In The Matter Of:

Doll, et al. vs. University Hospitals, et al.
No. 297828

Deposition John G. Nemunaitis, M.D.
October 13, 1997

Dennis A. Parise & Associates
Court Reporters
500 Park Plaza
1111 Chester Avenue
Cleveland, OH 44114
(216) 241-5950 FAX: (216) 241-5952

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COURT OF COMMON PLEAS
CUYAHOGA COUNTY

PATTY DOLL, ET AL.)
Plaintiffs,)
vs.) Case No. 297828
UNIVERSITY HOSPITALS OF)
CLEVELAND, ET AL.,)
Defendants.)

DEPOSITION OF JOHN GEORGE NEMUNAITIS, M.D.
Monday, October 13,1997

Deposition of JOHN GEORGE NEMUNAITIS, M.D., called by Defendant University Hospitals of Cleveland lor examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Mary Ann Flynn, Registered Professional Reporter, a Notary Public in and for the State of Ohio, at the offices of Becker & Mishkind Co., L.P.A., Skylight Office Tower, Suite 660, 1660 West Second Street, Cleveland, Ohio 44113, commencing at 1:00 p.m. the day and date above set forth.

APPEARANCES:
On Behalf of the Plaintiffs:
Howard **D.** Mlshklnd, Esq.
David A. Kulwicki, Esq.
Becker & Mishkind Co., L.P.A.
Skylight Office Tower, Suite 660
1660 West Second Street
Cleveland, Ohio 44113
On Behalf of Defendant University Hospitals of Cleveland:
Patricia Casey Cuthbertson, Esq.
Arter & Hadden
1100 Huntington Building
Cleveland, Ohio 44115

JOHN GEORGE NEMUNAITIS, M.D.
called by Defendant University Hospitals of Cleveland for examination under the Ohio Rules of Civil Procedure, after having been first duly sworn, as hereinafter certified, was examined and testified as follows:

(Defendant s Exhibit A was marked for identification.)

EXAMINATION
BY MS. CUTHBERTSON:

Q: Good afternoon, Doctor. My name is Patty Cuthbertson. I represent University Hospitals of Cleveland in this matter.

MS. CUTHBERTSON: Before proceeding with the deposition, I've been asked to reserve Joe Farchione's right to question this witness at a later time because he was unavailable, perhaps due to our joint failure to notify him of this deposition, and I take it that's okay with you?

MR. MISHKIND: It is my understanding that he's not available,

right.

Q: Doctor, I'm going to ask you a series of questions. If you answer the question, I will assume you understood it. If you don't understand it, please ask me to rephrase it and I will do so.

Have you been deposed before?

A: (Nods affirmatively.)

Q: And you do have to answer audibly.

A: Yes. I understand, yes.

Q: This is not a memory contest. If at any time you need to refer to any of the records that are in front of you, please feel free to do so. If at any time you need a break, please let me know and we'll interrupt the deposition.

A: Okay. Thank you.

Q: Fair enough? First of all, would you state your name and please spell your last name for the court reporter?

A: John George Nemunaitis, N-E-M-U-N-A-I-T-I-S.

Q: Doctor, what is your business address?

A: My business address right now is Meridia Euclid Hospital, *18901* Lake Shore, Euclid, Ohio *44119.*

Q: And your home address?

A: *390* Timber Ridge Trail, Gates Mills, *44040.*

Q: Doctor, I have marked what has been represented

to me as your curriculum vitae. I would just ask you to take a look at that and identify that that's, in fact, what it is.

A: Yes, it is.

Q: And that's current as to approximately when?

A: Oh, probably the beginning of the summer.

Q: Do you have a professional practice group of which you're a member?

A: Well, I was practicing with University Mednet but I'm in the process of transition, retirement transition, from them. I'm not practicing there right now.

Q: You're not an employee of University Hospitals of Cleveland, are you?

A: I'm not an employee of University Hospitals. I'm on University Hospitals' staff, though, yes.

Q: And you are currently licensed to practice in Ohio?

A: That's correct.

Q: Any other states?

A: No. I have my national boards but I'm not licensured.

Q: You're not retired, in other words?

A: Not yet. Sort of but not yet. Let's say I'm in transition.

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Q: And do you have privileges -
A: University Hospitals, Meridia Hospital Systems, Meridia Euclid, the rehab unit, St. Vincent's Hospital, which is Columbia System, and also Lake County Hospitals System. I'm also on the staff of Parma but I don't really function at Parma.
Q: I don't want to rehash your CV, but why don't you summarize very briefly, if you can -
A: Training?
Q: - your education and training.
A: I trained at Western Reserve University here in Cleveland. Undergraduate school, I went to Western Reserve University Medical School. I did an internship in Nashville, Vanderbilt University and St. Thomas Hospital in Nashville, Tennessee. I then did my residency at Albert Einstein Medical Center in New York. (Javina University) I was there for three years. My residency was in physical medicine and rehabilitation. Following that residency I did research and teaching at Rusk Institute in Manhattan, New York for about two years. Came back to Cleveland; was on University Hospitals' staff; was involved part time with - at that time it was called Euclid Clinic and then I became full time at Euclid Clinic and continued part time at University at the medical

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school up until about the present time.
Q: Would you say your practice has primarily consisted of the physical medicine rehab area?
A: My practice has been solely rehabilitation medicine, physical medicine.
MR. MISHKIND: Let me interrupt for one second. I know that you know the answer to the question, but for the benefit of the court reporter who has got to take down your answers, wait until she is done with the question before you start answering.
THE WITNESS: Okay.
MR. MISHKIND: Thanks.
Q: In other words, he doesn't want you to read my mind.
Tell me a little bit about the specialty of physical medicine and rehabilitation. If you were describing it to a layman, what do you do?
A: The primary mission of a rehabilitation physician is to assess impairments, either to the brain or to the spine and to other parts of the body, relative to helping the individual restore their functional capabilities as much as they possibly can. We work with a team of people that are all specialists

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in areas that relate to functioning: speech pathologists, psychologists, physical and occupational therapists, social workers, recreational therapists, nutritionists, nurses. I mean, there are a whole team of people and we meet on a regular basis to both assess and interchange as a team, our mission being helping that individual improve their functioning.
The improvement of functioning is physical, biomechanical, medical, emotional, psychological and, of course, in all functional areas, communication, ADL, ambulation, et cetera.
So the primary role of a physical medicine physician is to assist individuals with impairments to function to the best of their capabilities.
Q: So in connection with that, you, I take it, call on specialists at some point, such as in Mrs. Dolls' case, referring Mrs. Doll to Dr. Layton, a neuropsychologist, to do particularized evaluations?
A: Yes. First of all, there are specialists involved throughout the program while in the rehab unit. After discharge we continue to work together where there is a need for assessment of impairments ongoing down the line, follow-up by the neuropsychologist in terms of what the status of that patient is from the neurophysiological and cognitive

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functioning, assessment of the communication limitations, or in the case of physical and occupational therapy, the physical biomechanical functioning and their ability to function, ADL in the community and home making and so forth.
Q: Has your practice changed over the years?
A: Not really. I think my rehab practice has been very, very active. There may be some minor changes whereby on the outpatient practice at University Mednet I saw back cases increasing, but it hasn't changed that much.
Q: Fair to say it's primarily neurology?
A: Neurologically, orthopedically. We deal with brain trauma, stroke, multiple sclerosis, spinal cord injuries, total knees and total hips, hip fractures, so that in the hospital practice we are dealing with impairments that affect the individual's ability to function and it can be anything from an orthopedic injury to brain injury, spinal injury, peripheral nerve injury.
Q: Is your practice confined to adults?
A: 15 and up, I would say. I do not focus on pediatric rehab, no.
Q: You've got a lot of experience. Have you ever taken care of a patient like Mrs. Doll in the sense

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that she had a postpartum stroke at a fairly young age, early 30s, with a fairly significant brain impact? Have you had anybody like that that you have taken care of!

