IN THE COURT OF COMMON PLEAS

SUMMIT COUNTY, OHIO

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Doc. I33

KATHLEEN LAVERICK, etc.,)
)
Plaintiff,)
)
vs.) CASE NO. 85-3-0860
)
CHILDREN'S HOSPITAL MEDICAL CENTER OF AKRON, et al.,)
)
Defendants.)

- - -

Deposition of HOWARD S. NEARMAN, **M.D.,** a Witness herein, called by the Plaintiff for cross-examination pursuant to the Rules of Civil Procedure, taken before me, the undersigned, William S. Bish, an RPR/CM and Notary Public in and for the State of Ohio, at University Hospital, Suite 2400, 2074 Abington Road, Cleveland, Ohio, on Wednesday, the 17th day of December, 1986, at 1:00 o'clock p.m.

COMPUTERIZED TRANSCRIPTION BY
BISH & ASSOCIATES, INC.
524 Society Building
Akron, Ohio 44308
(216) 762-0031

APPEARANCES :

On Behalf of the Plaintiff:

Messrs. Tomberg & Tomberg, P.A.

By: Jeff Tomberg, Attorney at Law
and
Thomas L. Spall, Attorney at Law
P.O. Drawer EE
626 S.E. 4th Street
Boynton Beach, Florida 33435

On Behalf of the Defendant Anesthia for Children, Inc.:

Messrs. Jacobson, Maynard, Tuschman & Kalur

By: Thomas H. Terry, Attorney at Law
and
Jerome Kalur, Attorney at Law
100 Erieview Plaza
Fourteenth Floor
Cleveland, Ohio 44114

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HOWARD S. NEARMAN, M.D.

of lawful age, a Witness herein, having beer, first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. TOMBERG:

Q. State your full. legal name and your professional address.

A. Howard Sloman Nearman, 2074 Abington Road, University Hospitals of Cleveland, Department of Anesthesiology, Cleveland, Ohio 44106.

Q. Dr. Nearman, my name is Jeff Tomberg and I represent Kathy Laverick as the personal representative or Administrator of the Estate of Clarissa Laverick, deceased. I'm going to ask you some questions today concerning the care and treatment received by Clarissa Laverick at Children's Hospital Medical Center of Akron during March and April of 1984. The purpose of these questions is not to trick you or confuse you but to find out what information that you have and what information that you're going to render as far as testimony is concerned in this case.

If you do not understand a question I would ask you to tell me EO, because if you answer the question I'm going to assume that you understood the

question. If you want a question repeated, Mr. Bish, the Court Reporter, will be happy to read it back to you.

Also I'd ask that you answer all questions audibly with verbal responses as opposed to "uh-huh" or "huh-uhs" because we have a disagreement sometimes with what the machine takes down. Is that okay?

A. Yes.

Q. Okay. Can you give me your date of birth, sir?

A. December 3rd, 1948.

Q. And what type of profession are you in?

A. I am an anesthesiologist.

Q. Okay. And where are you licensed?

A. In the State of Ohio.

Q. Okay. Is this your curriculum vitae?

A. Yes, it is.

MR. TOMBERG: Okay. Any objection if we attach it to the record for purposes of trial or discovery?

MR. TERRY: None.

BY MR. TOMBERG:

Q. Are you a Board certified anesthesiologist?

A. Yes, I am.

Q. And how long have you been Board certified?

September -- no, sorry, excuse me. I think

it was October of 1983.

Q. And Doctor, what is the sig- --

A. I'm also -- excuse me.

Q. Okay.

A. It's not on my CV, not yet updated, but I also have just passed the Boards for special certification in critical care, September, '86.

Q. Okay. And what is critical care?

A. Critical care -- good question. Critical care is the -- is the field of medicine that is a multi-disciplinary specialty that each of the general specialties, that is, surgery, medicine, anesthesia and pediatrics have now come to recognize as a specialized branch within their own field, and are now in the process of licensing people who have special expertise and training in critical care, the care of the critically ill patient.

Q. Is that the area of anesthesiology that you specialize in, or is a sub-specialty of anesthesiology that you are participating in?

A. Yes.

Q. Okay. And what do you as an anesthesiologist have to do with critical care patients?

A. I am the Medical Director of the Surgical Intensive Care Unit at University Hospitals.

Q. Okay. And do you take care of all persons that have surgical problems?

A. I take care of all patients, I help to take care of all the patients in the Surgical Intensive Care Unit.

Q. Okay. And what qualifies someone as a Surgical Intensive Care patient?

A. Patients who are -- who need specialized monitoring that are not -- that is not available in a regular nursing floor. For instance, patients who have come from the operating room after having coronary artery by-pass surgery or major abdominal surgery, thoracic surgery, trauma patients, transplant patients who are in the -- who are in an unstable phase. Any patient, even after minor surgery, who may have had a complication in the operating room or have had bad heart disease before the operation, so we take care of people who are both -- who are both sick and need specialized monitoring as well as prophylaxis for making sure that people don't get into trouble immediately after their operation.

Q. What were the requirements for certification in the critical care area?

A. In -- excuse me, in anesthesia requirements were a specialized year of training after the anesthesia residency and/or having spent at least 50 percent of your

time taking care of critical care patients for two years after your training of anesthesia. I have done both.

Q. Okay.

A. As well as a test.

Q. That's a written and oral exam?

A. Just written. For the Anesthesia Boards it's written and oral. For the special certification in critical care it is written only.

Q. How much of your time is spent in Surgical Intensive Care?

A. Most of it.

Q. Okay. Is that involving maintaining people on life support systems?

A. Correct.

Q. Okay. Do -- are you actually involved in the surgical procedure or process itself?

A. Not usually.

Q. Although you've had specialized training in that particular field as an anesthesiologist?

A. Correct.

Q. Has most of your professional time, even with the anesthesiology background, been in the area of critical care?

A. Professional time meaning training --

Q. Professional time --

A. -- or since training?

Q. Well, after you received your basic training and residency, and I believe you said you went through an anesthesiology residency?

