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IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

MARY LOU ZIMMERMAN,
et al.,

Plaintiffs,

-vs- JUDGE BURNSIDE
CASE NO. 399411
VOLUME IITHE CLEVELAND CLINIC FOUNDATION,
Defendant.

Continued deposition of ALI REZAI, M.D., taken as
if upon cross-examination before Laura L. Ware, a
Notary Public within and for the State of Ohio, at
The Cleveland Clinic Foundation, 9500 Euclid Avenue,
Room M8-09, Cleveland, Ohio, at 3:37 p.m. on Friday,
September 14, 2001, pursuant to notice and/or
stipulations of counsel, on behalf of the Plaintiffs
in this cause.

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EXHIBIT INDEX

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MR. LINTON: Let the record reflect
this is the continued deposition of Dr. Rezai,
as well as the 30(B)(5) deposition concerning
The Cleveland Clinic web site. I'd like to
first see what --

MR. MALONE: I don't think that's true,
the web site business. He didn't come here
until 2000. We've been through all this. He
is Dr. Rezai, clearly, but I can't agree he's
the most knowledgeable person as to any web
site.

MR. LINTON: Who is, Jim?

MR. MALONE: I don't know.

MR. LINTON: Well, Jim, we requested
that deposition last October.

MR. MALONE: Bob, I didn't come here
prepared to respond to that. He's the current
head of psychosurgery. He's all the things he
was when he began his deposition last time.

MR. LINTON: We'll cover that, but it's
been represented to us that Dr. Rezai also is
the web site person.

MR. MALONE: Currently that's correct,
but your patient allegedly -- and by the way,
where is my discovery on that?

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MR. LINTON: On the web site?

MR. MALONE: Where are the materials
you claim your client was given or that Dr.
Donnelly gave them?

MR. LINTON: I got your letter. We'll
respond to that separately.

MR. MALONE: Well, that's on old, old
discovery request, too. I actually forgot it.
I thought you responded.

MR. LINTON: We will get that. As to
the web site, that was noticed for last
October.

MR. MALONE: Is there a reason you
haven't responded to my request, or is it
something you haven't been able to get to?

MR. LINTON: Exactly, that's all it is.

MR. MALONE: Fair enough.

MR. LINTON: The 30(B)(5) was sent out
last October.

MR. MALONE: Uh-huh.

MR. LINTON: When can -- just so we're
clear, for the record --

MR. MALONE: The truth is, I don't
know, nor does anyone know, who was responsible
for that page on the web site that you pulled

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1 out. No one knows that. There are things
2 that, in institutions of this size, no one
3 knows when or how that was done. Ask him.
4 He's here. But I mean, I can't tell you that
5 he's the most knowledgeable person as to that
6 web site in 1998.

7 MR. LINTON: You're not producing him
8 for that purpose?

9 MR. MALONE: No.

10 MR. LINTON: And you don't know who
11 that person would be?

12 MR. MALONE: I have no idea who that
13 person would be.

14 - - -

15 CONTINUED CROSS-EXAMINATION OF ALI REZAI, M.D.

16 BY MR. LINTON:

17 Q. Dr. Rezai, I'd like to, first of all, cover what
18 you've done since the last time we were here and
19 took your deposition as it relates to this case.
20 Can I do that?

21 A. Sure.

22 Q. First of all, have you had a chance to review your
23 deposition, the actual transcript?

24 A. Yes.

25 Q. Have you reviewed any other documents in connection

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1 with your deposition?

2 A. I reviewed a series of papers in this binder.

3 Q. And may I see those papers?

4 MR. MALONE: We will make copies for
5 you, and you can look at them, but you can't
6 keep the set that's here. Fair enough,
7 agreed?

8 MR. LINTON: Sure. Let's mark this.

9 - - -

10 (Thereupon, Plaintiffs' Exhibit 3 was
11 mark'd for purposes of identification.)

12 - - -

13 Q. The materials that are marked Plaintiffs' Exhibit
14 Number 3, this is the binder materials. Did you
15 assemble this or were these provided to you?

