance, like, you know, when you sit on your foot or crossed leg or you have a paralysis, immediately you might have essentially no use of the hand or fingers for a few minutes, but within an hour or so or less than that it gets better, so you know it's progressing. And here we had it for over a week and there was absolutely no imprcvement at all. So we knew there was something that had to be done.

And I said there may be some early atrophy, which means that the muscles are shrinking. And we advised her that we better get after it. And so we made arrangements for the surgery on July 23, '92.

Q All right. Before you tell us about that, I noticed in your medical records that you made reference to what you called a marked clawing of her hand?

A Yes.

Q What was causing this, Dr. Nahigian?

A Clawing, that is the attitude that comes from the paralysis of the nerve, the ulnar nerve, That's a typical, classical position in which -- I think I took pictures of it which you can see later on, she has -- in which the -- I think I just demonstrated it a while ago -- in which the index and middle finger can come out straight but the little and ring finger remain in this curled position.

Q And that's what you identify as a clawing?

A As clawing, yes.

Q And this --

A It gets in your way. The fingers will not go out, they cannot extend out to the flat

position, they stay permanently this way, they get in the palm.

Q And this was being caused by the injury to the ulnar nerve --

A Yes. Yes.

Q -- with the suture that had been --

A Yes.

Q All right. Doctor, if you would be nice enough, since we have slides there and no way to project them for the jury to see here today, if we can have these.

A Yes.

Q And we'll mark these Plaintiff's Exhibit Numbers 1 and 2. And we will have --

A They can be converted to prints or you can project them.

Q We'll do that.

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(Plaintiff's Deposition Exhibit Nos. I and 2 were marked for identification.)

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Q Would you be kind enough to tell us first of all, please, do they fairly and accurately represent --

A Yes.

Q -- what the condition of her arm and her hand was when you took those photographs on July 14, 1992?

A Yes. They're dated. And they're two colored pictures. And this is all I could do because she was in such discomfort that first day. We only took two pictures. She said, I can't stand it anymore." You like to make them do different things and positions, but I could not do it. And you'll see that her hand is sort of fixed in one position. And the pictures show this typical position of the fingers curled in. And these are out straight but these two are stuck in this position.

Q All right.

MR. MONTELEONE: We will mark those as Plaintiff's Exhibits 1 and 2 and we'll ask our court reporter to do that so we can use them and the jury can see them themselves.

Q All right. So you rec --

MR. GOLDWASSER: Before you do that, could I see those pictures, please?

THE WITNESS: Yes. Sure.

MR. MONTELEONE: Oh, certainly.

MR. GOLDWASSER: Thank you.

THE WITNESS: Here's a --

MR. GOLDWASSER: That's all right, Doctor. I can just look at them.

THE WITNESS: Here.

MR. GOLDWASSER: Oh, you've got a little gizmo there?

THE WITNESS: I've got a little gizmo. You can really see them.

MR. GOLDWASSER: Thanks.

THE WITNESS: She can see them, too. Hold it to the light. This one shows the clawing a little better, I think.

Q All right, Dr. Nahigian.

A Yes. Excuse me.

Q While Mr. Goldwasser is looking at those pictures.

You recommended that she have surgery and she was admitted to St. Luke's Hospital --

A Yes.

Q -- July 23, 1992 under your care?

A Yes.

Q Would you tell us, please, what you did for her when you admitted her to the hospital?

A Yes. This needed a general anesthetic. Obviously, this is exquisitely painful. There's

no way this can be done with any kind of a local or easy anesthetic. You need plenty of relaxation.

And at that time we went back in and explored the entire nerve. We used an operating room microscope to make sure all the scarring and any embarrassment of the nerve was clear. You can't -- you have to have magnification because this has been operated, remember, two times. So there's going to be a lot of scar there and we want to make sure we don't damage the nerve any farther. So we used the microscope.

And then to get the nerve out of this bed -- you cannot put it back in the bed where it was before. The nerve then has to be transferred into a soft bed to allow it to heal. So we had to move it way over to the median nerve. I'll show you on this picture here. I don't know if it will come through.

But you take the nerve from behind the bone, resect some more bone. Dr. Anouchi had already done some of it. We took some more. And we moved that nerve from there all the way over next to the median nerve, which is in a

nice, soft bed that's been untampered. And with that the nerve lies under the muscle. We have to divide the muscle, which you see here, cut it and lengthen it a little bit and stitch it back and put the nerve back into a new soft bed and allow it to move and not be hampered anymore by the scar.

That's a fairly major procedure and it takes specialist knowledge on how much tension, how much mobilization you can do, because you can do more harm if you're not careful with it.

Q I notice according to the hospital records that the surgery took over three and a half hours?

A Yes. Uh-huh.

Q Dr. Nahigian, it sounds like it was a fairly extensive surgery?

A Oh, it is, yes.

Q And so that the jury is clear on this, the reason you needed to do this surgery was because of the damage that had been done to the ulnar nerve when Drs. Anouchi and Fabian had operated on this lady on June 4, 1992?

A Yes, that's the original problem. Then when they reexplored her there's more scar. I mean there was nothing done wrong the second time,

but that made the job even more difficult from my standpoint because there's going to be more scar involved. They even did some bone work the second time trying to get this part of the bone away from the nerve hoping that would be sufficient. And that causes more bleeding and more scar. And so the surgery has to progress very, very slowly. That's why it's three and a half hours. You have to take your time.

Q All right. You mention in your operative note that you dictated for the official 'hospital records that you could still see the indentation in the ulnar nerve where Dr. Anouchi and Dr. Fabian had put the suture accidentally into this nerve?

A What paragraph are you looking at?

Q If you look at the third page of your operative report, I believe that's where you'll find it, Doctor. Can you find page 3 over there?

A I've got it.

Q Okay. It's the second paragraph starting with, "There was an area where the patient had --"

A "Had had a suture placed in the nerve," yes, "just proximal to the cubital tunnel."

The cubital tunnel is just the name for

the tunnel where the nerve sits. And an indentation was seen. And it was so marked that an internal neurolysis had to be done with a microscope.

And what would we do, what we mean by internal neurolysis, that means we go right within the substance of the nerve. And you have to do with a microscope control.

Q What does it indicate to you, Dr. Nahigian, as an experienced hand surgeon, that you were still able to see an indentation in the nerve from the suture that had been placed there accidentally by Drs. Fabian and Anouchi?