A. Correct.

Q. After that period of time you've been primarily involved in the critical care area?

A. Correct.

Q. Have you performed anesthesiology services for tonsillectomies and adenoidectomies?

A. Yes, I have.

Q. Can you tell us approximately how many?

A. I would have to think. Probably in the area of 50, 60.

Q. And that would be over the period of how many years, sir?

A. Since -- since 1979, so it would be about

Q. Last four years?

A. No.

Q. So these 50 or 60 anesthesiology cases that

you handled as an anesthesiologist would have been during your residency and internship?

A. It -- yes, some after, but not many.

Q. Can you give any of the -- does this take into consideration all of your professional education in the area --

A. Yes.

Q. -- of medicine?

A. Yes, it does.

Q. Okay. Have you attended any type of seminars or specialty classes that have been provided by other institutions?

A. I go to national meetings, I end up usually giving seminars to other institutions.

Q. Okay. And that's in the area of critical care?

A. It's in all areas, anesthesia, critical care.

Q. What areas of anesthesia would you handle?

A. As -- as far as --

Q. As far as --

Q. -- lectures?

A. I've talked about anesthesia for the geriatric patient, I've talked about blood replacement,

fluid therapy in the operating room. I don't recall off the bat anything -- any of the other anesthesia related ones.

Q. Any anesthesia cases involving pediatrics?

A. No.

Q. Any post-graduate studies in the area of anesthesia and pediatrics?

A. No.

Q. By whom are you employed, sir?

A. I'm employed by University Anesthesiologists, Incorporated.

Q. Okay. And that's at University Hospitals in Cleveland?

A. Correct.

Q. Okay. Are you associated with any particular school --

A. Yes.

Q. -- or university?

A. Yes.

Q. Which?

A. I'm with Case-Western Reserve University School of Medicine.

Q. And in what capacity?

A. I'm Assistant Professor of Anesthesia and Assistant Professor of Surgery.

Q. And what type of courses, if any, do you teach?

A. I teach first year medical students, the pre-clerkship patient based program once a week.

Q. It's a what?

A. The pre-clerkship patient based program.

Q. What is that?

A. That -- that is a program that introduces first year students to clinical training, the types of things that one sees when one gets out of the book phase into the ward phase, how to interview patients, how to interact with patients, the basic essentials of patient interviewing, history taking.

We talk about things like the types of cycle, life cycles that patients go through, anywhere from birth through what happens with illnesses, catastrophic illnesses, how does it feel to be a patient who is on a dialysis machine. I give -- I give a lecture that's -- that is a small group preceptor where one person gives the lecture about various and sundry things like we talked about, sexuality, patient/doctor relationships. These -- are you starting to get the gist?

Q. Okay. Is this a short course type of thing?

A. This is a course that goes through the

entire -- that goes through the eight months of the first year medical students, and I'm a small group preceptor. After the one hour lecture we generally break into small groups with the physician preceptor and talk about that kinds of things. I also teach to the whole group, to the whole first year students one hour during the year, I give them a lecture on death and dying.

I -- I have other medical students, first year medical students who come for one day a week at various -- throughout various six week periods of the year to see what kinds of things go on in a Surgical Intensive Care Unit. That's called a medical apprenticeship program.

I give two lectures every -- every six weeks -- every eight weeks for the surgical students, third year surgical students who come through the unit. I also give six or eight lectures to the anesthesia residents and students. I have a fourth year medical student who rotates through the Surgical Intensive Care Unit twelve months out of the year.

Q. And you're responsible for all of these students?

A. Correct.

Q. Do you teach the basic principles and the application of anesthesia and anesthesia equipment?

A. Among other things.
Q. Okay. Is that --
A. Not so much equipment, but a -- but a lot of the basic principles of anesthesia.
Q. Do you supervise students in the administration of anesthesia?
A. No, I don't.
Q. Do you supervise anyone in the administration of anesthesia except for the situations in which you yourself are personally involved? I believe you indicated that --
A. I'm -- I -- please repeat that.
Q. Okay. In the -- in the Surgical Intensive Care Unit you indicated that you take care of patients who are on ventilators --
A. Correct.
Q. -- and other types of equipment.
A. Correct.
Q. Other than your professionally being responsible for their care, do you supervise students in that area?
A. If you are asking are there students in that area who help -- who I supervise taking care of patients, the answer is yes.
Q. Okay.

A. If you're asking do I supervise students in the operating room, in doing anesthesia, no. I have supervised residents in the operating room.

Q. Do you currently?

A. Do I currently? Not in the last six months.

Q. Have you been involved in any type of research in the area of anesthesia as it pertains to the use of Forane in tonsillectomies or adenoidectomies?

A. No, I have not.

Q. Have you been involved in any type of research in that area at all?

A. No.

Q. Are you a member of any committee, member, organization that's involved in the research of those areas?

MR. KALUR: "Those areas" meaning Forane?

BY MR. TOMBERG:

Q. Pediatric care in Forane tonsillectomies, adenoidectomies, this type of -- that type of area.

A. I'm not sure I understand what the definition of a committee is that's involved --

Q. Are you involved with any group that reviews the procedures, that investigates the use of anesthesias or the appropriate use of anesthesia agents, anything in that area related to tonsillectomies and adenoidectomies?

A. No, I don't believe so.

Q. Are you familiar with the anesthetic Forane?

A. Yes, I am.

Q. Do you use Forane in anesthesia cases?

A. I have in the past. Again, not in the last six months.

Q. Okay. Are you familiar with the book Pharmacological Basis of Therapeutics, Fourth Edition, by Goodman and Gillman?

A. Goodman and Gillman, yes.

Q. Is that the standard basic book that is taught in medical schools?

A. That is one of the pharmacological books that is used quite frequently, yes.

Q. Okay. And do you consider it to be authoritative?

A. What do you mean by authoritative?

Q. I mean is it basically a good standard reference book to use for medical?

A. It basically is a good standard reference book, yes.

Q. That's true about all basic standard reference hooks, is that as medicine changes they may not be as updated in some areas?