16 A. This was in my office.

17 Q. Your office put these together?

18 A. It was -- I don't know who put it together.

19 Q. Okay. Tell me how this file came to exist.

20 A. It was sitting in a box in my office along with the
21 transcripts.

22 Q. And do you know who put this file together?

23 A. No.

24 Q. Did you request it be put together?

25 A. No.

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1 Q. Do you know if this was provided to you by Reminger
2 & Reminger, the lawyers for The Cleveland Clinic?

3 A. I don't know.

4 Q. You have no idea where it came from?

5 A. No.

6 Q. Was there a cover letter that went with it?

7 A. No.

8 Q. This just simply showed up one day in your office?

9 - - -

0 (Pager interruption.)

1 - - -

2 A. Sorry. Okay. Sorry.

3 Q. You went to your office one day and there was this
4 binder; is that correct?

5 A. Yes.

6 Q. The highlighting, is that your highlighting or was
7 it highlighted when it came to you?

8 A. No, it was highlighted when it came to me.

9 Q. And have you taken any steps to find out who
0 prepared this?

1 A. No.

2 Q. Have you reviewed the materials?

3 A. I've glanced through it, yes.

4 Q. How much time did you spend glancing through this
5 binder?

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1 A. I would say about a half hour.

2 Q. And when did you glance through it?

3 A. I glanced through it, I would say, in the past
4 couple of weeks.

5 Q. Is that when you found it in your office?

6 A. Yes.

7 THE WITNESS: Let me get this page,
8 please.

9 - - -

0 (Thereupon, a discussion was had off
1 the record.)

2 - - -

3 Q. Did you recognize the information contained in this
4 binder?

5 A. What do you mean; can you rephrase that?

6 Q. Had you seen any of these writings before?

7 A. Some of them, yes, yes.

8 Q. The handwriting that's in here, is that your
9 handwriting or someone else's?

10 A. Some is mine. I have to look through to tell you
11 which one is mine or not.

12 Q. Sure.

13 A. That's mine.

14 Q. The black ink?

15 A. Uh-huh.

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1 Q. Why don't you go through here and tell us which of
2 these articles you were aware of before you reviewed
3 the binder.
4 A. This one I had not seen before.
5 Q. This, representing tab one?
6 A. Uh-huh.
7 Q. Correct?
8 A. Yes. Tab two I have seen before, three I have seen
9 before, four I have not seen, five I have not seen,
10 six I have seen, seven I have seen, eight I have not
11 seen before, nine I have, ten I have, eleven I have
12 not, twelve I have not, thirteen I have, fourteen I
13 recall vaguely seeing that before, and fifteen I
14 have.
15 Q. Who is a Candice, is it, Keiffer?
16 A. Uh-huh.
17 Q. Who is Candice Keiffer?
18 A. I don't know.
19 Q. You don't know who she is?
20 A. No. A lot of names, they're different colleagues,
21 individuals.
22 Q. Vicki Bokar, do you recognize her name?
23 A. No.
24 Q. You don't recognize her as a paralegal in the legal
25 department at The Cleveland Clinic?

1 protocol?
2 A. He's not part of the protocol.
3 Q. But you said you discussed it with him?
4 A. Right.
5 Q. What input did he have?
6 A. No input. I just gave him the information, that we
7 have this protocol we're running.
8 Q. It was simply to inform him of what the protocol
9 was?
10 A. Inform him, yes.
11 Q. And is that a written protocol?
12 A. Yes, yes.
13 Q. And did you provide him with a copy of it?
14 A. No.
15 Q. You just let him know it was now available?
16 A. Yes.
17 Q. Is Dr. Barnett doing any DBS?
18 A. No.
19 Q. Are you the only one doing that here at The
20 Cleveland Clinic as it relates to psychiatric
21 conditions?
22 A. Yes.
23 Q. Is Dr. Barnett doing DBS for any other conditions?
24 A. He has done it in the past for Parkinson's.
25 Q. Is he presently doing it?