A What does that mean?

Q What does that indicate to you, when you can still see the indentation in the nerve?

A Well, the nerve is still contracted. You take the suture away but the -- it's like tying up something with a rope and you take the rope off but it leaves an indentation. The nerves are very, very soft. They're like -- they have the texture of spaghetti. And if you just squeeze this spaghetti with a suture and squeeze it down, it just cuts into this very soft material.

Now, to merely remove the suture, if

you're lucky, it will bounce back up, it will expand up. But this had not. This was now two months later. Oh, no. A month, month and a half later. And the nerve, you could still see this, like a waist, like a corset effect, where you squeeze the waist down tight. And then you could see a bulge on either side of it.

So you have to then release that nerve in that area, which you can do, gradually tease it free and then allow this to expand. There's no longer any suture effect but there's scar effect. I worked on the scar.

Q Caused by the suture?

A Yes.

Q Okay. Dr. Nahigian, how could the damage to the nerve up in the elbow cause this clawing defect with her hand and the other paralysis you were talking about? How does that happen?

A Well, I thought I just explained to you on the nerve.

Q All right.

A Yes.

Q Maybe you did.

A Do you want to do it again?

Q Well, --

MR. GOLDWASSER: I think you did an excellent job already.

Q Gary --

A Do you want it again for Mr. Goldwasser?

Q No. If Gary doesn't want to hear it again, that's all right.

A All right.

Q I'm just trying to figure, if the nerve is up here in the elbow, how does it --

A I'll show you. Here it goes. The nerve is a long conduit, it's like a cable, and it goes from the elbow all the way down. It has no branches above the elbow. All the branches come down in the forearm and it branches here into the muscles that contract the fingers and then it goes into all these small muscles within the hand itself.

Q Okay. All right.

A Yes.

Q Very good.

A Yes.

Q Now, you discharged her from the hospital then?

A Yes.

Q All right. And did you see her after that, Dr. Nahigian?

A Yes. Okay. Yes. Now we have to follow along to see how the improvement is going to come along. And I saw her on the 20 -- excuse me, the 31st of July, which is about a week later. And I took her dressings down and took some of the clips out. And she at that time had 30 to 40 degrees range of motion, which means she could start to move and she had none of that exquisite pain that she had before. But she still had a complete ulnar palsy at this level. The nerve had not recovered, obviously.

And she now had what we call a second Tinel's starting to come, which means there's going to be some recovery of the nerve beginning to come in the forearm. She still had a claw hand. And I gave her a splint to allow general motion, bathing and let her do what she could do. She's a very athletic woman, very good muscles, and she could take care of herself. And she had very good, what we call, neuromuscular control, so we could trust her to do so. Some people, they can't, you know, but we felt she could.

Q Did she have normal use of her right hand?

A No. Not at all. Not at all. No.

Q All right.

A Anyway, so we wanted to start at that time with what we call electrical stimulation. Now, what happens is, if you damage a nerve like this, and we don't have any idea when it's going to recover or if it's going to recover, so you have to go through what we call muscle stimulation, in which you take the device electrically. And she'd have to do this with an experienced hand therapist.

There's only one or two places that you can do this. One of this was at Green Road, which was outside the Kaiser system, and that makes it -- with this bureaucratic business now. It's very difficult to get this arranged. But we finally did through Dr. Anouchi's efforts to get her to go to a therapist outside the Kaiser system. And we have a very fine hand therapist in our own office, but this special equipment had to be done over at Green Road. Anyway.

And they showed her how to do it. And what you have to do is stimulate these muscle on a very disciplined basis in the hand. And these are all these intrinsic muscles -- maybe I can show you -- around the hand. These are these

muscles back here, all these small ones. And they have to be stimulated regularly, because while the nerve is healing or if it's going to heal, it does no good if you allow these muscles to atrophy, or wither away, because when the nerves gets down here there are going to be no muscles to work on.

So you're walking a tightrope. As fast as you can you're trying to keep the muscles going with the electrical stimulator and hope for the good Lord to heal the nerve, because once you have released it there's no way you can accelerate nerve healing, you just have to wait, So we tried to keep the muscles in shape waiting for the nerve to come back.

Q All right. So the electrical stimulation that you recommended for her --

A Yes.

Q -- hand was intended to do artificially what the ulnar nerve would have been doing --

A Yes.

Q -- had it not been injured?

A Right. Yes.

Q Okay. Very good.

A And it has to be done under supervision and done

a lot.

Q All right. So she had a lot of physical therapy for this?

A Yes. And it's annoying. Yes.

Q All right. You continued to see her throughout, it looks like, July 31 of '92, August 11, '92, August 21 of 1992, September 15, 1992?

A Yes.

Q Why don't we just take that two- or three-month period of time --

A Yes.

Q -- right after the operation?

A She's making some progress. As she went along we were quite encouraged. She had what we call a profundus activity, which means this finger here, the little finger, could bend, but it was only a trace. That means something was corning through. She still had some, what we call, cubital tunnel syndrome, which if you compressed her nerve she could still feel some discomfort, but it was getting better. She had less clawing but she still had a claw deformity. This was just -- it looked like it was a little better than it was, say, compared to her visit in early July.

Now, in September still she had no return of her normal function. The sensory branch was still out, meaning that the sensation that I showed you on that blue area was still gone. She had no flexor carpi ulnaris function. These are all muscles that we expect to see to gradually come back. That's how we monitor them.

Q All right. So during that two-month postoperative period of time --

A She's making, her elbow -- oh, by the way, she was quite pleased. Her elbow could now come out almost all the way out flat and could bend basically the whole way in. So all that exquisite elbow pain that she had before had improved. So you know the nerve is now in a comfortable bed, it wasn't being tethered anymore.

Q Okay.

A So now we're just waiting and basically holding her hand and trying to keep her spirits up. She's very distraught because she's an athlete and she's right-handed, and she can't serve and coach and pound the volleyball to her -- for her team the way she would like to do it.

Q All right.

A So this is particularly annoying.

Q So why don't you tell us, then, about 1993. She saw you several times there?

A Yes.

Q And you started her -- you've got a TENS unit now. What is a TENS unit?

A Well, a TENS is that stimulation unit,

Q Okay.

A And it also helps the pain a little bit, yes,

Q All right. And she continued to see you several times in 1993.