A. That is correct.

Q. Okay. Are there any journals or professional magazines that you receive on a regular basis in your area of expertise?

A. *Yes.*

Q. Which ones are they?

A. I receive Anesthesiology, Anesthesia and Analgesia, Critical Care Medicine, and Journal of Parenteral and Enteral Nutrition, Journal of Clinical ~~Monit~~oring and one or two more that I can't remember the official titles of, so I'll not -- so I'll not discuss them.

Q. Do you read these particular publications on a regular basis?

A. I -- I don't read every one of them cover to cover every month, but I do scan them to try to glean the information that I feel is useful to me.

Q. Okay. So those articles that are particular or pertaining to your field you would review, and those that aren't you wouldn't review but just scan?

A. Glance at them, yes.

Q. Do you rely upon the information from those journals?

A. *Yes,* I do.

Q. Does that keep you up-to-date in the medical practice?

A. Yes, it helps.
Q. Okay. Do you know Mr. Kalur?
A. Yes, I do.
Q. How long have you known Mr. Kalur?
A. Oh, I guess for about a year.
Q. Did Mr. Kalur contact you concerning this case?
A. Mr. Terry contacted me concerning this case.
Q. He works with Mr. Kalur?
A. He works with Mr. Kalur, that's what he tells me.
Q. And when did he contact you concerning this case?
A. Do you mind if I look at my -- sometime -- sometime in probably October or November of this year.
Q. Did he contact you by telephone or in writing?
A. I don't remember what the initial was. I think -- I think by telephone initially.
Q. And can you tell me what materials he provided you?
A. If I may?
Q. Certainly.
A. All right. To the best of my recollection he provided me with some of the records of the chart, the

depositions of Dr. Lee and Dr. Milo initially, and more recently some other pieces parts of the chart, depositions of Nurse Lewis, Nurse Fiehn, an affidavit of Dr. Breitenbach as well as his deposition, and today the deposition of -- which I haven't had a chance to review either Dr. Breitenbach's deposition or Dr. Morris' deposition.

Q. Okay. You received both of those?

A. I received both of those.

Q. Okay. Which of those depositions have you reviewed?

A. I reviewed all of the above mentioned material except for the depositions of Dr. Breitenbach and the deposition of Dr. Morris, which I did not get until the last 24, 48 hours.

Q. Okay, Did you do any medical research associated with this particular case?

A. No research per se. I discussed some points of this with some of my colleagues.

Q. What parts or portions did you discuss with your colleagues?

A. Portions of it for opinions of appropriate tube size for patients, the types of procedures and type of standard procedure that goes on during, you know, what are we doing now currently in the ear, nose and throat

room as far as airway control, anesthesia management, things like that.

Q. So because you're not familiar with those particulars --

A. Well, it's because I haven't done them for about three -- for about four years or so, and I wanted to make sure that things were still doing the same type of things as when I was in there doing it on a regular basis.

Q. Did you find out that they were doing it the same way?

A. Nothing much had changed.

Q. Did you do any other research in associated with -- in association with your review of these records

A. No, I did not.

Q. Were you asked to assume any facts by Mr. Terry or Mr. Kalur, assume any facts, any factual situation, any --

A. No.

Q. Did they ask you to do anything in particular other than review these records?

A. Not -- no, I'm not sure I understand what you mean.

Q. Okay. Well, I understand that you're going to testify that you have certain opinions as to the

appropriateness of the care and treatment rendered to Clarissa Laverick in this case.

A. Correct.

Q. What were you asked to do as it pertains to the care and treatment of Clarissa Laverick in reviewing them?

A. Just to look at the records and render an opinion.

Q. Okay. And what parameters were you to use for rendering your opinion?

A. To -- to ascertain whether or not Dr. Milo had -- had used the standard practice of care with respect to the anesthetic involvement within the case -- in the care of this young girl.

Q. Okay. Can you tell us what your opinion of the history was of this little girl?

A. The history?

Q. Her history.

A. As I recall she had chronic recurrent tonsillar infections, and she had been seen -- referred to the -- the clinic that the ear, nose and throat people, Dr. Milo had -- was involved in at Akron, at which time she was scheduled to have the tonsillectomy/adenoidectomy. I don't remember there being any other significant portions of the history, I hadn't seen any

other medical problems.

Q. Was there a physical exam done, to your knowledge?

A. I would have to go back and look at the record.

Q. Okay. Would you expect there to be some type of physical exam done before the -- before induction of any type of anesthesia?

A. By?

Q. Anyone, by any medical doctor.

A. I would -- I would expect that she would have been seen by an anesthesiologist to -- before anesthesia would proceed, yes.

Q. And you would expect him to perform some type of physical examination?

MR. TERRY: Objection. What "him" are we talking about? Are you talking about the anesthesiologist, are you talking about the ENT, who?

BY MR. TOMBERC:

Q. I believe the question was would he expect somebody to make a physical examination. He testified that ,he expected an anesthesiologist to. Would he expect that anesthesiologist to do a physical examination?

A. I would think a limited physical examination, yes. I would expect a history would be more

important at this particular junction, but --

Q. Okay.

A. -- I would expect that person to at least to listen to the lungs and listen to the chest, yes.

Q. Okay. Why would an anesthesiologist do some limited type of physical examination?

MR. TERRY: Objection. This -- Dr. Milo is the subject of this deposition. Dr. Nearman has an opinion regarding the care rendered by Dr. Milo. Rule 26 you can get to the opinion, you can get to the basis of the opinion. We have already admitted negligence and proximate cause as far as the anesthesiologists are concerned. If you want to get to what his opinion is and what the basis is, fine. If not we can pack it up and go home.

MR. TOMBERG:: Well, I think I'm entitled to ask him the questions that -- step by step.

MR. TERRY: You're entitled under Rule 26 in this State to ask him what his opinion is and what the basis of the opinion is. We are not going to go into the anesthesia. We have already admitted everything we need to admit with the exception of the amount of damages, which is where the disagreement is here. If you want to get on to Milo, fine. If not, that's it.