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1 A. No.
2 Q. Did anybody request that you review this binder?
3 A. This binder was along with this.
4 Q. Did somebody tell you to review it?
5 A. I was requested to review this.
6 Q. This, being the transcript?
7 A. The transcript, and that was with it.
8 Q. And you assumed --
9 A. Nobody specifically requested that for me.
10 Q. Did you review any of these before you prepared your
11 paper in CNS Spectrums?
12 A. I may have.
13 Q. Did you refer to any of these in your paper?
14 A. I may have.
15 Q. Did you speak with Dr. Barnett at all about this
16 case?
17 A. No.
18 Q. Did you speak to him at all about any psychosurgery
19 issues since the time of your last deposition?
20 A. We've discussed the protocol that I'm putting
21 together, sure.
22 Q. And what was discussed about your protocol?
23 A. My deep brain stimulation protocol for psychiatric
24 patients.
25 Q. And what input did Dr. Barnett have in the DBS

1 A. No.
2 Q. Will you be the sole person here at the Clinic in
3 charge of DBS?
4 A. Me and the other two partners that just joined us.
5 Q. And who is that?
6 A. Dr. Jamie Henderson and Dr. Nicholas Boulas.
7 Q. Do either of them have any experience in performing
8 psychosurgery?
9 A. I don't know the details of that. I can't tell
10 you.
11 Q. When did this protocol take effect for the DBS?
12 A. This protocol still is being performed confidential
13 through the FDA, so I cannot disclose the details of
14 that yet.
15 Q. So it has not yet been adopted as formal protocol or
16 it is protocol?
17 A. It is protocol.
18 Q. Pursuant to the FDA study?
19 A. Yes.
20 Q. Is this the same study you referenced before
21 involving the Clinic, Bingham & Brown?
22 A. Yes, correct, correct.
23 Q. And as I understand it, just in a generic sense,
24 you're comparing the success rates for radio
25 frequency, for gamma knife and DBS?

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1 A. No, we're not doing a comparison. This is just deep
 2 brain stimulation.
 3 Q. Is there any study being done at The Cleveland
 4 Clinic, to your knowledge, as it relates to
 5 psychosurgery, either radio frequency or gamma
 6 knife?
 7 A. Not that I know of.
 8 Q. So the study you referred to before, the joint study
 9 with Bingham, Brown and the Clinic, is involving
 10 only DBS, correct?
 11 A. Correct, yes.
 12 Q. Is DBS now your treatment of choice for patients
 13 with psychiatric conditions who you believe need
 14 surgery?
 15 A. It is one of the options that we offer patients.
 16 Q. In addition to gamma knife, capsulotomy?
 17 A. Possible gamma knife, capsulotomy.
 18 Q. Or radio frequency cingulotomy?
 19 A. Radio frequency cingulotomy or capsulotomy.
 20 Q. Now, when we last talked, you said you had
 21 personally seen about five patients for psychiatric
 22 conditions who were considering surgery?
 23 MR. MALONE: That was just at the
 24 Clinic. He's seen more than that, and he's
 25 participated in more surgeries than that.

1 patients?
 2 A. Yes.
 3 Q. And how many of the five?
 4 A. I don't recall the exact number of all these
 5 patients.
 6 Q. More than one of them?
 7 A. Yes.
 8 Q. What procedures did you recommend?
 9 THE WITNESS: Do I have to answer that
 0 in terms of the confidentiality of the
 1 patients?
 2 MR. MALONE: No, you can't name the
 3 patient. He's talking in the abstract.
 4 Q. Only in the abstract.
 5 A. Well, we've discussed the options and put that forth
 6 to the patients and let them choose.
 7 Q. And what options have you put forth to the patients?
 8 A. Gamma knife, radio frequency or deep brain
 9 stimulation.
 10 Q. And capsulotomy or cingulotomy for the gamma knife?
 11 A. Capsulotomy for the gamma knife.
 12 Q. Radio frequency capsulotomy or cingulotomy or both?
 13 A. Both.
 14 Q. Both, by that meaning either a cingulotomy or a
 15 cingulotomy radio frequency?