A Yes.

Q I won't go through all the visits.

But you make reference in there, Doctor, that she was well motivated?

A Yes. Oh, extremely so.

Q Meaning what?

A Well, motivated? Well, she wanted to get better. She was trying and cooperating and working to get her arm up. Sure.

Q Now, May 21 of 1993 you make a note, she still can't set the balls for her volleyball team, that the claw deformity was persisting, she could not cross her fingers, she had a weak

profundus muscle, --

A Yes.

Q -- the one you were talking about earlier.

And then you saw her again August of 1993, Doctor?

A Yes.

Q Would you summarize your important findings at that time, please?

A Yes. This is now about a year out, over a year out. So this is giving you some idea of how she's coming along. With this major nerve damage like this, you really can't make much of an assessment until a full year goes by anyway. Qkay. July.

Q It's August of '93.

A '93. I've got the cards here, Do you have that? February '93. All right. August 27. I've got it now. August 27.

She has progressive improvement in the distribution of the nerve. She has sensation over the dorsal branch of the ulnar nerve, which is the one that goes on the back of the hand. Still has none over the palmar side. As I showed you, the palm side was still numb. She cannot hold a tennis racquet. She still had the

contracture of the PIP joint of the little finger, which was contracted down, which has to be splinted to help. I had given her some small splints so her fingers -- not only are the finger crooked, but it does not clear the palm. It's very annoying. If you have to walk around with your fingertip flexed all the time, every time you touch something it gets in the way and you have to pull it away. So we gave her a splint to allow it to get out of the palm, We want the fingers out straight.

She had 1 over 5 activity. That means -- 5 over 5 is normal. So 1 over 5 means just barely enough to record it. So it's basically not very much. And that's on these muscles down here. She still could not cross her fingers. That's a very accurate sign for ulnar nerve loss. If a patient cannot cross their fingers, their ulnar nerve, the motor activity is absent, That's just a physical diagnosis sign we use. She had still fairly -- she had good first dorsal intercsseous muscle. This is this one here which was recovering. The clawing was still present.

Now, the second Tinel's is now definitely

just distal to the pisiform. That means this little bone in the hand. That means it had come from all the way up here down to here. And that second Tinel's means that the nerve is progressing very slowly but -- I mean, excuse me, improving, not progressing, but improving or healing.

Q Yes.

A So that's encouraging. She had a good grasp of her rehab exercises. She had a new splint. She still had a primary Tinel's over the nerve injuries, which means that there was still embarrassment of the nerve way back high. So you could still -- the nerve had not recovered. If you have no Tinel's, you know the nerve is normal. But she still had one back up in the original area up in the elbow.

Q All right. Did she still have this clawing deformity in August of 1993 when you saw her?

A Yes, she did.

Q All right. Doctor, and then it looks like she then came back to see you just a few months ago, March 1 of '94?

A Yes.

Q All right. And you have a fairly extensive note

there regarding your discussion with her how she was doing at that time.

Would you summarize for the jury, Dr. Nahigian, the important items during your examination and discussion?

A Of March?

Q Please.

A Okay.

Q March of 1994?

A So that's within, what, a couple months ago,

At that time when she came in she said she had burned her hand on the ulnar border of the hand here with second degree burns, being blisters. When she was cooking the Christmas turkey, she apparently had her fingers against the hot -- either the turkey or the pan and didn't feel it enough that it allowed her to burn the hand without noticing it. She had no feeling. She only smelled the odor, that something is burning, and she looked at it, which is a very common problem. People who have no nerve innervation, they can burn their fingers right off without even knowing it. And this is what she did. Fortunately, she smelled it and took her hand away so she didn't get a

third degree burn, because it can burn all the way through to the muscle or bone.

She still had some clawing. She could now cross her fingers, which was good news, the index over the middle finger, vice versa. The first dorsal interosseous, which is this important muscle here in the first web space, this was getting better. She had some increase! in the sensibility over the nerve on the back. But still she had no return to the sensation on the palm side, which is more important. She resigned as a coach because of her inability to use the right hand, and she was now on the full professional faculty at the university but she was not coaching her girl's volleyball team.

Q She had resigned you learned?

A Yes. And she was going to work on her Ph.D. And she was having trouble utilizing the computer. Now, that's a very real problem with people with ulnar nerve weakness or palsy, that she cannot use the ring and little fingers as accurately and as fast, because you cannot extend it out, and the little finger apparently is very important in using the keyboard. She could form a letter O, which is good. She could

extend the index finger against gravity, which means that there's some improvement, but she didn't have the same muscle bulk as she had on the opposite hand.

Q What does that indicate to you, Doctor?

A Well, these intrisic muscles that I showed have not come back to normal, and that may be permanent. You can't tell. But certainly they're not normal at that time, which is about a year out.

She could not spread her fingers, that means opening her fingers out, but she did not have paralysis of the third palmar interosseous, which is one of the muscles in the palm, which is very important. It would allow the little finger to sort of hang down if that's paralyzed. This is a very common complaint of people who have ulnar nerve palsy. They say they can't get the little finger into the side and it catches on their pockets and on their purses and things. But she could get it into the side of her hand, which is very good news.

And she had seen Dr. Lacey for another opinion. And let's see. Oh, at that time she had no Tinel's at the elbow, which meant she was

getting some better. I could not get one as I percussed around the elbow. MOW, she had had that the summer before but that had cleared up. At that time I asked about an EMG and nerve conduction test.

Q Okay. You make some reference, Doctor, to a tendon transfer to restore the little finger extension when you saw her in March of '94.

What are you talking about there, sir?

A Yes. If this continued to be paralyzed, if this little finger could not get out of her palm and the only way you could get it out of the palm would be with a splint, you can't wear it 365 days a year, there are tendon transfers that you can do to help extend the little finger. And also there's another operation we do in which we stabilize this joint by doing what we call a capsulodesis, or tenodesis, fixing of the capsule which locks the joint like this and then will allow the weakened muscles to then extend this joint so it gets out of the palm.

It's a very nice operation for someone who doesn't do heavy work. If she was going to, for instance, do basketball coaching again, it wouldn't be a good operation because she could

probably tear it loose. But someone who just wants to get the finger out of their palm and take care of it, so if you're doing attorney's work or you're doing school teaching or something light, that's a very nice operation. And it's done under general anesthetic and it takes, oh, about six months to get over it. The operation itself only takes about an hour, hour and a half, but the rehab and waiting for the capsule surgery to be perfect takes about six months. So it would be some nonsense to go through that.