BY MR. TOMBERG:

Q. Doctor, did you render an opinion in this case?

A. Yes, I have.

Q. Okay. Did you render that opinion in writing?

A. No, I have not.

Q. Okay. And as it pertains to the care and treatment rendered by Dr. Milo, what is your opinion?

A. As pertains to the care and treatment rendered by Dr. Milo, in general I'm not an ear, nose and throat surgeon so I am not going to comment on that, but as far as his conduct and interaction with the anesthetic management of the case I have rendered an opinion that he -- his care was within the standards of care.

Q. Does your opinion encompass the issue of whether or not Dr. Milo participated in the anesthesia management?

A. I'm --

Q. Did he participate in the administration of anesthesia?

A. Did he participate in the administration of anesthesia? No, he did not.

Q. And that is -- that is one of the facts that you assumed in this case?

A. Yes, that is one of the facts I -- that is

one of the facts that I assumed from reading the record.

MR. TOMBERG: Can we have the anesthesia record marked as Plaintiff's Exhibit 1 for purposes of this deposition.

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

MR. KALUR: I believe the Doctor has a copy of it.

BY MR. TOMBERG:

Q. All right. Doctor, is that a copy of the anesthesia record that you reviewed? For some reason the little criss-cross lines aren't there, but --

A. The time lines aren't there, yes. Yes, it is.

Q. Okay. And you reviewed, as I understand it, Dr. Milo's deposition?

A. Yes, I did.

Q. And you reviewed Dr. Lee's deposition?

A. Yes, 1 did.

Q. To your knowledge was Dr. Lee present during the administration of anesthesia?

A. At what point, the entire time?

Q. At any time.

A. Um-m.

Q. Up and to the point in time where the code was -- or he was summoned or there was a code of some nature when he was summoned.

A. I don't remember whether or not he was -- I know he was not in the room at the time of the question of the code. I don't recall specifically whether he was in the room at the time of the induction or not. 1 would have to go back and look at that.

Q. Would that be a significant fact?

A. With regards to the behavior of Dr. Milo?

Q. Yes.

A. No, I don't think so.

Q. Okay. Do you know who would have been administering the anesthesia in the absence of Dr. Lee?

A. As I understand it there was a nurse anesthetist and a nurse anesthetist student in the room.

Q. Okay. Do you know whether or not during the period of time involved concerning Dr. Milo's -- well, strike that, let me ask it this way.

Did your review of the record indicate whether or not Dr. Milo extubated the patient at any time and reintubated the patient?

A. Yes.

Q. Do you recall the number of times that that occurred?

A. He extubated and reintubated twice.

Q. All right. Does your review of the record indicate whether or not Dr. Lee was present during those extubations or intubations?

A. I don't recall him being there during that -- during those two.

Q. Do you recall the name of the nurse anesthetist?

A. The student?

Q. No, the --

A. The nurse anesthetist?

Q. The certified --

A. No, I don't recall. I think it was a gentleman. I don't recall his name right offhand.

Q. Okay. If you take it for granted that his name was Mr. Sturniolo, does your recollection of reviewing the record indicate whether or not he was present during the extubation/intubations by Dr. Milo?

A. I don't believe he was.

Q. And it's my understanding of your review of the record that Dr. Milo did the actual extubations and re-intubations?

A. That's correct, yes.

Q. Would you agree with me, sir, that Dr. Milo was the only physician in the operating room at the time

the extubations and intubations were done?

A. Yes, that's correct, to my understanding.

Q. Okay. And in that time the anesthesia was being handled by the student nurse anesthetist?

A. That's my understanding, yes.

Q. And would you agree that Dr. Milo's testimony indicated that he noticed an air leak with a highly objectionable odor of Forane?

MR. TERRY: Objection. You're entitled to ask him his opinion and the basis of the opinion. This isn't cross-examination. If you want to ask him what the basis of his opinion is, fine. If you want to cross-examine him you can do that in Akron in a few weeks,

MR. TOMBERG: I was just wondering if you'd let me go ahead and establish the facts from which he based his opinion on.

MR. TERRY: Why don't you let him establish the facta that he based his opinion on, because he's the one who's got the opinion, not you.

BY MR. TOMBERG:

Q. Doctor, what --

A. Could you please restate the question, reread the question for me?

Q. Okay. I was just asking if --

MR. TERRY: No, he's going to put a new question.

BY MR. TOMBERG:

Q. -- if you could tell me what facts you based your opinion on.

A. My opinion as to Dr. Milo's --

Q. Dr. Milo, yes.

A. -- care? From my review of Dr. Milo's deposition and Dr. Lee's deposition, Nurse Lewis' deposition, Nurse Fiehn's deposition and the records.

Q. What facts did you -- what facts did you adduce that lead you to this opinion to conclude that Dr. Milo did nothing wrong?

A. Because I don't think that Dr. Milo, from my reviewing the records, was responsible for the anesthesia care for this patient.

Q. And what factors or facts did you take into that consideration?

A. Because there was a nurse anesthetist there, or a nurse anesthetist student who was being supervised or should have been supervised by a nurse anesthetist, who was being or should have been supervised by an anesthesiologist.

Q. And in the absence of the supervision by the anesthesiologist and the certified nurse anesthetist of

the student who was left to supervise the student nurse?

A. The anesthesiologist and the nurse anesthetist should have been supervising the nurse anesthetist student.

Q. Okay. We agree with that.

A. Yeah, yeah.

Q. And they didn't, we agree with that?

A. I -- I agree with -- they did not supervise her closely enough, obviously.

Q. And in their absence in the operating room are you saying that you don't believe that it's the responsibility of the surgeon to supervise?

A. No, I don't.

Q. Okay. And you're familiar with Dr. Milo's description of the odor of Forane?

A. Yes.

Q. Okay. Were you also familiar with the fact that Nurse Lewis became acutely ill?

A. Yes.

MR. TERRY: Objection to that characterization. She became nauseous and left the room.

THE WITNESS: I'm familiar with the fact -- with the fact that she became nauseous and left the room.