MR. MISHKIND: Excuse me. Before you start to answer, let me object to your suggestion that she suffered from postpartum stroke, because that is not factually correct. She may have had suffered a stroke during the postpartum period, but she didn't suffer postpartum stroke.

But with that note, certainly I think you meant in a generic sense in the postpartum period.

MS. CUTHBERTSON: Let me withdraw the question and go ahead and be more specific.

Q: A patient such as Mrs. Doll who suffered a stroke during the six weeks following delivery.

MS. CUTHBERTSON: I think that's a fair characterization of what happened here.

A: I may have but I don't recall. You see thousands of patients. I haven't had probably in the

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last 20 years, but I don't recall.

Q: Have you ever done specific research either in preparation for this deposition or for taking care of Mrs. Doll on that sort of population, if you will?

A: No, my focus has been her rehabilitation irregardless of the cause.

Q: Doctor, you may have answered this already, but did you have any academic appointments during the 1990s?

A: I've been assistant clinical professor at Western Reserve University Medical School -

Q: What percentage of your time -

A: - for 30 years. Go ahead.

Q: What percentage of your time do you split between the teaching realm and the direct patient care, if you will?

A: Half a day a week is teaching.

Q: And the balance would be?

A: Balance would be probably - well, I do joint commission survey work and that's probably - well, I couldn't summarize. I would be here for a couple days. Let's say ten percent of my time in administrative, another ten percent is what I would say is quality assurance, Academy of Medicine, Joint Commission, hospitals, et cetera, at QA committees.

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That would also be administrative. Then probably ten percent of my time is teaching and the rest, 60 percent or so, is patient care.

Q: Are you boarded in any particular area?

A: Physical medicine and rehabilitation.

Q: Is that a specialty?

A: Yes, it's a specialty since 1947, Howard Rusk.

Q: You also do disability evaluations?

A: Yes.

Q: And you still do those now?

A: Yes. Not right now, but I have up until - yes.

Q: And you also told me before -

A: Actually, I am a member of the Academy of Disability Evaluating Physicians and also the Academy of Quality Assurance and Utilization Review. I'm heavy into quality assurance outcome, performance outcome, but relative to disability stuff, as part of my office practice, I did do quite a bit of disability assessment.

Q: You told me before we got on the record a little bit about your local memberships and affiliations. Just tell me a little bit about your membership in the Academy of Medicine.

A: Yes, I'm on about three committees in the Academy of Medicine.

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Q: Dealing with neurology?

A: One is peer review actually relative to utilization, quality of care physicians. I work with them in the same regard. Locally I'm involved in, obviously, a number of hospital staffs, but my primary practice is at Meridia Euclid. I'm on a number of committees there relative to the rehab unit from the standpoint of local and nationally that I work with.

And then I'm on the joint survey internationally. I am a member of the Academy of Quality Assurance and Utilization Review. I don't know what else to say. I'm a member of the Royal Society of Medicine. I'm on the forensic committee in the Royal Society of Medicine, but basically it's pretty much in my curriculum vitae in terms of my academy membership. I'm not sure what else you want besides that.

Q: That's fine. Are those quality assurance, those kinds of activities, confined to rehabilitation as opposed to acute care?

A: I've been trained in acute care. The joint commission wanted me for monitoring because they needed survey in acute care, but most of my responsibility relates to rehabilitation, utilization review, admissions to rehabilitation, quality care,

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mostly that relates to my specialty, rehabilitation medicine.

Q: Today we asked that you bring your office record with you, and I understand that you don't have those records.

A: I don't have those with me.

MS. CUTHBERTSON: And, just for the record, Mr. Mishkind has informed me that he has subpoenaed the doctor's office records and we anticipate getting it within some reasonable amount of time.

A: I have copies of everything right until the last two visits, but I don't have the actual records, no.

Q: And are those visits from 1997 then?

A: The '97 visit, March of '97 visit, I do not have here. There may have been a visit in '96 just before I ordered the MRI scan, and I don't have that here.

Q: Is the last time you saw Mrs. Doll in the office -

A: March of '97, that I can recall.

Q: Let me just ask you, for the record, to please tell us what you reviewed in preparation for the deposition.

A: Let me see if I can get the record. It will be easier.

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I reviewed the hospital's, Meridia Euclid rehab unit's entire records. I reviewed that. I reviewed the University Mednet records through May of 1995. I reviewed my letters, two letters, that I dictated to Howard Mishkind. I reviewed the reports of the speech pathologist as of 9/11/97, the ophthalmology associates report as of April 17, '95, the neuropsychology evaluations as of, I believe it was August of '95. Yes. It's June, July and August of '95 as well as August of '97. I also reviewed the deposition of Patty Doll and the deposition of her husband, and I have St. Vincent's and University Hospitals' records which I did review as well.

I believe that covers everything. There were reports, of course, radiology reports, MRI scanning reports and, of course, the radiological lab reports associated with St. Vincent's, Meridia Euclid and University Hospitals that I had available to me for review as well.

Q: Okay. You didn't review the actual films themselves in prepamtion for today?

A: No, I reviewed none of the films.

Q: Did you review any of the expert reports that had been produced in this case?

A: No.

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Q: Dr. Margulies, Dr. Millikan, any expert reports?

A: You mean did I review them that they were sent to me?

Q: Yes.

A: No.

Q: Did you ask to see any other medica1 records or studies that were not provided to you?

A: Well, originally, no. The ones that were not provided to me, no. The ones I asked for, I got.

Q: Did you make any notes or any writings of any kind in preparation for today?

A: I did jot some notes for myself in review of the records.

Q: Do you have those with you?

A: Yes. They are not very legible but they were done at 5:00 o'clock this morning.

Q: Why don't I make it easy.

MS. CUTHBERTSON: Mark that as Exhibit B.

(Defendant s Exhibit B was marked for identification.)

Q: Doctor, I'm handing you what we have marked as Defendant's Exhibit B and we just ask you to identify

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that one-page document written on the front and the back, please.

A: Yes, these are the notes when I went over the records early this morning that I jotted some notes for myself.

Q: Besides these and the other records that we have not been provided with, those office records, are there any other writings of any kind pertaining to Mrs. Doll that would have been generated by you or at your request?

A: No, not other than what you have here, no.

MS. CUTHBERTSON: Off the record.

(Discussion had off the record.)

Q: Do you conduct any research of any sort, a Medline search or other type of professional search in terms of taking care of Mrs. Doll?

A: No.

Q: In preparation for this deposition?

A: No, I didn't.

Q: Let's go ahead and turn to your direct care. I take it the first involvement you had with Mrs. Doll was December 1994 when she was admitted to the Meridia -

A: Yes. When she was admitted, yes.

Q: Would you be -

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A: December 2nd.
Q: Were you her primary treating physician there?
A: Yes, she was on my service throughout the rehab stay.
Q: Prior to or in connection with that admission, did you have occasion to talk to any of her treating physicians such as Dr. Gyves, Dr. Lerner, Dr. Brodkey or anybody else from St. Luke's relative to the plan of care for her?
A: I don't believe I did. I mean, it's possible, you know, it is a few years ago, but I don't believe I talked to them at that time.
Q: At least as you sit here today you don't have any memory of that?
A: No, I don't have any memory of discussing her case with any of them.
Q: Feel free to look at the records. Just give me the Reader's Digest version. What was Mrs. Doll's condition on admission to Meridia?
A: When she was admitted to the rehabilitation unit she essentially was aphasic. She had cognitive impairments. She had a right hemiparesis. Those are the three major areas of her physiological dysfunction that resulted in problems with walking and problems with communication, problem with thinking, et cetera.