Q All right. Dr. Mahigian, I would like to ask you a few opinions here, --

A Yes.

Q -- professional opinions. And I would like you to give them only to a reasonable degree of medical probability, if you would, please.

A Sure.

Q I would like you --

MR. GOLDWASSER: Just for the record, I'm going to object to any opinion questions. And I would like to just preserve that, Mike, so we don't have to interrupt all the time.

MR. MONTELEONE: Okay.

MS. VANCE: Join in the objection.

MR. GOLDWASSER: Could we have a continuing objection to opinion questions?

MR. MONTELEONE: You certainly may.

MR. GOLDWASSER: Okay.

MR. MONTELEONE: What's the basis for it, Gary?

MR. GOLDWASSER: I don't have a letter from the Doctor in which he authors any opinions.

MR. MONTELEONE: I don't have a letter either. You've got his medical records. You've got what I've got.

MR. GOLDWASSER: I just told you the basis of my objection.

MR. MONTELEONE: Qkay.

BY MR. MONTELEONE:

Q Dr. Nahigian.

A Yes.

Q Give us your professional opinion, to a reasonable degree of medical certainty or probability, whether Mary Motley's hand, her

right dominant hand, will ever be normal again, sir? Do you have an opinion?

A Yes. The exact amount of disability cannot be determined for at least another two, three years, how much deficit there's going to be. From a probable standpoint, it probably will not be normal again.

Q All right.

A But it could. But it probably will not.

Q Okay. Can you tell us what impact this injury to her hand has had on her career and her love for sports and athletics?

A Up to the present --

MR. GOLDWASSER: Now I'm going to object on a different basis.

THE WITNESS: Oh.

MR. GOLDWASSER: I just don't think the Doctor, as fine a physician as he is, is qualified to answer that particular question. So my objection is noted. And I'm going to ask the court to strike from it the jury's consideration. You may proceed.

MS. VANCE: Join in the objection.

A Now, you want to know it to the present time as

of March of '94?

Q Yes. In the two full years.

A As of March of '94, yes, she still had a weak right hand. She has still clawing of the fingers, which means the hand doesn't have the dexterity and the balance that you would need for any type of competitive athletics. She certainly could do any simple sports. I don't know, I didn't ask her about whether she could hold a tennis racquet now. It's a hampered hand. The intrisic muscles are the muscles that give balance to the hand, that allow you to do these complex motions with the joints. And the hand basically is clumsy, the muscle mass is not there. As I mentioned, a year from now it may be improved.

Q All right. Dr. Nahigian, will she continue to need to see you, a specialist in hand surgery, for the indefinite future?

A Well, I had scheduled for her to come back. As you know, she did not ccme back. I wanted to see her after she had these electrical tests, and she's still awaiting them, as I understand.

Q All right.

A And I do want to see her. Then I can give her

much more counsel if I see what the -- what we call and EMG and nerve conduction tests show.

By now, this is now going to be almost two years. Is it going to be two years? '92, '90 -- yes, it will be two years out. And you should be able to start seeing some earmarks of either recovery or irretrievable damage or some areas that are still in transition that are starting to heal, getting better by now. As I told you initially, it takes five years for a major nerve to recover. So she would be about halfway along by now.

Q Dr. Nahigian, can you please give us your professional opinion to a reasonable degree of medical probability, --

A Yes.

Q -- as to whether these injuries to her ulnar nerve and hand that you have described this afternoon are a direct result of the suture that was placed accidentally into her ulnar nerve on June 4, 1992 during the surgery that was performed by Drs. Anouchi and Fabian?

A Yes.

Q All right. In order to testify here this afternoon, Doctor, has it been necessary to take

some time away from your professional practice, sir?

A Yes.

Q And you expect to be compensated for your time?

A Yes.

Q All right.

MR. MONTELEONE: Dr. Nahigian, thank you for testifying or taking the time to testify on behalf of your patient. Perhaps one or both of these attorneys would Pike to ask you some questions now.

EXAMINATION OF STANLEY H. NAHIGIAN, M.D.

BY MR. GOLDWASSER:

Q Doctor.

A Yes.

Q I take it from the marked improvement that you have observed in March of '94 as compared to July of '92, that the nerve is, in fact, regenerating to some degree, is it not?

A Yes, it is.

Q And as you have been candid enough to tell us, you just do not know yet how much further this nerve will regenerate and improve as to function for this particular patient?

A You mean the end point, the exact end point?

Q That's correct.
A Yes, that's correct.
Q Now, Doctor, my impression is that the surgery you performed was, in fact, successful; is that correct?
A Yes.
Q It accomplished the purposes that you were intending to accomplish; am I correct?
A Yes, trying to -- you're waiting for the Lord to heal the rest of it, I just put it in the proper bed, yes.
Q Sure. You did all that you could do?
A That's all I could do.
Q And you did a darn good job of it, didn't you? Don't be modest. You did, didn't you?
A Well, ask her.
Q Well, she wouldn't know, and you would. And I think --
A Well, yes, she would,
MR. MONTELEONE: Well, --
A She would know. Ask her if she's better now than she was in June or July of '92.
Q Well, she told you she's better; isn't that true, sir?
A That's okay.

Q From your own records.
A All right.
Q Isn't that true?
A That's helps, yes.
Q Okay. Now, Doctor, you examined the nerve in question --
A Yes.
Q -- under the microscope, correct?
A 'Yes.
Q And you describe your findings on page 3 of your operative note?
A Yes.
Q I'm not sure I know how to pronounce the word,
A Go ahead.
Q It's fascicles?
A Fascicles, yes.
Q Oh, I did good on that. And what are fascicles?
A Those are the -- you know what a cable is. All right? The nerve is a cable in which it has wrapping. And then the cable has multiple small wires running through them within the cable itself. It's not a solid structure; it's a group of nerve fibers, or fascicles. Those are the -- those are the smallest bundles of nerves that you can see with the naked eye or with a

conventional microscope. So you're down to the very basic nerve conduits.

Now, the axon, which is the true -- the true nerve cell which sends the fibers into the hand, is so small you'd have to have special stains and a special microscope. An operating room microscope doesn't get any smaller than a fascicle. So the state of the art in nerve surgery is that that's the smallest we can go right now.