BY MR. TOMBERG:

Q. Are you familiar with Section 4731.35 concerning the rights of a nurse anesthetist to practice in Ohio?

A. No, I'm --

MR. TERRY: Objection. Unlike your witnesses, mine are doctors, not lawyers. That asks for legal information and conclusions which he is not prepared to give, and I'm not going to let him answer the question even if he was familiar with it. This is a medical issue, not a legal issue. The Judge will decide what the law is and how it applies, not Dr. Nearman and not Dr. Morris and not Dr. Lauren Breitenbach.

BY MR. TOMBERG:

Q. You're not familiar with that statute, sir?

A. No, I'm not.

MR. TERRY: Do not answer that.

BY MR. TOMBERG:

Q. How many times have you reviewed cases for either Mr. Kalur's firm or Mr. Terry?

A. This is the second one that I've -- that I've given a deposition at.

Q. Okay. How many cases have you reviewed?

A. I have another -- I have another two cases that I have reviewed or are reviewing.

Q. Okay. And in each of those cases are you

reviewing them on behalf of the doctor who is being sued?

A. That's correct.

Q. Okay. Approximately how many cases have you reviewed in medical malpractice cases overall?

A. Probably about eight or nine.

Q. Okay. And in each of those cases was that on behalf of the doctor being sued?

A. No.

Q. Okay. Can you tell me approximately how many were for the patient suing the doctor?

A. I've reviewed two of those for plaintiff cases.

Q. Were you required to testify in deposition other than in the other case that you indicated you had for -- with Mr. Kalur OK Mr. Terry?

A. Are you asking me if I've given any other depositions for them? No.

Q. Just those two?

A. Just those two.

Q. Okay. And have you given any other depositions in any of the other cases?

A. Yes, I have.

Q. And in which cases were those?

A. In any of the other cases that I've reviewed?

Q. Yes, sir. How many times?
A. I would say two or three. I know I gave one in one of the plaintiffs cases, and I -- probably one other. I don't remember, it's been over a five, six year period, so I don't recall specifically.
Q. Do you have some type of an agreement with Mr. Terry or Mr. Kalur as concerning your fees?
A. Yes.
Q. What is that agreement?
A. That I am paid, reimbursed by the hour.
Q. What is your standard hourly rate?
A. $125.
Q. Is that what you will be charging me for this deposition?
A. I -- I don't know what the arrangement is.
MR. KALUR: He has to pay for your time during the deposition.
THE WITNESS: Oh, yes, okay.
BY MK. TOMBERG:
Q. Are you a member of any organization that's -- a medical organization that's involved in changing the medical malpractice laws?
MR. TERRY: Objection.
THE WITNESS: Not to my knowledge. If they have, they haven't asked me about it.

BY MR. TOMBERG:

Q. Do you agree with the changes that they propose?

MR. TERRY: Objection.

THE WITNESS: I'm not -- I'm not entirely familiar with all of them, no.

BY MR. TOMBERG:

Q. Do you -- in your opinion did you take into consideration as to when Dr. Milo noticed the cyanotic or the bluing of the blood?

A. Yes.

Q. Okay. And in your opinion when did he notice it?

A. As -- as I understand it he noticed it after the cuffed tube -- after he reintubated the second time with the cuffed tube.

Q. To your knowledge did he continue with surgery after noticing it?

A. Not that I remember. It's my -- I can go back and look through this if you would like me, but as I recall it was around that -- when he noticed that that he realized that something was awry, and I don't remember whether he finished packing something to stop bleeding or what. I don't know what you constitute going on with the surgery.

I know at that point -- if I were -- as I recall, at that point -- at that point he noticed -- he noted that something was wrong. Whether he called for -- he called for some -- or brought it to the attention and said, "There's something going on here." I don't remember exactly what happened --

Q. Okay.

A. -- as far as finishing the surgery or not.

Q. In your review of the anesthesia record were you able to correlate Dr. Milo's testimony with the events recorded on the anesthesia record?

A. The events recorded on the anesthesia record are -- a lot of events occurred in a very short time and the anesthesia record doesn't really allow, as you can see, for things happening on a one or two minute basis. As far as I could tell there seemed to be correlation.

Q. Is that an accurate anesthesia record of what transpired in the operating room that day?

MR. TERRY: Objection. That's an accurate copy of a record that was made. That's all he can testify to.

THE WITNESS: I really can't -- again, there was things, we are talking about 15 minute blocks here and things that happened within a period of one or two or three minutes would be hard to compress and put

exactly in -- in the correct time structure.

BY MR. TONBERC:

Q. Doctor, what is tachycardia?

A. It's a rapid response from the heart rate.

Q. What is bradycardia?

A. A slow response.

Q. What is cardiac arrest?

A, No -- no heartbeat, no contraction of the heart.

Q. Is there a sequential nature between tachycardia or bradycardia or cardiac arrest?

A. There -- there is, and it varies dependent upon the nature of the insult and the -- the host organism.

Q. If we are talking about a cardiac arrest induced by anesthesia, is there any cor- -- is there any sequence that you would anticipate seeing?

A. By what type of anesthesia, by --

Q. Say Forane.

A. By too much anesthesia, is that what you're asking?

Q. By an overdose. In this particular case, there's no question this was an overdose case?

A. Yeah, no, I understand that. I'm not arguing that. I'm trying to specify your question.

Q. Okay. In this type of case where there was an overdoes is there any type of sequence that occurs involving either tachycardia or bradycardia or both of them prior to cardiac arrest?

A. There's no -- probably no characteristic response. One could see, either one, but the Forane is a myocardial depressant. When the myocardium becomes depressed and there's not enough output from the heart to supply the tissues with the needed oxygen, then sometimes one will get a sympathetic response from the nervous system, fight or flee type of thing, in an attempt to try to get more out of the heart. And if one -- if that -- if the heart is in a situation to respond then there will be a tachycardia. If the heart is thoroughly depressed, it can't do that, then bradycardia will ensue as the automenticity of the electrical fibers decreases.