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But the three major areas were aphasia, right hemiparesis and her cognitive dysfunction.
Q: What was the primary goal of her stay, then, at Meridia in terms of motor abilities, emotional, cognitive? What were you folks looking at?
A: Everything. We had a team. The team included, obviously, the physical and occupational therapist who were dealing with her biomechanical function, her gait, her ability to take care of herself.
The social worker was, of course, helping with her planning, making arrangements for what equipment she would need at home or any support services following discharge.
The speech pathologist was working with her communication problems, and the psychologist, Dr. Fero, was working with her in evaluating her cognitive dysfunction. But we all worked together as a team. Obviously, the speech pathologist, the psychologist and occupational therapist are the cognitive behavior team and at the same time work with the patient's function and how it relates to their needs comprehensively.
Q: So, Dr. Fero, is that F-A-R-R-O-W?
A: F-E-R-O. I think it's misspelled in one document, but it's F E-R-O.

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Q: There is not a F-A-R-R-O-W?
A: No. Somebody misspelled that name.
Q: And Dr. Fero is a psychologist?
A: He's a neuropsychologist.
Q: And you referred Mrs. Doll to Dr. Fero or asked him to see her in order to do a -
A: Within the unit, yes, it's part of the team.
MR. MISHKIND: Excuse me, Doctor.
I just noticed that the court reporter looked over at me, and normally when she does that that's an indication that the instructions that I gave to you before about waiting until the lawyer's done, you're violating it. She has got the toughest job so -
THE WITNESS: I understand.
MR. MISHKIND: - wait until Mrs. Cuthbertson is finished with her question.
Q: Why don't you let me restate the question again. So you referred Mrs. Doll to Dr. Fero to do a neuropsychological evaluation. Is that an area that's outside of your particular area of expertise then?
A: No, part of my training, obviously, is related to psychiatric and psychological issues associated with individuals who have brain damage and other

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problems that are related to disability. In fact, in my residency at Albert Einstein we were part of a research program where Dr. Peck of Harvard University focused - it was called therapeutic community. In fact, I was the resident and chief resident on the experimental ward to deal with the fact that psychosocial problems are real, the impairment over the long haul in terms of an individual's ability to survive and adapt to community functioning. So I have a lot of training in that.
On the other hand, the team consists of professionals that are involved with all aspects of the patient's needs comprehensively. Dr. Fero is our neuropsychologist. He works with most everyone that has brain damage and so basically my referral to Dr. Fero was almost automatic for any individual that comes in with brain damage or down the line may have problems adapting to their disability with the psychiatric problems as well.
Q: What did you learn, then, as a result of his evaluation?
A: That basically she had problems with communication. She had problems with perception and she had problems cognitively, psychosocial.
Q: There was also a referral to Dr. Kimbell?

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A: There was a referral to Dr. Kimbell. I always have an internist on every case. Dr. Kimbell is an internist and **she** is available to follow the patients medically while on the rehab unit. She follows them as needed, usually couple times a week.

Q: What's Dr. Kimbell's first name?

A: Susan.

Q: Now, I noted on the discharge summary that you stated that Mrs. Doll progressed rapidly?

A: Uh-huh.

Q: Did she make faster progress than you had actually anticipated on admission?

A: It is hard to say. It's hard to predict rapidity of progress, but at least from the functional standpoint, physical function, her ability to walk and dress herself and so forth, she progressed rapidly, yes. By the time of discharge, she was at a supervisory level essentially in those activities.

Q: What does that mean?

A: Ambulation and ALD with supervision. As I stated in my functional level at discharge ambulates and ADL with supervision, needs supervision because of safety **risk.** She had some problems with her balance at that time and her cognitive function was not intact. These individuals tend to do things that may

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not be safe so they need supervision, somebody to watch them. But physically her walking and her self-care functioning had progressed quite good.

Q: Was your expectation at that point she would continue to become more and more independent, her balance would improve, some of her motor skills would continue to improve?

A: Well, you know everybody improves because the brain is a very wonderful computer and it has great capabilities to use backup circuits. I can't really say I had expectations. I had a lot of concerns and my concerns had to do with the cognitive and aphasia problems that she had and to a certain extent her personality. She tended to be a little bit impulsive. You worry about people that will do things, A, because they don't have the cognitive capabilities to retain them or they can't connect to that part of the computer that says, "Hey, there is a danger here. You better be careful."

An individual who tends to be impulsive and has that problem is a risk, big risk, because these are the people that go out and do things that are not safe without being able to think about it, especially if they are impulsive and especially if they are functional physically.

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In some ways it's better not to be functional physically if you have safety risks, cognitive problems because you can't do it, but if you have a person that can walk and function yet is not reliable from the standpoint of safety risks, you've got big problems.

This is the type of person I actually worry about more than one more disabled from the physical standpoint. That's why somebody has to be around with them all the time because they do things that aren't smart.

Q: Are you aware that she had any particular problem with that impulsiveness, falls or -

A: No. See, some of it can be related to the brain damage itself. I suspect she probably was impulsive and had a somewhat compulsive/impulsive type personality before her disability, which, obviously, **still** gives us a problem from that standpoint, but, you know, there are times when these individuals can be impulsive because of the brain injury itself. This is common to head trauma.

So, yes, it could have been part of it. Our discussions at our team conversations were a little concerned about that part of it. So that was one of my big concerns.

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Q: Let me just ask you, did you have concern with her ability to safely take care of her infant son?

A: I knew she was going to have help. Yes. Yes, I would have had if we didn't have social workers and everyone, nurses and that. She actually had her child there. In fact, you may have noticed in the notes I was concerned about Dilantin and I made sure that we communicated back so the baby wasn't at risk.

So we spent a lot of time as part of her functioning - you know, we do functional evals and functional rehabilitation. You try to address everything they are going to have to deal with when they are discharged, and, yes, we spent time. Yes, we were concerned but we knew that her husband was going to be there and, yes, we knew that there was other help that she was going to have with her.

Q: Now, during her stay at Meridia did you have occasion to talk to Dr. Lerner about her progress and home-going discharge planning?

A: I don't recall talking to him. I may have but I really don't remember. I looked through my notes to see if I documented that. You know, I vaguely remember something. I may have talked to him about the Dilantin stuff and that, but the point is that I didn't write it down. So being I didn't document it,

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I can't say it happened.
Q: And you have no memory of any discussion with him?
A: No, I have a vague memory that I talked to somebody, especially about Dilantin, but I don't recall specifically what I had said or a specific date or whatever.
Q: Why was she on that Dilantin?
A: Seizure risk.
Q: And that was eventually discontinued?
A: Ultimately it was, yes.
Q: Now, on the discharge summary it indicates that you did not apparently intend to follow her subsequent to discharge?
A: Well, that's true in a way. I didn't intend to follow her medically. I wanted to make sure she was followed by her internist and her own neurologist. Relative to rehab follow-up, that was another story. I had intended to see her on occasion from the standpoint of following up with her functional capabilities and how she did from the standpoint of her communication and that, yes.
Q: And eventually, then, you did see her in the office. Why don't we at least talk about the January 30, 1995 visit. How was she doing at that point in

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terms of her progress?
A: Well, my note states that she still has problems with her balance. Her general endurance was quite poor, although her motor capabilities have improved.
I made a note that she was followed by a physical therapist. I believe Joe Fidelli was following her and she also was being followed more intensively by the speech pathologist because one of her big problems was her aphasia problem, which is far more than speech communication, and also, of course, the associated cognitive problems, and, again, a little problem on the side that I was concerned about, especially with her impulsiveness and I did make a note of that, was her residual hemianopsia that she had that the ophthalmologist later further documented.
You know, she wanted to drive and already that was her impulsiveness and I was very concerned about the fact that this was not a smart thing to do and that's why I sent her back to the ophthalmologist to be re-evaluated relative to her visual fields especially and other vision. So that based on my first visit, you know, she was progressing in all areas to a certain extent but she had those three major areas of impairment.
Q: You saw her again, then, in May, same year?