Q All right. Well, you talk about the fascicles?

A Yes.

Q And in some area it was in good condition and in another area, --

A Yes.

Q -- where the ligature had been, there were some wavy fascicles?

A Yes.

Q But the fascicles, in fact, were intact?

A Oh, yes.

Q That is, they were not severed?

A They were not severed, that's correct.

Q And, in fact, you state, "There appeared to be no damage to the fascicles themselves"? Isn't that what you say in your report?

A Can you tell me what --

Q Sure. About the middle of page 3, second paragraph, about the middle. "There appeared to be no damage to the fascicles themselves."

A Yes. That means they were not severed, no. That's correct.

Q And you talk about the fact that the circulation above the nerve appeared to be in good condition, correct?

A Yes. Correct.

Q So does this not imply to you, sir, as a hand surgeon, that, in fact, this nerve after your surgery has the ability, depending on whatever nature's way is going to have with this particular --

A Potential ability. Potential, yes.

Q -- this particular lady, it has the potential to heal?

A Yes, it does.

Q Doctor, you talked about the function of the ulnar nerve, in response to questions asked by Mr. Monteleone. And it's my understanding from the little bit I know of this subject, which I could assure you is relatively little, that it is primarily the little finger, or some people

call it the little pinky finger, --

A Yes. Yes.

Q -- and the ring finger, or the fourth finger, --

A Uh-huh.

Q -- which is primarily innervated by the ulnar nerve; is that correct?

A The sensation of it is.

Q The sensation?

A Yes.

Q That's right?

A Yes.

Q And, in fact, according to that wonderful book that you made reference to earlier, --

A Yes. Yes.

Q -- Dr. Netter demonstrated that the sensation really is on the outside portion of the --

A Yes.

Q -- third, fourth finger?

A The little finger side of it.

Q And the little finger, correct?

A The little finger side of the ring finger and the little finger itself.

Q Right. Right.

And as to the motor function, while it is true that the ulnar nerve does affect some of

the muscles that control them --

A Most of the muscles.

Q Most of the muscles.

Nonetheless, as is demonstrated in your March '94 visit, Mrs. Motley has made some significant improvement in that regard, has she not?

A Yes, sir. Yes.

Q Doctor, without making light of the fact that this, of course, significantly affects her hand function, isn't it true that in the normal course of day-to-day living that the two most important digits in the hand are the thumb and the first, or the forefinger, second finger?

A For precision. Not for grip. For power grip and for balance the little finger is actually more important than the -- most hand surgeons rank the fingers thumb, little finger, and then the other three are basically equal.

Q So for all fine motor function, like she could button her blouse, --

A Yes, that's not --

Q -- she could grab a paper?

A If the muscle balances com back, yes. The sensibility is not altered over the thumb and

the index and middle finger in her case, yes.

Q All right. Now, you have been kind enough to review some of your office records with Mr. Monteleone. And I don't want to belabor that.

But I have the impression that, as one looks at your office notes in chronological order, that, in fact, she starts making improvement gradually, slowly,

A Uh-huh.

Q For example, as you've indicated, she by February has full range of motion in the elbow?

A Yes.

Q And that I give you due credit for. Your surgery, in fact, was successful in that regard, correct, sir?

A Yes.

Q In fact, in February she was able to cross her fingers, according to your note, and then apparently in a later visit she had difficulty crossing her fingers?

A Uh-huh.

Q But by March of '94 she was able to cross her fingers in both directions?

A Yes.

Q Correct?

A Yes.
Q And as you've indicated, that's a very good sign?
A Oh, excellent sign.
Q Doctor, if we look at your office records, -- you could place them in front of you if you care to -- look at your August 27 sheet you have there. That's the one I'm going to make reference to here.
A Yes, I have it.
Q You have her instructed, according to the last line under August 27, to return to see you in three months?
A Yes.
Q And, in fact, it was about five or six months before she came back to see you; isn't that true?
A Yes. We sent her an appointment and we wondered what happened. This is -- I was just discussing it with --

THE WITNESS: Can I say your name? Monteleone.

Q Mr. Monteleone.

MR. MONTELEONE: Monteleone.

A Can I say that? Okay. I was discussing it with

him.

Q Sure, you can say it. I say it all the time.

A All right. I was discussing with Mr. Monteleone -- well, I didn't know if you want to do that.

Q No. That's fine.

A -- that I don't know if that was our system that broke down in the retrieval or whether this was indeed her fault. I can't tell. But anyway we picked it up that in three months she had not come back, so we sent her an appointment in November to come back here. Okay.

Q Of course, Doctor, there's nothing to prevent your patient from calling you.

A Well, sometimes we see -- yes, that's correct.

Q Isn't that true?

A Sometimes if we say "fail," that means they didn't show up. So I can't incriminate her one way or the other why she didn't come in.

Q Of course.

A Yes.

Q But, Doctor, if a patient of yours --

A Yes. Yes.

Q -- is having difficulty or is concerned about their progress, --

A Yes.
Q -- they could call you, right?
A Yes.
Q In fact, you probably encourage your patients to call you?
A Oh, I would. Absolutely, yes.
Q And if a patient calls you and is concerned about their level or comfort or function, you are ready, able and willing to see that patient promptly; isn't that true, sir?
A Oh, absolutely.

THE VIDEOGRAPHER: Excuse me, counsel. I need to go off the record.

(Off the record,)

BY MR. GOLDWASSER:

Q So, Doctor, the point is, nonetheless, it was about five or six months before she returned to see you again on March 1, 1994. And as I recall. your testimony that you shared with us just a few moments ago-, she seemed to have made some significant improvements; isn't that correct, Doctor?
A That's correct.
Q One, she could cross the fingers, right?
A Yes, sir.

Q She has some increase in the sensibility in the dorsal branch of the ulnar nerve, correct?
A Yes. Correct.
Q That's something that she wasn't experiencing before; isn't that true?
A That's correct.
Q The ring finger is now lying in a more extended attitude. That's an improvement, isn't it, Doctor?
A Yes, sir.
Q And she has excellent adductor power in the little finger. That's an improvement, isn't it?
A Yes.
Q And she can extend the index finger against gravity. That's an improvement, is it not?
A That it is.
Q And you also say, "Significantly, she does not have paralysis of the third palmar interosseous." And you explained that prevents the little finger from flying out on the hand?
A Yes.
Q And that again is pretty significant evidence to you, is it not, Doctor, that in the course of time, as you described it, sometimes taking as long as five years, that there is, in fact,

progressive improvement as to her ulnar nerve; isn't that true, sir?