Q. Okay. If there's a tachycardia would a bradycardia follow?

A. Right, it might. It may not. It may -- I have seen in cases where -- not specifically Forane overdoses, but in situations where the myocardium is depressed by another type of agent or by a disease process where one can go right from a tachycardia to a standstill.

Q. Okay. What is succinylcholine?

A. Succinylcholine.

Q. Or succinylcholine.

A. It's an agent -- it's a non-depolarizing -- sorry, it's a depolarizing neuromuscular blocking agent.

Q. What does that mean?

A. What does that mean? It's a paralyzing agent that one uses in the operating room and in the Intensive Care Unit --

Q. Okay.

A. -- when one desires complete muscle relaxation quickly for a short period of time, i.e. for intubation.

Q. What is the appropriate dosage to give as far as, you know, on a weight basis or something like that?

A. Usually a milligram per kilo.

Q. And what effect does the succinylcholine have on the heart?

A. It -- it is a conestration, con- -- anti-conestration inhibitor, and by doing that it can produce a bradycardia, not always -- usually not with an initial dose, oftentimes it takes a second or repeat dose to produce a bradycardia.

Q. Okay. And would that be -- could that also be caused by an overdose of succinylcholine, the

bradycardia?

MR. TERRY: Objection. That's pure speculation. You're dealing with a concrete case here and it has nothing to do with Dr. Milo at any rate.

THE WITNESS: It could.

BY MR. TOMBERG:

Q. And how do you, as a physician, diagnose bradycardia?

A. How would I diagnose bradycardia?

Q. Yes, sir. As an anesthesiologist what do you look for in bradycardia?

A. Slowing of the heart rate. I mean, that's the definition of bradycardia. It's not a diagnosis, either it is or it isn't. It's like being a little bit pregnant. You see what the pulse is, the pulse is slow, then that's bradycardia.

Q. What would you anticipate the pace to be, or the pulse to be of a nine year old undergoing anesthesia, Forane, specifically?

A. The type of anesthesia doesn't usually matter. We anticipate the pulse -- well, there's -- the resting pulse in a nine year old may be somewhere around a hundred, give or take. If the patient is undergoing the -- undergoing intubation it is -- is asleep and not quite, may still have some sympathetic discharge, the

pulse may go up --

Q. To what?

A. -- If there's light anesthesia. Oh, the pulse could go up to 140, 150 in a nine year old, easily.

Q. Were there any assumptions that you made in coming up to your conclusion, other than the facts that we have discussed?

A. Not that I -- I'm not sure I understand the question.

Q. Okay. Did you make any assumptions about certain procedures that were performed or certain steps that were done or the timing of certain things in order to come to your conclusion?

A. No, not other than what we discussed or what I got from the records.

Q. Can you tell me approximately how much time you spent in reviewing the records?

A. Approximately three hours.

Q. Was this an avoidable accident?

MR. TERRY: From Dr. Milo's point of view or from the anesthesiology group's point of view --

MR. TOMBERG: Read it back to him, please.

(The last question was read back by the Reporter as requested.)

THE WITNESS: I think from the anesthesia's point of view it was an avoidable accident.

BY MR. TOMBERG:

Q. How about from the surgical point of view?

A. I don't think that the surgeon did anything that was -- there was no accident by the surgical -- by the surgeon, therefore there was nothing to avoid.

Q. If we were to assume that there were an anesthesia problem in a case like this where the surgeon is in the operating theater and he has a student nurse with him, would you anticipate that he would contact the anesthesiologist if he detected there being a problem with the anesthesia or the delivery of the anesthesia?

A. There was a student nurse with him, meaning there's a student nurse not with the surgeon but there was a student nurse administering anesthesia?

Q. Yes, sir.

A. And your question then?

Q. If the surgeon detected --

A. Detected --

Q. -- or was suspicious --

A. -- thought that there was an anesthetic

problem --

Q. Yes.

A. -- who would he contact?

Q. Yes.

A. I would imagine he would contact the person who was in the room. And if he felt -- yeah, I would imagine he would contact the person that was in the room.

Q. The student nurse?

A. (Nodding head up and down.) And could -- that would be the chain of command that I would assume --

Q. Okay.

A. -- would he followed.

Q. Okay. Would you agree that the surgeon and the anesthesiologist are basically equals within -- within their own disciplines?

A. Equals --

Q. Equals --

A. -- in what?

Q. -- Equals in that the surgeon is responsible for the surgery, the anesthesiologist is responsible for the anesthesia.

A. Yes.

Q. Okay. Would that chain of command or protocol change if the -- if the anesthesiologist is not present, as far as the doctor being able to direct the

nurse anesthetist or student nurse anesthetist?

A. I don't know. No, I don't think so. I mean, I -- that's a very generalized question. I'm not sure exactly. I'm not sure exactly if you're asking for a specific protocol or a protocol in this case or, you know, what generally happens.

Q. How about first --

A. What generally happens, if the surgeon thinks there's a problem with the anesthesia he contacts the person who is giving the anesthesia at that point, who was in the room responsible for the anesthetic management of that patient.

Q. Okay. Can you detect the difference between an appropriate dosage of -- of an anesthetic agent such as Forane and an obvious overdose if you were in there and you were able to detect it?

A. By what means?

Q. By smell.

A. No.

Q. Have you ever smelled an overdose of anesthesia being delivered?

A, I don't think I've ever been in a room when an overdose of anesthesia has been delivered. I certainly know that one can't smell the difference between a half percent of an anesthetic agent and four

percent.

Q. How about an appropriate dose and ten times the appropriate dose, would something like that be detectable?

A. By the nose?

Q. Yes.

A. No.

Q. Is it unusual to smell an odor of anesthetic agent in an operating room?

A. Not if -- if there's a closed system it would be unusual. If there's an open system such as a leak, you know, a leak anyplace in the system, either the tube or scavenger system or something then it's not unusual to smell it. It would be unusual not to smell it under those circumstances.