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A: Yes.
Q: Now, at that point what prompted the referral to Dr. Layton?
A: Again, the problem in her case – let's see if I have it mentioned here.
Yes, this is where they misspelled Fero where you have F-A-R-R-O-W.
The concern with her and the reason for the neuropsych assessment is that these individuals who have brain damage, who have cognitive dysfunctioning, many times can adapt or mask their impairments with normal layman conversation, discussion and you want to get objective data as to where they are at at that point. I knew she had rather significant brain damage and I knew she had major problems with her communication, visual, perception and all the associated computer dysfunction.
When I say "computer," it's going to be brain. It refers to brain. Her computer dysfunction. That, I knew, and I had reasonably good contact with the speech pathologist on how she was doing there. On the other hand, she still had quite a bit of problems cognitively that wasn't so evident just on routine office communication and I wanted a more baseline assessment. I wanted a battery of tests to

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get a baseline assessment of where she was at at that point in time and perhaps subsequently in order to get a better objective measure of what she's doing cognitively.
These individuals can look functional but they are really not because they are not making judgments properly that they might have if they hadn't had the brain damage.
Q: Can an individual in that situation compensate perhaps for some of those impairments by desire and hard work and that type of thing to overcome some of those limitations?
A: This is very complex, Everyone adapts. I mean, the body is a wonderful thing. I mean, we have the best machine around and computers are designed after what our brains do.
So a variety of things happen as people improve. You know, one, is individuals, in order to survive, in order to function, do do better as time goes on in part because of the fact that they are able in a variety of ways to compensate. One way they compensate is by doing things differently. Another way is they kind of get help another way. They learn to adapt to their disabilities.
As I get older, I keep notes now for myself of

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what I have to do because if I don't - so we compensate in a variety of ways. Doesn't mean we get better. It means we adapt to it better, and that was a danger in her case because she was such a good compensator from the standpoint of doing beyond what I expected at that point in time in her life and wanting to do more.

Again, these people scare me because this is where you want the objective monitors because that's where they get into trouble. You have a person, for example, not her. Let's say a person whose had brain damage, who can walk and they decide to go down in the basement and they are not safe. Their balance is not good. They fall down and break a leg. I have seen this happen in my 30 years of practice many, many times because their judgment wasn't there and they don't know they have a problem. That's the problem. We don't know when we have a problem, all of us.

And so, therefore, again, getting back to your original question, it was at that point in time that I wanted more objective data on this gal.

Q: Let's go ahead and turn to the August office visit. Now, I noticed you mentioned that there were endurance problems?

A: Do you mean May *24?*

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Q: No. I was going to go ahead and move to the next visit, which I think is dated in August.

A: Let's see if I have that. Do you have a copy of one there? Maybe you have a copy of it. I don't see the office note.

MS. CUTHBERTSON: This one, Howard.

A: I don't care. I don't have that one here. May I look at this?

MR. MISHKIND: Why don't I run off a copy.

(Discussion had off the record.)

Q: But, in fact, just to follow up on one thing. You mentioned the falling down the steps. That didn't happen to Mrs. Doll?

A: No. That was an analogy. You worry about individuals who have judgment problems cognitively and why there are safety risks for these individuals, yes. No, she did not have the falling down the steps and nor does she have that type of dementia problem.

Q: I don't know if it would help you to have your office records in front of you for the subsequent visits, but tell me -

A: I could probably touch Base after - do you have any more beyond the August one?

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Q: I do not, and I understand you saw her -

A: I know I saw her in March of '97. I may have seen her one more time between the two visits but I can tell once I look at that visit.

Q: That visit will be dated August 28, '95.

A: I ordered the MRI scan then or the next visit, I know, because I had to verify the psychologist's report. That was done in caution in terms of what degree she had continued anatomical pathology damage to her brain to explain his subsequent report.

MR. MISHKIND: Doctor, excuse me.

For the one visit, March 5, '96, the bottom of the letter you reference her being evaluated in September of '95 and then you go into some of the documentation. That, in fact, may not be the August '95 visit. It may be a subsequent visit, but if you want to refer to that, your report, as well, certainly you can do that.

MS. CUTHBERTSON: Off the record for just a minute.

(Discussion had off the record.)

Q: I was going to ask you about the August 1995 visit, Doctor. Tell me what her status was at this point.

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A: Well, at that point in time the patient had advised me that she was planning to return to work, which I believe she did in September. I felt that she still had problems with her aphasia, especially relative to her reading and writing skills and to a certain extent her verbal skills.

I made a note that she may have reached the level of capability that allowed her to trial back to work, and I said that because these individuals many times have problems that may not be apparent, I even specifically suggested that when she returned to work, that her performance assessments by her employer be forwarded to her attorney because I would suspect there would be some frustration on the part of the patient and perhaps her employer in terms of her efficiency or degree of competence.

I am reasonably certain I may have mentioned that because I anticipated there might be problems. There always is, although she's fortunate that she has a very reasonable employer that allowed her to just return back progressively. I was reasonably confident that if she is allowed to continue to function at work, that she will ultimately be able to perform within reasonable capability, but her initial assessment and its impact on her and her job should be

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clearly viewed in light of the issues here.
Once again, many times people lose their job because initially they can't do it for a variety of reasons, and if they don't have a very patient employer, they end up getting fired or whatnot.
And, again, fortunately, her employer was patient and her fellow employees were patient and helpful, and in my experience, this is a very important part of an individual's life, is to get back to normalcy. This is all of our goals and that's why I was concerned about, "I'm not sure you're ready, but, okay, we will give it a trial." That is where my attitude was.
And then because of that I wanted the neuropsych assessments. That's an additional reason because, I don't know, I wanted to be sure of what we are going to be dealing with in terms of her work functioning and her ability to work. Now, that pretty much addresses the cognitive and communication problems from the standpoint of my overview.
From the motor standpoint, she did improve considerably. She was able to walk without restriction. I'm reading from my own notes. There were limitations in sports and recreation, which she probably will not overcome completely in terms of her

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coordination in sports activities such as basketball or volleyball or whatever. There may have been, I felt, certain occupational functioning problems in operating a computer that may relate to her coordination.
I mentioned her endurance was still a problem. Most individuals following any disability, if you go from the physiologic exercise standpoint, if you were put in the hospital or three weeks in bed rest, it would take you six, eight months to get back to where you were before you were in the hospital, even if you had no disability. Her endurance was yet to be tested at work. I mentioned that might be a problem.
I made mention that she apparently was an avid badminton player but now she has problems where she can't play like she played before because of her motor problems. What I was addressing here was the motor problems.
There was a question about whether she should ski again that I addressed. Apparently she skied before her impairment and I mentioned it would be a problem.
I think the major issue there is these individuals may walk and they may look fine. On the other hand, when it comes to their ability to do

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things that involve more complex computer functioning, integrating data to carry on more difficult maneuvers and coordination, then they begin to see that, you know, they can't do that anymore and may never be able to do it.
I mention that her activities, recreationally, occupationally, are affected by the impairment and that may need to be tested down the line.
I also suggested after the review of the assessment of the neuropsychologist is completed, that I would like to see her in three to four months, so I must have seen her after I got the neuropsychologist's reports. And when I ordered the MRI scans, which would have been sometime before – the MRI scans were done November 20. So I probably saw her a week or two before that the next time, and I think the last time was the following March.
She had some question about jury duty or something, plus probably a routine follow-up.
Q: Okay. Let me back up and just follow up on a couple things you mentioned to me. How did you learn that the Dolls had contacted an attorney?
MR. MISHKIND: Objection.
A: I don't recall, I don't recall. I'm sure it

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came out in the times we followed up. I don't recall if I had already gotten a request for a report from an attorney or not by then.
MR. MISHKIND: Okay. Don't guess if you don't know.
A: I don't know, I don't know. I don't recall.
Q: Let me just ask, do you have any memory of whether the Dolls told you that they had contacted an attorney?
MR. MISHKIND: As opposed to him receiving something from an attorney as the first point of reference?
MS. CUTHBERTSON: Yes.
A: I think it more likely came from the Dolls.
Q: Do you have any memory of when you were told that?
A: I don't know.
MR. MISHKIND: Show an objection.
Doctor, if you recall, fine. If not, don't guess.
A: I don't know specifically.
Q: In terms of your being contacted by an attorney, when were you first contacted by –
A: When you asked –
Q: Let me just ask you, when were you first