A That's correct, sir.

Q You also indicate that there's no Tinel's elicited after the primary Tinel's at the elbow?

A Uh-huh.

Q That also is a sign of improvement, is it not?

A Yes.

Q So, Doctor, isn't it fair to state that when one observes the extent of the improvement that Ms. Motley has had between June -- I'm sorry, July of 1992 and March of '94, March 1, that with probability there will be some continued improvement, albeit you cannot tell us specifically to what extent?

A That's correct.

Q You have mentioned that Dr. Anouchi made arrangements for her first to see you, correct? Dr. Anouchi --

A You mean way back in '92?

Q Yes, way back.

A Yes. Yes.

Q Sure.

A Okay.

Q And that he also made arrangements within the

Kaiser Permanente system for you to, not only take care of her and be compensated for that, quite appropriately, but also for the appropriate therapist to become involved?

A Yes.

Q Correct?

A Correct.

Q And I assume it's fair to state that Dr. Anouchi clearly demonstrated to you that he was concerned about this patient's welfare?

A Oh, extremely so.

Q And he was very contrite and upset about the fact that a suture had inadvertently been placed through the epineurium of the ulnar nerve; isn't that true?

A Absolutely.

MR. GOLDWASSER: Doctor, that's all the questions I have. Ms. Vance may inquire if she cares to.

THE VIDEOGRAPHER: We're off record,

(Off the record.)

EXAMINATION OF STANLEY H. NAHIGIAN, M.D.

BY MS. VANCE:

Q Doctor, I just have a couple clarifying

questions, if I might, for you.

You told us that, when Miss Motley first came to see you back in July of 1992, that one of her most severe complaints was the exquisite elbow pain that she suffered; is that right?

A No, not purely. It was pain at the elbow. It was secondary to the nerve being tethered at the elbow. It was not like she had arthritis of the elbow or a fracture at the elbow or something. It emanated -- the pain emanated from the elbow.

Q And it severely restricted her ability to move her elbow?

A Oh, very much so.

Q And I think you indicated that that was, at least at that point, a very significant problem to her, the fact that she had such limited movement of that elbow?

A Yes. Yes.

Q As I understand it, then, since July of 1992 --

A Yes.

Q -- and following your surgery, through March of 1994, that particular problem with the elbow has entirely resolved?

A Yes. It's not a factor.

Q She now has the full range of motion of that

elbow and can move her elbow just as well on her right hand as she can on her left; is that right?

A Yes. It might be a few degrees off, but no measurable problem.

Q But what had been a very significant, very painful problem --

A Yes. Oh, yes.

Q -- has resolved?

A Yes, that has resolved.

Q And you indicated in the course of your notes that, within about a year or so following your surgery or a little bit less than that, she was back in her gym doing her gym work with her classes although was still having some problem with the setting of volley balls?

A No, she never really -- she managed to do it through her own courage. She was not at all, in her own estimation, back to what she was before June of '92, whatever, yes.

Q But she was back in the gym and was back --

A Yes.

Q -- trying to do her best --

A Trying to do it, yes.

Q -- to resume her daily activities as it relates

to her career?

A Yes. Yes.

Q You have indicated that, when you did last see her in March of this year, at that point you understood that she had taken a full-time faculty position at Cleveland State University?

A Yes.

Q And was then pursuing her work in Ph.D.?

A Yes, she was going on.

Q Obtaining a Ph.D. degree?

A Yes.

Q Okay. You have not seen her since March of 1994?

A No, ma'am.

Q I thought you indicated that you had expected to see her, though, since March of 1994?

A Oh, yes, we do. we discussed this before. I wanted to see her, absolutely.

Q Okay. And why is it that you want to see her again after March of 1994?

A She was to have an EMG and nerve conduction test, which is an electrical diagnostic test, to see -- which is very helpful in predicting what the eventual outcome of this nerve is going to be. She's now two years out. And I told her

she should have one to see -- for her own. I mean you don't have to. But I mean if she really wants a real solid opinion as to what her nerve is going to be like three to five years from now, she better have electrical tests, yes.

Q Have you discussed that with her?

A I did.

Q Did you make your recommendation to her that she have those tests?

A I did. I have an appointment, even a carbon copy of it. I don't know why she didn't have it.

Q Were arrangements made for her to actually undergo those testing at some facility?

A That I don't know. I mean she would have to have it through -- I don't know whether she'd have to go back through the Kaiser plan again, I think they would have to approve it. But I thought because of all the litigation business that I said her attorney? whoever would be looking after her, should have it approved. The Kaiser thing is very complex. Some things they let go through very quickly, sometimes they don't. And so I -- as a consultant I can't say, "You can have this test," "You should have that

test." Everything has to go back to their system and then they farm it back out again.

Q Understanding --

A But it was my feeling that she should have it. And if she had to pay for it herself and then get reimbursed later, I would suggest that. I mean this is her right hand and so she shouldn't let the insurance business stop it,

Q You would consider this to be an important set of tests for her to undergo?

A Oh, yes, absolutely.

Q You would find it important from your standpoint --

A Oh, yes! absolutely,

Q -- in being able to continue your care for her?

A Yes. Yes

Q And in able to come to some estimation as to what the future would hold for her --

A Yes.

Q -- in terms of her nerve injury?

A Yes.

Q Okay. Have you made any other recommendations to Miss Motley in terms of further treatment or further evaluation, other than getting this these particular tests?

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A Well, no. We would way wait for this, and then we would wait to see how the hand functioned over the next six to 12 months or 18 months and see if we have to do any further tendon work or capsule work, if she wants to have it done.

Q As I understand it, there are various surgical procedures or options that might well be available to Miss Motley after consultation and discussion --

A Sure.

Q -- that might significantly help some aspects of the strength and the motor ability and the functional ability of that right hand?

A Yes, if it comes to that.

Q Okay.

A If she still complains from it, I would not do any tendon surgery or any major reconstructive surgery for at least another year, year and a half.

Q The fact is or the only point I guess I wish to make --

A Sure.