Q. What do you do as an anesthesiologist when you discover a leak or something that's not appropriate?

A. If there's -- if I have a tube in, it's a cuffed tube, the first thing I do anyway is I check the airway. If the airway is okay and the tube is up and there's not a leak around the cuff, then I go through and look at other parts of my circuit, my scavenging system, the ventilator circuit, to see if there's a leak someplace.

Q. Those comprise the units of the machine,

correct?

A. Correct. If there's an uncuffed tube in, as in this case, or as in most pediatric cases under puberty then, you know, I still would -- I would assume that it would come from there. I would still, you know, assume it would come from there, just giving a glance at the other components of the system as well. It would depend on where the smell seemed to originate from.

Q. Do you have an opinion as to whether or not Dr. Milo's conduct was below the standard of care in not summoning Dr. Lee when he is faced with a highly objectionable odor of the anesthetic agent and the nurse became nauseous and left the room?

A. Yeah, I have an opinion.

Q. And what is that opinion?

A. In my opinion, his behavior was within the standards of care.

Q. Does the surgeon have any responsibility to check the vital signs of the patient under anesthesia?

A. It's the anesthesiologist's responsibility for the vital signs of the patient.

Q. Do you commonly use nurse anesthetists in your practice?

A. In -- our group does employ -- our group does utilize nurse anesthetists, yes.

Q. Okay. And do you have any standards by which you use to supervise them?

A. I -- I don't think there are written standards per se. There are certainly the same type of care would be given to supervise them as we would give for any non-attending individual administering anesthesia, i.e. residents. I don't know what the rules are, I don't know if there's a written set of rules.

Q. What do you generally do as far as your practice is concerned when it comes to supervising nurse anesthetists --

A. Supervising --

Q. -- or residents?

A. -- residents, medical students, I -- I usually, as far as my practice is I -- if I've never worked with them before I will -- I supervise them closely during any phase of any participatory management that may be of significance to the patient until I know them better and know what their capabilities and qualities are. You know, I'm pretty much hovering around them most of the time. And as we work together more I tend to let them, and I see what their abilities are and capabilities and whether they know enough to know when they don't know what they're doing, and then widen the gap between my -- my supervision and their -- and their

participation.

Q. Do you allow them to perform procedures on a regular basis, the entire procedure, without your being present at all?

MR. TERRY: Objection. He's already answered what his practice was.

MR. TOMBERG: Well --

THE WITNESS: No, I -- you know, as far as my -- no. No, I don't.

BY MR. TOMBERG:

Q. In this particular case in which there is an anesthetic overdose, and cyanosis is one of the signs that the surgeon can see, approximately what type of time frame are we talking about when the blood goes from bright red to being very, very dark?

A. Depends on what the cause of the cyanosis is.

Q. On this particular case it was obviously --

A. In this case it was anesthetic overdose. It was not lack of delivery of oxygen from the machine to the patient but lack of cardiac output because of myocardial depression. The time course is seconds to -- not seconds, but minutes.

Q. Okay. So it would go within minutes she would go from having bright red blood to having very dark

blood?

A. Yes.

Q. When you say minutes you mean two minutes, maybe three?

A. It would -- it depends on a lot of things. It depends upon the state of her oxygenation prior to this, it depends on her metabolic rate, the desaturation -- the desaturate of the blood depending on her metabolic rate. We are talking about going from blood that has a lot of oxygen carried on it to blood that doesn't have very much; and what happens to the oxygen is it gets taken up by the tissues, and if the -- the heart output, cardiac output falls because of an anesthetic overdose then there's not as many trucks carrying oxygen molecules, so each of the trucks unloads more, then when it gets back to the other side there's nothing on it.

And it -- it would depend upon what her cardiac output was, how many molecules of oxygen the trucks had in them before, when they started and how fast they were being unloaded at the other end. So it's --

Q. Is there anything in this record to indicate to you any of those facts or figures that you would need to make that calculation?

A. It's -- it's variable. You know, we are talking it certainly wouldn't be more than two or three

minutes. It could be less.

Q. What would be the least amount of time that you would consider, one minute?

MR. TERRY: Objection. He's already said two to three minutes.

THE WITNESS: I would be guessing if it was, you know, I would be guessing at this point.

BY MR. TOMBERG:

Q. What --

A. The least amount of time, perhaps a minute.

Q. All right. The most amount of time?

A. Three to -- three to four minutes.

Q. Okay.

A. I said it depends upon the rate at which -- I mean, if the heart was to stop, this depends upon the rate at which the cardiac output falls. I try to outline to you the various factors and all of those -- there are several rate dependent steps. It would depend upon the rate at which the cardiac output fell.

Q. Is there anything in the anesthesia record that you've reviewed to assist you to tell you what cardiac output was?

A. No.

Q. Whether there was proper oxygenation or anything?

A. No.

Q. Would that be the type of information that you would expect to find in this type of record?

A. No, not -- one doesn't normally monitor things like cardiac output in elective cases of healthy individuals. One monitors blood pressure and pulse which there is here, but that does not --

Q. Okay.

A. -- necessarily reflect the other variables that I've gotten into. You know, you can tell she had a decent blood pressure at the beginning and had a decent pulse, so once there's adequate cardiac output, yes; but how fast it fell off, that's the real key here. As far as you're talking about time course for desaturation, how fast the cardiac output fell. There's no way that -- there's nothing on this record that tells us that.

Q. In looking at the anesthesia record, what do these little dots right here by these little checkmarks -- there's a line that says a hundred, just below it it starts and then goes upward, do you see that?

A. Yeah.

Q. Okay. What are those dots?

A. These dots?

Q. No, no, no, not where the CR is, but above that. See above here, these dots that go almost up --

A. That's her heart rate, it's my understanding, from the record.

Q. Okay. And how would you describe that heart rate from the way it's charted?

A. Well, the 80 or 90 when we started was -- is with induction, and then she became tachycardic up to 140 range shortly after which may have been due, you know, may be due to any number of factors. It may have been due to light anesthesia at the beginning and she needed, you know, she had a sympathetic response because she may have been feeling some stimuli from the surgery -- from the surgical field or that.

Q. Would this be affected by the amount or lack of amount of succinylcholine that would be administered, the fact that she had a sympathetic response?