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contacted by an attorney relative to the Doll matter?
A: I don't recall, but it was sometime probably near March 5, 1996.
MR. MISHKIND: He's referencing his letter to me of March 5, 1996.
A: It had to be prior to that. But it was before, sometime before that.
Q: And was that by Mr. Mishkind or someone from his office?
A: I don't know. I don't know.
Q: Since we are on the subject, I take it you were asked by somebody from this office to prepare this report that's dated March 5 of -
A: March 5, '96, yes.
Q: Do you remember who you spoke with?
A: Probably got a letter. I don't remember. Usually it comes as a letter. I rarely get called.
Q: Is that something that would be in your file?
A: Probably. Maybe not, though. They don't always save all the letters, but if it's anywhere, it's in the file.
Q: When you say "the file," your file?
A: Mednet, the University Mednet chart. We don't have it here.
MR. MISHKIND: I can save you a

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lot of time. I sent him a letter, I don't have it right here, just basically asking him to provide me a report summarizing his fiidings relative to his patient and my client. I was the one that sent the letter to him and then he responded in March of 1996 with the letter that you have. Simple as that.
MS. CUTHBERTSON: Makes it nice and easy and straightforward.
MR. MISHKIND: Yes.
Q: In terms of preparing this report, then, for Mr. Mishkind, did you evaluate Mrs. Doll again or conduct any other or additional testing?
A: No, I think it was from the chart, from the medical records that I had in the chart.
Q: So to recharacterize, this is basically a summary of her status at that point in your care?
A: Yes.
Q: Did you prepare any drafts of this report, Doctor?
A: Did I prepare a draft? Well, I always dictate and I always get a draft to review to make any corrections.
Q: Would the drafts be contained in your Mednet

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records?
A: No, that's just for the secretarial service.
Q: This would be the only version that appears?
A: Yes.
Q: Let me go back to this August 1995 visit.
A: I have a funny thought.
Q: Let me just back up to that August visit. I think you asked Mrs. Doll, at least your notes reflect asking her to make a list of activities that were impaired or she couldn't perform. Did she ever do that for you?
A: I suspect she had. I don't recall, but it would be probably in the next visit documentation if she did.
Q: Which we don't have?
A: Which we don't have, yes.
Q: Sou were the person that ordered the MRI/MRA scan?
A: That was ordered back after that, after Dr. Layton's initial assessment. So that was done November 20th, 1996.
Q: And at that point had you talked to Dr. Layton about his findings from his various -
A: I didn't talk to him. I did get a very good report from him.

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MR. MISHKIND: For the record, his letter of March 5, '96 indicates a very important part of the assessment was provided to me today, namely, the neuropsychological assessment. So he obviously had that when he prepared his report.
A: Yes. That was a very important report. I had that one. He did the evaluation. He did it over a three-month period of time. The last month was 8/25/95 after which he sent it to me. I don't have it noted when I received it, but probably a few weeks after that.
Q: Did you have -
A: That led to the follow-up visit for the MRI scans.
Q: So you believe you probably saw her in the office again sometime during the fall of '95?
A: Ses, I believe so, or I had some communication. It could have been a phone communication that wasn't documented, but after I had digested this report, I had elected to go ahead to get a follow-up MRI scan and MRA scan in order to verify to what extent she had residual anatomical pathology. So I either saw her in the office or I called her by phone and told her to

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get the MRI scan done, and my nurse probably ordered it. I suspect I saw her in the office, though, because I do recall reviewing elements of the report with them, but I think it was in the office.

MS. CUTHBERTSON: Let me put something on the record. Once we get those records, I may want to recall the doctor to ask him questions just for the limited purpose of addressing any issues that are raised by those records that he doesn't have today.

MR. MISHKIND: That's understandable.

Q: Tell me what you remember, then, about the March '97 office visit.

A: March '97 office visit was initiated because of the fact that she had been selected as being a juror and she and I and her husband didn't feel she could handle it physically and also -

Q: Were both present?

A: Yes, they were both present. They almost regularly came in together.

Q: Goahead.

A: Anyhow, we didn't think she could handle that and, therefore, I wrote her a letter. At the same

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time I reviewed, I'm sure, how she was doing and so forth and assessed her progress, but its primary objective was to provide her with an appropriate letter that would allow her to be excused from that responsibility.

Q: Did you keep a copy of that letter?

A: Probably not. It was probably handwritten. It was because of a concern on their part.

Q: Tell me basically what you remember about the letter. What did it say?

A: It probably said something like she was unable to perform responsibilities as a juror for medical reasons, and I do not usually put in the medical reasons because I think that's her privacy. If they had any questions, please call. It would have been a very brief letter, might even have been written on a prescription pad, but it was a very brief thing and I left it open. If they wanted any more information, please feel free to contact me, and I gave my number.

Q: Did you do an evaluation at that time?

A: I evaluated her from the standpoint - a lot of her evaluation is an assessment of how she does in communicating with me and it is almost an intuitive evaluation of how she is progressing. I didn't do a formal neurological examination as such, I don't

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believe, at that time. I certainly watched her walk when she came into the room and I certainly watched her answer when I asked her questions. We all do that as physicians automatically.

Q: Did you talk to her about her work performance to that point?

A: I may have. I don t recall, though, but, yes, it was usually a topic that we covered each time and each time we saw her after she went back to work, so I suspect I did. Again, I probably didn't record any of that, though, but I'm sure I must have because that's always something I was focused on.

Q: That would be in the notes?

A: It may not be in the notes but I'm pretty sure I would have discussed that. I can t specifically remember what I said. It may or may not be in the notes. I don't know.

Q: If she would have expressed some concerns about her work performance or perhaps her ability to parent or driving, would those kinds of things be reflected in the records?

A: Sometimes.

MR. MISHKIND: Objection.

Go ahead.

A: Sometimes; sometimes not.

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Q: Did you have occasion to speak with Dr. Layton prior to the time you ordered the MRA studies in November of '95 about the results of his testing?

A: I don't think so. I don't think I talked to him. I think I had read his report and that was enough to provoke me to go ahead and do the studies.

Q: Have you had occasion to talk with him since then right up to today about his findings and recommendations?

A: I don't think so. I don't think I talked to him. I know I had a second report that was done from this year, but I don't recall talking to him.

Q: Is your role now with respect to Mrs. Doll, to use layman'sterms, kind of a monitoring role?

A: Yes. Her primary medical neurological responsibilities for her medical neurological situation are her neurologist and her internist. So my role is monitor, overseer, yes.

Q: I take it at this point there are no further therapies in terms of PT, OT. that kind of therapy that are necessary now or in the foreseeable future for her? She has gone as far as she can in terms of her progress?

MR. MISHKIND: Just one second. Before you answer the question -

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You've limited it to PT/OT. Then you said she has gone as far as she can, because we know the speech therapist has made certain recommendations. So I want the question to be clear before the doctor answers. If you're limiting it to PT/OT, that's fine. If you're talking about any therapies, then I want the record to reflect that your question is unclear.

MS. CUTHBERTSON: Okay.

Q: Why don't we strike the question and start over. I did not have an opportunity to read the recommendation of the speech therapist. Doctor, I won't ask you to comment on that. Just tell me from your perspective in terms of Mrs. Doll's overall condition and what is reasonably foreseeable, short of specific recommendations that have been made by other practitioners, not yourself, unless you disagree with something. Just tell me what you think she is going to need for the foreseeable future from your perspective.