Q -- is that there are options, there are surgical options, that may well be available to her in the future --

A Oh, yes. Oh, yes.

Q -- that could significantly improve her present situation?

A To improve her --

Q Could improve the function, improve the strength?

A Yes, assuming she never -- if you assume that she never improved beyond this point, yes. If she said, "Yes, I still have a claw hand; yes, I still have difficulty with pinching or grasping," there are. Yes, there are. But that would be -- I could not do anything to help her sensation.

Q But these are --

A Yes.

Q -- surgical opportunities that might well be available for her in the future?

A Yes. Yes.

Q Very good.

MS. VANCE: Thank you, Doctor. No further questions.

REEXAMINATION OF STANLEY H. NAHIGIAN, M.D.

BY MR. MONTELEONE:

Q Dr. Nahigian, just a couple more before we wind up here this evening.

A Sure.

Q Mr. Goldwasser pointed out very nicely what a fine job you did in the surgery.

No matter how good a job you did in surgery, you could not undo all the damage that had been done to that nerve when the suture was put through it, though, could you?

A No, sir.

Q No hand surgeon could do that, could they?

A NO.

Q And certainly, as both Dr. Anouchi and Dr. Fabian indicated already, they never intended, they didn't want to put this suture, or stitch, through this nerve, but it happened, and it's for this very reason that surgeons avoid this kind of thing, because damage to a nerve with a suture, or stitch, can be very severe for a patient, can't it?

A It sure can.

Q All right. These surgical options that Ms. Vance has brought up, Doctor, for Mary Motley, no matter what future surgery is done, either upon your recommendation, sir, with her agreement is any guarantee that her hand is ever going to be normal again, is it?

A No, not at all. It would be just to help it. No way could you restore it back to what the opposite side is.

Q All right, Doctor, The final thing is, would you just tell us, please, this three-page statement, which I will mark as Plaintiff's Exhibit Number 3, because the photographs are 1 and 2, just tell us, is that, in fact, a copy of your bill and services to date, charges for the services you rendered to Mary Motley?

A Yes. Some are mine and some are the therapist's and different things, yes.

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(Plaintiff's Deposition Exhibit No. 3 was marked for identification.)

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MR. MONTELEONE: Thank you very much, Doctor. That's all I have,

MR. GOLDWASSER: No further questions.

MS. VANCE: No.

THE VIDEOGRAPHER: Doctor, you have the right to view this videotape to approve its accuracy and you can also waive that right.

THE WITNESS: I waive it.

THE VIDEOGRAPHER: Will counsel waive filing requirements on this videotape?

MR. MONTELEONE: Yes. Vickie?

MS. VANCE: Yes, we'll waive the filing requirements.

MR. GOLDWASSER: What's that? Oh, sure, we'll waive all that, Mike. I will anyway.

MS. VANCE: Sure.

MR. MONTELEONE: You'll waive your signature won't you, Doctor?

THE WITNESS: Yes.

- - - - -

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THE STATE OF OHIO,)
COUNTY OF CUYAHOGA.) SS: CERTIFICATE

I, Charles A. Cady, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, Stanley H. Nahigian, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed on a computer/printer, 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, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 2ND day of June 1994.

Charles A. Cady

Charles A. Cady, Notary Public
within and for the State of Ohio
My Commission expires November 3, 1994.

STANLEY H. NAHIGIAN. MD.. INC.

BRAINARD PUCE

29001 CEDAR ROAD

SUITE #519

CLEVELAND. OHIO 44124

TELEPHONE 473-3434 (AREA CODE 216)

STANLEY H. NAHIGIAN. M.D.

ORTHOPAEDIC SURGERY

SURGERY OF THE HAND

May 4, 1988

DOC. 330

Samuel R. Martillotta
Mansour, Gavin, Gerlack & Manos Co., L.P.A.
2150 Illuminating Building
Cleveland, Ohio 44113-1994

[redacted]

Dear Mr. Martillotta:

This is in response to your correspondence of April 20, 1988, regarding [redacted] whom we examined in considerable detail on April 26, 1988, at your request because of a longstanding problem with her left hand.

You kindly forwarded a copious amount of materials, including past operative notes, past hospital admissions, etc., etc., which we reviewed in considerable detail. This is not the usual simple review and the records although were numerous, still had one or two items which I think would have been helpful.

1. The original findings of the carpal tunnel release done at the Lutheran Hospital in 1982.
2. The path detail as to what the median nerve neuroma showed and the surgery of October of 1985, by Dr. Keith and associates, in which they resected the nerve and this would help to see if indeed the nerve had been separated within the past three or fourth months as implied by her history.

I was able to piece together a good bit of helpful information, which we gleaned by the various charts and previous records, and a very good history which she gave to us along with the examination of April 26, 1988. At that time, she was very co-operative, was not particularly uncomfortable, and I was surprised to see the relatively good appearance and function of her hand, despite the rather complicated and extensive history, in which she had had so much surgery directed to this left upper extremity. She has as many complaints referable to the right ankle and foot as she did to the hand. This was the site of the harvesting of a sural nerve graft.

Without going through the past history in too much detail, I will try to put this in a perspective that will help you in preparing your case.

1. I feel that the fall on the outstretched hand on November 24, 1984, in which she complained of severe pain in the left wrist was a genuine injury of a symptomatic sort. This was a previously injured nerve with two large neuromas confirmed by two competent explorations at Metropolitan General Hospital and review of the history, there was known damage to the nerve and I feel that she landed on the nerve on a direct blow manner, causing excruciating pain.

   I do not feel that the nerve was separated with that type of impact. The neuroma was well established, fibrous and if there were adhesions about the nerve

[redacted]

trapping it, the nerve would have been torn asunder and it would have been obvious with the exploration at the time of the carpal tunnel exploration on September 17, 1985 and again at the time the nerve graft was done on October 15, 1985. Neither 'operative note mentions that the nerve had been separated or "strung out" as if it had been torn apart. From the mechanism of the fall, with no fracture and no significant tendon damage, I feel this was merely a compression type crush to the already damaged nerve which could give a horrendus amount of pain, but would not cause any mechanical damage.