A. No, not really. It would not have any much -- I don't know how that would interplay with the succinylcholine.

Q. Okay. Because you indicated that succinylcholine --

A. Could cause a bradycardia. She didn't have a bradycardia.

Q. Okay. And the blood pressure, you indicated these little checkmarks; is that correct?

A. That is -- I assume that's a systolic blood

pressure, yes.

Q. What does systolic mean?

A. Well, when you take blood pressure with a cuff you put a cuff around the upper extremity and you pump air into the cuff until the pressure in the cuff exceeds the pressure in the arteries going below perfusing the limb, and then you slowly let the air out. And the first time you hear a pulse of blood flow, that's called the systolic blood pressure. Then when it becomes muffled it falls away, it becomes a diastolic.

Q. Okay. Do you see any markings indicating a diastolic blood pressure in there?

A. No, I don't.

Q. Wp=ould that be something that would ordinarily be charted?

MR. KALUR: What difference does it make? Anesthesia said they're negligent, so what?

THE WITNESS: Sometimes it is, sometimes it's not.

BY MR. TOMBERG:

Q. Up at the top it indicates gases; is that correct?

MR. TERRY: Oh come on, Jeff. You've got his opinion on Milo and you've got the basis of the opinion, and we have been through the record with Dr. Lee

and with Mawer, Schmidt and the people who created it.

MR. TOMBERG: Well, I'd like to have his interpretation of the record.

MR. TERRY: There's no need for his interpretation because the record and what's on that record really plays no role in the opinion that he's already rendered; and if you want to ask him if there's anything on there that plays a role in that opinion that he's given, fine, but otherwise this is an educational session and I've got other things to do than watch you get educated.

MR. TOMBERG: Thank you.

BY MR. TOMBERG:

Q. Is there -- is there anything that you took into consideration in rendering your opinion from this anesthesia record?

A. Nothing more than just to looking at what the vital signs appeared to be and the time frame of -- of the events that occurred.

Q. Anything in that record appear unusual to you or depart from what you would expect to find in an anesthesia record?

A. In an anesthesia record?

Q. Yes, sir. That's an anesthesia record, isn't it?

A. Yes, that's correct.

Q. Okay. And is there anything --

MR. TERRY: Objection, and the same basis for the objection.

BY MR. TOMBERG:

Q. Is there anything in that record that you took into consideration that was different than what you would expect or anticipate of finding in a normal anesthesia record?

MR. TERRY: Objection to that question, that's incomprehensible. If you can decipher that you can try and answer.

THE WITNESS: Yeah. Okay. Some of the things aren't as legible as I would like to see. Some things I would -- I would have done differently. You know, there's X's by when the -- where the drugs were given and there's not always a -- readily -- you know, you got Forane was on, at what percent I don't -- I don't know whether we can interpret what percent it was on there.

Succinylcholine was given, but you see an X and you have to go someplace else to find where it is. The times of events that occurred quite close to each other are not -- are just sort of circled and put all within a half hour time frame of when those that state

from the depositions they were closer than that, and I would have marked those with a time at 14 -- at 1400 or 1352, so --

BY MR. TOMBERG:

Q. Much like the drugs were done here on the right-hand side?

A. Correct, correct.

Q. Do they have additional pieces of paper available to them in the operating room where they can do those kinds of things?

MR. TERRY: Objection, that's speculation.

THE WITNESS: I don't know.

BY MR. TOMBERG:

Q. Is it your opinion that the surgeon has no responsibility for the administration of anesthesia in any respects?

A. If there's an anesthesiologist who is assigned to the case, it's the anesthesiologist's responsibility for the administration and delivery of anesthesia.

Q. And that's true whether he's present or not?

A. That's true whether he's present or not.

Q. Does your review of the record indicate whether or not Dr. Milo observed any bradycardia prior to the darkening of the blood?

I don't recall that he did, but I don't remember for sure. But I was not -- I don't recall that he observed that, no.

Q. Did you come to an opinion as to whether or not, if Dr. Lee had been summoned when the first air leak was noticed, and that he had made an inspection of the anesthesia procedures, monitors and the like, whether or not this would have been preventable?

MR. KALUR: "This," you mean the death?

MR. TOMBERG: The death.

THE WITNESS: No, I did not reach an opinion as to that. I don't really know. It depends -- to me it was not clear. The death, as we have said, is obviously by an overdose of Forane. When the overdose occurred, you know, was it turned up at the first leak, was it done in between, I don't know. That's not clear to me.

It was not clear to me from the depositions when -- when the bobbin went up, when the overdose occurred, so therefore I don't -- I can't say if Dr. Lee had been called in at the first -- at the point of time of the first leak whether or not she had already had it at that time or not.

BY MR. TOMBERG:

Q. Approximately how long a period of time

would it take to overdose a patient on Forane if it were -- if the flow meter, if the Vernitrol, were turned on full?

MR. TERRY: Objection. That calls for speculation. That calls for the Doctor knowing the volume that the Vernitrol is going to churn out, it calls for speculation as to any number of variables and I'm going to direct the Doctor not to answer.

THE WITNESS: No comment.

BY MR. TOMBERG:

Q. Doctor, has all of your testimony today been based upon a reasonable degree of medical probability or certainty?

A. Yes.

MR. TOMBERG: I don't have anything else.

MR. TERRY: You have the right to review the document after it's been typed up by Mr. Bish, or you can waive that right; and I would suggest to you that you might want to read this one before it's typed up. We will not waive signature.

THE WITNESS: Okay.

- - -

(Deposition concluded at 2:05 o'clock p.m.)

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CERTIFICATE

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

I, William S. Bish, an RPR/CM and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, HOWARD S. NEARMAN, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to Stenotypy in the presence of said witness, afterwards transcribed upon a computer; and that the foregoing is a true and correct transcription of the testimony so given by the witness as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, 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 Akron, Ohio on this 22nd day of December, 1986.

William S. Bish, RPR/CM and Notary Public in and for the State of Ohio.

My Commission expires November 4, 1989.