A: From the rehabilitation perspective, I think that she has primarily three major areas of impairment that are going to have a significant affect on her quality of life for the future. Let me start out with saying the one area that would have an affect on the

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quality of her life, but not as serious as the others, is her motor functioning. She is able to walk. She is able to do things for herself independently but she is never going to be able to do a lot of things in life that she might have done if she didn't have the brain injury, things like skiing, things like playing badminton the way she used to, volleyball. In other words, her coordination is not there, and even with the best of coaches and the best of experience, she will never get her coordination back to allow her to do those motor activities ever.

She is vulnerable from the motor standpoint for the future, and by that I mean she is in her mid 30s now. As she gets older and as she loses more circuits from the standpoint of aging, I would be concerned that down the line, ten, 15 years from now, she may have more difficulties with her motor function than if she didn't have damage to her computer.

I mean, you know, she has done well in adapting to her brain injury, but we have the objective monitor of her anatomical damage, namely, the MRI scan that shows significant cephalomalacia. So those circuits are gone. They are never going to be there. So what happens in these individuals, they do better because the brain adapts and other circuits kick in. As time

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goes on, however, they begin to lose more cells because of aging and then they begin to demonstrate more problems.

A classic example is post-polio syndrome. We talk about these people that get into their 50s and they start having problems walking, weak. Why do they do that? When we have polio when we are a kid, we may have destruction of an anterior horn cell that supplies 350 muscles. Well, the next anterior horn cell may take over for those muscles, but now that anterior horn cell is responsible for 700 muscle fibers. Not muscles, muscle fibers. And when that anterior horn cell dies because of age, now you have lost 700 muscle fibers instead of 350. That's the type of thing that happens with these people.

So she improved tremendously from the standpoint of her physical functioning with her limitations in the recreational area. That would probably plateau for another ten, 15 years, maybe ups, downs, some improvement, maybe skiing but not like she used to. But then you're going to see a decline at an earlier age than it would have if she didn't have this degree of brain damage, and we all go through it but we don't have this loss of reserve fiber.

I could talk for hours on this stuff. It's one

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of my life interests, but the bottom Line is, from the motor standpoint, the future is not going to be as rosy as it looks. But for the next ten, 15 years she will probably be good, pretty much where she's at now. From the standpoint of her aphasia problems, the speech problems, she is going to need continued speech pathology and, again, she will never recover. She will learn to adapt. She will learn to communicate better. They learn all kinds of tricks for how to remember things like we do, because memory is part of her problem there. And the purpose of the speech pathologist is not going to make things happen. It's going to teach her how to adapt to it, how not to be frustrated when she can't think of a word, because in normal conversation she has word-finding problems. So that she will need ongoing speech pathology.

How long? It all depends on probably how long she has the desire to continue, but this can go on for years with decreasing frequency of need in order to guide individuals in areas of hyperlevels of dysfunction.

But from the standpoint of her speech, this involves her ability to read and understand what she has read. It involves her ability to write and communicate in writing efficiently. She has a problem in terms of fiidinn words to communicate and that will

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always be that way.
Again, same thing with understanding communication verbally. So that, again, I think she will plateau there for ten, 15 years and then you're going to start seeing, you know, now the impact of the loss of more circuits because, again, she has lost a lot of circuits, a lot of cells, from the brain damage. Again, her circuits have adapted utilizing her circuits that you normally wouldn't use for this purpose and she shows improvement, but when she starts losing more circuits with aging, then, obviously, she is going to have more difficulties. To what degree, I can't say.
The other area, obviously, her visual fields, those will never come back. She has right upper quadrant hemianopsia that doesn't recover. That's gone. **Now,** she adapts to that, too. She drives. It's amazing. Now, you know, her lower field is intact. So she adapts very well but, you know, whether she is going to have future problems with that more than normal, I can't say for sure, but, obviously, as her visual acuity goes with age, if she gets cataracts, at 50 she is going to have more problems with that than now because she is not going to be able to adapt as well.

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People adapt by turning their head more, and the big problem with that, they don't know that they have a problem and that's why I was scared about her driving originally, but she was cleared by the ophthalmologist and everything. So that's a permanent problem.
Communication, which means writing, reading and everything. Now, her thinking and judgment, if you want my gut feeling on that, I think there is going to be problems here. She is not the same person she was before. She had a parietal temporal major injury. She is a different person.
She is not behaviorally the woman she was before she had the stroke, and it's interesting. And, you know, her husband really has not shared this with me to the degree that he did in his deposition. I had a feeling that with him and his wife that there was a problem there, that there are some marital problems going on, but they never really shared this with me to the degree that I would have liked in order to help them with it. But he did mention it in his deposition, how she is difficult now, she is not affectionate. She is not the same person she was, but all these people with brain damage do change because their behavior directly relates to the same circuitry

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and chemistry that other parts of the brain functioning does.
That's the area I'm very concerned about because they are very fragile people. They are dealing with, you know, impairments that they have to learn to adapt to and they have a difficult time from the standpoint of even depression or psychological impact on their disability, and she has done relatively well there because of her personality. She adapts beautifully in that area. On the other hand, I think that as time goes on, her relationship with her husband is going to become an increasing problem because he's probably having more problems dealing with this because he's not dealing with the same person, and this is very common in people with brain injury, with head injury. Large percentage of them do end up in divorce and so forth because one or the other can't cope. That's where I think she is at.
Q: Let me follow up on a couple things you said. Your information regarding this thinking and judgment area -
A: That's based on the neuropsych assessments, the two - I can go over that with you if you want in more detail, but essentially she has got memory problems, executive functioning problems, some judgment

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problems, some cognitive problems, especially with memory, but that's well-documented in the neuropsych Stuff.
Q: You don't have firsthand knowledge, other than what Mr. Doll has said in his deposition, about this latter area?
A: The marital stuff? No, not really. I sensed problems, but, you know, they are always in and out of there so fast, But when I reviewed his deposition, I was kind of upset myself because, you know, this is one of the things I do is cry to prevent these kinds of things, and I know I did sit down and tell them she is going to be difficult. I remember even specifically in the rehab unit saying she is not the same person she was before, because none of them are. But I sensed with reading his deposition that he's having some problems with this, and from the clinical standpoint, medical standpoint, it concerns me because I'm going to have to address it in the future, I think.
Q: You mentioned that you can prevent this. How would this -
A: You don't prevent it, no. You don't prevent the changing personalities. What you do is help the individual, her husband, her children, recognize that

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mom has changed because her computer has been injured and help them adapt to that change, and over a period of time - this is the role of the. psychologist. That's his primary responsibility, actually have them adapt to the behavior changes, the whole family. They need counseling, the family. They need to spend time in group programs, support groups with head trauma cases.

This is very, very common in brain trauma rehabilitation, but in stroke, any type of brain damage, even alcohol, epilepsy and so forth, this is a big area that many times is put on the shelf but it's probably one of the more important areas of quality of life and the whole family.

Q: This is something that could or should be addressed by counseling?

A: I think that, based on what I saw of his report, I mean, his report in the deposition, that he should have counseling, family counseling. They are probably not going to accept it. They are very closed people. They don't like the outside getting involved in their personal lives, but he has that need. He's going to have to recognize it.

Q: Is this the type of recommendation that should come from the neuropsychologist as opposed to -

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A: It should come from me and probably the neuropsych, but he is aware of the neurobattery of testing for cognitive functioning. He may or may not be dealing with the behavior stuff. I'm not sure. But I think that that certainly is going to be one of my recommendations after today.

Q: To back up a little bit about her impairments, you discussed the motor impairments?

A: Uh-huh.

Q: The changes that she is going to experience, are those similar to the changes that we are all going to experience as we get older?

A: Except she is not going to have the backup circuits we have. Visualize yourself as a robot. Did you ever see the movie The Terminator?

MR. MISHKIND: Tell us your movie preference.

A: This is very important because -

Q: Even though I'm supposed to ask the questions, no, quite frankly.