2. I feel that the neuroma surgery done by Dr. Keith and his assistants on October 15, 1985, was directed making her more comfortable and resecting a rather large neuroma, which caused her incapacitating discomfort. She had a past history, as I read through, that there was indeed multiple episodes of incapacitating hand pain mentioned on prior hospitalizations and limited to the median nerve distribution that were a sequelae to the original trauma several years ago, in which she had caused self-inflicted lacerations to the flexor aspect of the wrist, the earliest that we can substantiate it was dated on or about June 26, 1961. She had no exploration of the wrists at that time but there was evidence of nerve damage clinically. Fortunately, because of an anomalous arrangement with her musculature, the thenar muscles remained quite good, the thumb fairly functional from a motor aspect because of cross-over innervation from the ulnar nerve. This was substantiated by electrical stimulation studies at the time of her exploration surgery on October 15, 1985, at Cleveland Metropolitan General Hospital.

3. In reviewing the extensive court deposition material given by Dr. Keith on March 30, 1988, that the primary reason for the exploration was that this woman was not responding to the usual treatment that will help neuroma pain and it was felt that a resection of this neuroma with an insertion of a nerve graft, would be helpful in helping her discomfort. In no way can a nerve graft done at this time, twenty-five years after the nerve has been damaged, do any good for a functional return. This was just to help the comfort, take the tension off the nerve and allow her to function with essentially complete absence of the median nerve sensibility pattern. There was another neuroma proximal to this, which was not resected at the best I can tell from the records. If there is something on the pathologist report, that indeed shows two neuromas, I would have to change my report. From a clinical standpoint, I was able to elicit a Tinel's sign proximal to the major surgery done at the wrist, indicating there is a neuroma several centimeters proximal to the wrist crease, which indeed was seen on the exploration of September 17, 1985.

4. From a functional standpoint, the median nerve is useless. There is no 2 point sensibility over the median nerve distribution within the functional range, neither moving or static 2 point sensibility. There is even an absent pseudomotor function, which may or may not come back in the next few years, confirming the distribution pattern. The radial nerve sensation is normal. As I mentioned above, the thenar musculature is normal because of her cross-over innervation so she has good circumduction of the thumb. All of her wounds are well healed, there is no entrapment of the median nerve now in the surgical scars.

[redacted]

5. There are substantial complaints in her right foot, secondarv to the excision of the sural nerve. This is a common sequelae from harvesting a nerve graft, particularly if someone has the temperament of [redacted] in which she has extremely sensitive'hands and feet and has a problem coping with the area of anesthesia and wound tenderness, which are needed when a graft is harvested in the distal right leg and ankle. The distribution of the decreased sensation and the tenderness is all compatible with the surgery described and there is no extenuating circumstance or unusual circumstance in her complaints or the patterns of pain that she complains about in the right ankle and foot.

6. I would reiterate that this hand was not normal at the time of her fall on November 24, 1984. This was a symptomatic hand, in which she was able to deal with, but there was no significant new lesion caused by this fall on the out-stretched left wrist. The patient stated in her history that she had the typical night pain distribution of her carpal tunnel syndrome, six months prior to her first surgery in 1982 and stated that she was relatively comfortable after it, until her 1984 fall, but there are complaints and hospital diagnoses, in which she indeed was having considerable pain over her left hand, compatible with only median nerve findings. It was noted by the operators in 1985, that the nerve release had been done, but they felt it was not complete and there indeed may have still been some entrapment of the median nerve within the carpal tunnel because of the extensive amount of scar present over the years. This would be expected in this case that it had previous glass lacerations and is not the typical virgin case of carpal tunnel syndrome, in which a simple division of the transverse volar carpal ligament gives permanent and complete relief if there is no damage to the nerve. Once there has been nerve damage, even when the carpal tunnel is decompressed, the patient will still have radiating pain, especially if the nerve was incompletely severed and there is a burning or causalgia type pain which I think she had from time to time according to the records I reviewed.

7. When she presented on April 26, 1988, she was well dressed, well groomed, had nail polish on both hands and stated she was now a housewife. She has had two marriages and has been divorced twice. She does not work. She has difficulty using small objects with the hand such as putting on necklaces, but can feed herself, drive a car, but: needs help from her family when doing heavy work in the yard, shoveling snow and has some cramps in the hand and foot over the nerve distribution. She definitely has cold intolerance over the pattern of nerve loss, both in the left hand and the right foot which is expected with a nerve lesion. She wears no special appliances or protective devices over either hand or foot. She has lost all of the acute sensitivity in the median nerve distribution in the left hand and she cannot use this to reach into her purse and look for small objects because of the loss of sensation, she isright-handed and is able to do most of the fine activities needed in the median nerve area, by using her dominant right hand. Her grip strength is decreased approximately 50%on the left compared to the right. Her key pinch, power pinch and chuck pinch are all decreased by 50%, which would be anticipated. She has no significant wrist deficit as far as her motion goes and is only a few degrees off on the flexion/extension arc, which is not significant on this non-dominant wrist. She states at this time she is now able to distinguish hot and cold with protective sensation over the median distribution in the left hand, which

was not present before the nerve graft. She has no fine tactilignosis and will never achieve this in the future.

In summary, I feel that she had:

1. A prior injury to the nerve, well substantiated.
2. A fall on the outstretched wrist on November 24, 1984, caused only a severely painful injury with a crush to the nerve already compromised and the patient could not cope with this for one reason or another, who has had adequate exploration of the nerve, adequate decompression and now a nerve graft to help decompress the neuroma. The nerve graft is done for comfort sake only and will never restore the normal 2 point sensibility needed in the median nerve distribution.
3. She has cross-over sensation from the ulnar nerve, which has preserved her thenar musculature throughout these many years, despite clear-cut damage to the nerve, the thumb moves well and there is no atrophy of the thenar muscles, which would be anticipated. At the present time, the hand moves well, there is no causalgia type pain. She has the Tinel's sign, which indicates irritability over the nerve, which would be anticipated and cold intolerance would be anticipated and it is encouraging that she does have some heat and cold or protective sensation over the median nerve distribution, in which she didn't have before.
4. The complaints referable to the right foot and ankle are all secondary to the harvesting of the graft and her complaints are appropriate in this area.

This is a very complicated problem. I hope this will be helpful in your case preparation. If you do find any new material that could be of more definitive use, I would appreciate discussing it with you. If you need further information, please feel free to contact me. Thanks again for having me see [redacted]

Sincerely,

Stanley H. Nahigian M.D.

Stanley H. Nahigian, M.D.

SHN/bi