A: Too bad. You should see it because it will give you a visual image. I mean, you have to visualize this, but visualize me as a robot, okay? I have all kinds of motors pulling wires doing this with my hand and so forth. I have sensory feedback circuits,

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censors in my hands telling my computer where my hand is so it can control it. That is part of her problem. She doesn't get the feedback as to where hers is to play badminton, yet she can use her hands to feed herself because it's less complex.

But the computer is also involved with, obviously, identifying, and you have circuitry to connect when you see a picture and you associate that picture, you associate it emotionally as well as what's in the picture, where it is, what it reminds you of. I mean, this is all part of your computer functioning, and the point is that when an individual has damage to their computer like this, they are also going to have some problems in perceiving things as they did before because the circuits that allow them to do that have been damaged, and that's part of the problem that they have in terms of their being a different person as times goes on.

Now, getting back to your question about what happens with time, as we get older, we are going to lose cells because of aging, and as those cells are lost, we are going to have lots of dysfunctioning. This begins at age 25, and by the time we hit mid 30s, we start to notice that when we play cards, we ask "Who dealt last?" We'll ask somebody, 'What were you

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talking about?" They say, "I don't know." This is recent memory problems that are kicking in. And the point being, this happens at age 25. It's going on through life except we don't recognize it. The computer automatically adapts to it. It uses other circuits. So if circuit Y that tells you that when you see an orange, that's an orange, then if that circuit is damaged, you kick in another circuit that calls it an orange. This is why some people maybe associate cognitively. You may notice yourself, you see a lemon, "That's an orange," because it's going to the lemon circuit. It's a citrus fruit and it's going to the lemon circuit. You say, "That's an orange." You know, you have little tricks in word finding which she has lost and will not have.

The point I'm making, we come with reserve circuits. If you have this large computer doing all this figuring, it's got millions of circuits that when one circuit or two circuits or 100 circuits or a million circuits go, it can compensate very well. But as we get older, we don't have those circuits anymore. They have died, so now our ability to compensate, to look at an orange, instead of going directly to orange, that circuit's been shut out. It may go to citrus fruit and connect back to orange. Then what

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happens when we lose that circuit? Now we are stuck with lemon. **No,** that's not a lemon. It's an orange color. It's an orange, because you looked up orange color, orange. See how it works? The point is, these reserve circuits are doing that for us all the time. As we get older or when we already have damage, like people with alcohol injury, these people are a lot younger. They are not able to compensate if they have problems with their memories, problems with their thinking, problems with their judgment. If I see a patient who has drug abuse history, they are in far worse shape following a stroke at any age than they would be if they had a normal brain because they have more lost circuits from brain damage from another source. Because they have a stroke, they are in bad shape.

In her case, she had the damage from the stroke, from the brain injury. She has compensated. Her computer's compensating. We know she has lost millions of circuits. Her MRA documents that. As time goes on, she is going to start losing other circuits. She is going to have more problems with word finding, for example, when she is 55 than she would have had if she didn't lose those circuits from the brain damage. That's all I'm trying to say. And

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that's what happens, unfortunately.

Q: With respect to the changes that accompany aging and that kind of thing, is that the bailiwick more of the neurologist or the neuropsychologist as opposed to the rehab, which seems to be more acute, short term?

A: No, rehab is long term. Rehab should be lifetime. I mean, we are the one field. Obviously, the neurologist evaluates the acute problem. The guy that's theoretically out there in the health care industry that should be in part would be the geriatrician and rehab guy that would be responsible for how a patient does over ten years or 15 years. In fact, that's one of the big problems in rehab. They haven't verified how people are doing over ten, 15 years, how alternate treatment may affect that outcome in terms of our research, and that's a necessity for the future. But the rehab guy is the overseer of functioning. He works with the neurologist and, of course, the geriatrician and that.

Q: Let me just ask you a couple things just in terms of your opinion. Have you been asked to render standard of care opinions relative to the care at University Hospitals?

A: No.

Q: In terms of liability, have you been asked to

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render any opinions in terms of the causes of the stroke?

A: No.

Q: Let me go ahead and ask you, then, about your reports, Let's just look at the March 5 report. I believe you told me earlier that this is basically a summary of her status as of this point in time when you were asked to prepare this?

A: Yes.

Q: Outside of the written request that you received from Mr. Mishkind, did you have any discussions at all with Mr. Mishkind or someone from this office in terms of preparing this report, the contents of the report?

A: No. They sent me a letter. I wrote them a report. That's it. There was not any discussion, I don't think, until now.

Q: We have talked about a lot of things this afternoon in terms of Mrs. Doll's current status and possible things that might happen in the future. Two problems are identified, however, in the March **5** report, cognitive dysfunction, and I take it that that deficit is primarily based and your discussion is based on Dr. Layton's evaluations and your own.

MR. **MISHKIND:** Let me just show an objection to your use of the term "possible

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things that might happen." I think you're mischaracterizing what the doctor already responded to. But go ahead and answer the question.

A: Weil, let me answer your question.

MS. **CUTHBERTSON:** Read it back.

(Record read.)

A: Relative to the cognitive dysfunction, it's based on, obviously, my evaluation and my experience with other patients, my knowledge of the literature and lifetime experience in file field and, of course, the evaluations of everyone, not just the psychologist but her husband and people that have – well, mainly her husband has communicated with me, but it has to do with inputs about function, how she is in addition to cognitive.

I did mention she has problems with her vision. I said visual acuity and right superior quadrant, not inferior, of her vision, her right-sided vision problem, which she has, and, of course, her communication problems. That's about it.

Q: And is that based on primarily Dr. Lystad's evaluation?

A: No, that's based on the time I followed her, my inputs from a variety of sources, plus his input on

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the evaluations, of course.
Q: You prepared a second report then?
A: Yes.
Q: In later December?
A: Uh-huh.
Q: Let me just ask you a couple questions about that report.
A: Uh-huh.
Q: Who asked you to prepare that?
A: I don't know if anybody asked me. He may have. I don't recall. This was done. It could have been another letter, yes. This was done. It may have been her husband asked me. I don't recall. Somebody probably did ask me because I wouldn't have just done it, but in any case, it was a request to review the outcome of the scans.
Q: Did you look at the scans yourself, Doctor?
A: No, I didn't. I knew that the neurologist did, though, but I did not.
Q: And the neurologist being?
A: Learner is it?
Q: Dr. Lerner?
A: Yes.
Q: Did you have any discussion with Dr. Lerner regarding the findings?

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A: No, I did not.
Q: And the opinion that you've set forth in that report, that is based on Dr. Lerner's reports?
A: Based on the radiologist's report of the MRI scan that I reviewed. Let's see who that was. It would be Dr. Adrian Krudy, M.D. at the MRI Imaging Center.
Q: And in terms of just interpreting the scans, that's the bailiwick of the radiologist as opposed to the rehab specialist?
A: Yes. It's the bailiwick of the radiologist and neurologist and neurosurgeon, but, yes, it's their bailiwick.
Q: Are these all of the opinions that you've been asked to render thus far in this case?
MR. MISHKIND: Let me just show an objection. When you say "all of the opinions," I will save you some time. I'm not going to ask the doctor to testify as to standard of care. He's already indicated that. The doctor will talk in great detail about the nature of her disabilities from a cognitive, communication standpoint and to a lesser extent the vision and how they will

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manifest and impact her now and in the future, but I think you have covered them in a general sense.
I just don't want him to be limited if I ask him to amplify on certain aspects of how it will affect her that you haven't questioned him at the time of the deposition. Globally I think you have covered it, though.
You answer the question, Doctor,
MS. CUTHBERTSON: Why don't you just let me interrupt here. Will you be providing us with a supplemental report with respect to the opinions as to her future functioning so that they are sort of set out as opposed to the lengthy discussion we have here?
MR. MISHKIND: No, that's the purpose of your deposition and he indicates in his report that they are permanent. The impairments are permanent. You've now asked him and the purpose of the deposition is to ask him how those impairments are affecting her.
I don't think I have any obligation

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under the rules to provide you with any greater report. The reports here. You've now deposed him and the only thing I would be obligated to provide you is a report to the extent that the doctor sees her before the trial.
MS. CUTHBERTSON: In terms of her future functioning and some of these other things that he talked about today, I don't think that's set forth in much detail at all.
MR. MISHKIND: Doesn't have to be as long as it says that her injuries are permanent, these impairments are permanent and he talks about some of the effects on her in terms of residual memory deficits, visual spatial functioning and other cognitive capabilities. The purpose of your discovery deposition is to explore the degree of those.
I do not feel that I have any obligation to provide you with a further report and I think you've done a very good job in terms of asking him questions relative to that, which is the purpose of a

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discovery deposition.
MS. CUTHBERTSON: Well, I will just say on the record that I think I may be entitled to a report, but understanding that, I'm going to ask him what I can. Since I don't have the benefit of the records of his most recent evaluations, I'm shooting in the dark a little bit here.
Q: Let me ask you, Doctor, in terms of the things that we have just talked about, her cognitive functioning and some of the other problems that you anticipate in the future, have we basically covered your opinions as to what you expect Mrs. Doll's status to be in the near future and ten, 15 years down the line?
A: You mean based on the questions you've already asked me and that I've already answered?
Q: Yes.
A: I think we have generalized reasonably well. I mean, obviously, I can't predict what her medical course is going to be, whether she has any other sequelae or problems, but based on her present functioning and neurophysiological status, I think we have pretty much covered most of it.
Q: Have you been asked to testify at trial?

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A: No.
THE WITNESS: Was I?
MR. MISHKIND: Yes.
THE WITNESS: You have asked me?
MR. MISHKIND: We already arranged a date for you to testify.
THE WITNESS: Are you serious?
MR. MISHKIND: Yes.
THE WITNESS: I didn't know that.
Q: Do you recall any discussions at any point in time with Dr. Lerner relative to the cause of Mrs. Doll's stroke?
A: No.
Q: How about Dr. Gyves, any of the other treating physicians?
A: No.
Q: Did you ever discuss some of the things that we talked about today, future recovery, future progress, with Dr. Lerner?
A: No. I haven't talked to Dr. Lerner about anything that I can recall.
MS. CUTHBERTSON: Do you mind if we take five?
MR. MISHKIND: Not at all.
(Recess taken.)

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Q: Let me just ask a couple of questions. Then I will wrap it up. Doctor, you're aware that the Dolls adopted a child in 1996?
A: Yes.
Q: I know I asked you earlier when Mrs. Doll was discharged from Meridia whether you had any concerns about her ability to parent, but you've seen her a couple of times since that point.
A: Yes.
Q: Do you have any reservations, then, any time since then up to today about her ability to be a good parent?
A: Do I have reservations? Well, I think time has eliminated reservations I might have had at the time. No, I don't have any reservations now.
Q: Has Mrs. Doll done better than you expected?
A: I can't say. I can't say one way or the other because, frankly, when you have all the experience I have had in rehab in dealing with brain injuries, humans just defy the rules. You see it both ways. You see people doing better than you anticipate; you see other people doing worse than you would have expected. So I have learned with age that we can't predict these things anymore.
And so that's a human ailment that comes with

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age. When I was a resident I could predict all of this but I was wrong half the time, but now you become less - not less knowledgeable. With experience you become a little more realistic about things.
Q: Now -
A: Humble.
Q: I take it you're aware that Mrs. Doll is back to work? She is working about 32 hours a week?
A: Yes.
Q: She seems to be doing well?
A: Yes.
MR. MISHKIND: Objection.
Q: Had a positive evaluation per her report?
A: I never got the report, but it's one of the things I wanted to see, yes. That's good.
Q: And I believe in one or both of the depositions it indicates that her employer had asked her to come onboard full time and she declined to do that to spend more time parenting her children. Is there any doubt in your mind that she could go back full time and perform as well as she is performing now?
A: I don't know. I can't answer the question. I think she is at risk for having problems. For example, if the marital problems occur, I think that's going to tip the balance on how she deals with them.

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She is not going to be able *to* deal with problems as well as you and I might because, again, she doesn't have the circuits. So I don't think I can say anything about that relative to what she is going to do in the future based on how well she is doing now, Let's just say she is on ice.

MR. MISHKIND: You're talking about work, vocation?

THE WITNESS: I'm talking about work. She is on ice, yes.

Q: Despite the fact that she has been back to work for, I think, well over a year and has had a good evaluation?

A: Despite the fact. I think she has got the support of her friends that work with her. She has got a very, very wonderful employer who is willing to, you know, be patient, and she is an extremely hard-working person and I just think everything has gone very well. That's wonderful, but if you ask me does this mean it will continue to go well, I can't say that because I have a lot of experience with other people who have gone through the same thing over *30* years. *I* mean, you have to realize I've been in practice in rehab for 30 years and eight, nine years I was a resident or teaching and whatnot and doing

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research in which case you see everything happen. So I can't predict anything. It may go wonderfully; it may not. There is always some chemistry that can cause the change, and in her case it's going to be the relationship with her husband if it's a problem. May not be, but, again, I can't predict.

Q: Can you give me some idea of either how many or what percentage of your practice you've taken care of patients with a stroke who has been under *35?*

A: These days, quite a bit. Percentage of my practice, if you were to ask me how many patients I have seen in a lifetime with a stroke under *35,* I would probably say, I don't know, 5,000. I mean, I have been around, both teaching and in rehab, but I can't give you specific statistics.

Q: How long have you followed those persons from the initial rehab contact?

A: Patients I followed 20 years, and not all of them, but I would say about *50* percent of patients I followed ten years, 15 years. I mean, I personally from the standpoint of my mission in life know part of it's probably the original training I had with therapeutic community in the psychosocial. I think from the standpoint from the overall quality of life, it's not going to be the physical impairment that's

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going to cause as much of a problem as it's going to be the psychosocial. A patient who has - you know the Rocky Bleier story from the Pittsburgh Steelers, People with physical impairment, some of these people can overcome that. When you're dealing with brain injury, computer injury, you're dealing with a whole different ball game and they are unpredictable. I can't say.

Q: In terms of a patient like Mrs. Doll with all the appropriate supports in place, if you will, supportive family, supportive work environment, how do those folks do?

A: They do better, but it doesn't - **see,** the big problem is you don't know what's going to happen over the **next** five years, ten years, 20 years. Physiologically she's going to decline and have more problem than the rest of us, as I already said. When it comes to dealing with **life,** her impairment is going to cause her to deal with life differently if the chemistry changes in life, like if she has problems with her husband or children get sick or get hurt or something. These are very fragile people from the emotional standpoint, and, again, I'm not saying it's going to **be** bad. I'm not saying it's going to be good. I can't predict this. They are at **risk** from a

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psychosocial standpoint.

MS. CUTHBERTSON: I think that's about all I have. Thank you, Doctor, for your time. I appreciate it.

MR. MISHKIND: Are you going to order the transcript written up?

MS. CUTHBERTSON: ***Yes,*** please.

MR. MISHKIND: Then if we can just reflect in the record that when it's written up, rather than the seven days, we have been extending it to 28 days. I will leave it up to you whether you want to send it directly to the doctor or send a copy to me and then I will forward it to the doctor.

MS. CUTHBERTSON: **Very** good.

(Deposition concluded at 2:45 p.m.)

John G. Nemunaitis, M.D.

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The State of Ohio,)
) SS: CERTIFICATE
County of Cuyahoga.)

I, Mary Ann Flynn, Notary Public within and for the Stale of Ohio, duly commissioned and qualified, do hereby certify that the within-named JOHN GEORGE NEMUNAITIS, 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 him/her 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 transcript of the testimony so given by him/her as aforesaid.

I do further certify that this statement 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 Cleveland, Ohio on this 21st day of October, 1997.

Mary Ann Flynn, Notary Public
in and for the State of Ohio.
My commission expires 10-22-01.

Lawyer's Notes

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Lawyer's Notes