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1 MR. LINTON: I understand. Here at the
 2 Clinic.
 3 Q. My question is, have you seen any additional
 4 patients for that purpose since the time of your
 5 deposition last April?
 6 A. Yes.
 7 Q. And how many more patients?
 8 A. I don't recall the exact number.
 9 Q. Give me your best estimate.
 10 A. Less than ten.
 11 Q. Less than ten total or less than ten additional?
 12 A. Probably less than ten total at this time.
 13 Q. Now, have you actually performed any surgery,
 14 psychosurgery, since coming here to the Clinic?
 15 A. No.
 16 Q. Have you -- we talked about the five patients
 17 before. I don't want to go back there. Let's --
 18 MR. MALONE: Was that question have you
 19 performed any additional psychosurgery?
 20 MR. LINTON: Yes.
 21 MR. MALONE: Additional, okay, I
 22 understand. Excuse me.
 23 Q. The additional five patients or so that you estimate
 24 you've seen since the time of your deposition, have
 25 you recommended surgery for any of those five

1 A. Yes.
 2 Q. You, yourself, do not perform a combined procedure,
 3 cingulotomy and capsulotomy, at the same time on a
 4 patient for OCD, correct?
 5 A. Not in one setting.
 6 Q. Have you ever performed that procedure for a
 7 patient?
 8 A. The combined procedure?
 9 Q. Yes.
 10 A. No.
 11 Q. That's not something that you've recommended for any
 12 patient either, correct?
 13 A. It's not the option that I provide.
 14 Q. Okay. So --
 15 A. Or offer.
 16 Q. You have not recommended that to a patient,
 17 correct?
 18 A. Not in my practice.
 19 Q. Correct?
 20 A. Yes.
 21 Q. And why do you not recommend that as an option?
 22 A. Let me get this straight, you're talking about the
 23 combined simultaneous staged -- what are referring
 24 to exactly?
 25 Q. Exactly what you said, the combined simultaneous

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1 procedure, combined capsulotomy and cingulotomy,
2 single setting.
3 A. I don't think, in my opinion, that's an option for
4 the patients, in my practice.
5 Q. And I appreciate that. And why is that?
6 A. Because I think it's too many lesions in one setting
7 for the patient.
8 Q. And what do you see as being the down side of that
9 or disadvantage?
10 A. Potential side effects.
11 Q. And what potential side effects?
12 A. There are a wide variety of side effects with
13 lesioning with either procedure alone. Either
14 cingulotomy or capsulotomy can give you the same
15 side effects.
16 Q. Would it be fair you would have double the side
17 effects if you combine the procedure?
18 A. I can't say that.
19 Q. But you certainly increase the side effects, in your
20 opinion, if you combine the procedures?
21 A. That's a potential risk.
22 Q. And what side effects would you be concerned about
23 causing or increasing the likelihood of them
24 occurring if you combined the two procedures in one
25 setting?

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1 A. Potential side effects, which, again, can happen
2 with each procedure alone, are frontal lobe
3 dysfunction, changes in mood, changes in patterns of
4 bladder control, changes in personality, seizures,
5 what's in the literature, a wide variety of things.
6 Q. And you don't know of any documented studies that
7 you find reliable that have said that there is an
8 advantage to combining those two in one setting,
9 correct?
10 A. I have seen studies saying they're combined, that
11 has been done.
12 Q. But my question is, in terms of the articles or
13 studies that you find reliable, you don't know of
14 any that advocate that?
15 A. In my practice, I do not do the combined,
16 simultaneous combined procedures.
17 Q. We went through, in your last deposition, you didn't
18 cite to those when you went through the literature
19 search?
20 A. I did not cite those in the paper.
21 Q. And your goal in preparing that paper was to provide
22 the best available literature that was out there, in
23 your opinion, to people considering these
24 procedures?
25 A. That's our way of practicing surgery for psychiatric

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1 conditions, my way and my colleagues' way.
2 Q. And you could not find, at the time you prepared
3 your paper, any reliable articles or studies that
4 combined those procedures in a single setting,
5 correct?
6 A. I did not include any in my paper at that time.
7 Q. Because you didn't feel that any were accurate and
8 reliable?
9 A. I think accurate and reliable -- in my search, I did
0 not believe that that was the thing to do for my
1 patients, so that's why I did not include it.
2 Q. And why not?
3 A. Because I think that it may carry increased risk, in
4 my opinion.
5 Q. And do you see any increased benefit?
6 A. There may be increased benefits because you're
7 disrupting the circuits, sure, so some advocates may
8 say doing it simultaneously may have increased
9 benefits to the patient.
0 Q. But you don't know of any documented studies that
1 have shown to you that there is, indeed, benefit?
2 A. There are studies in this that I have seen. Where
3 did it go, the binder?
4 Q. The binder?
5 A. The binder shows these procedures, cingulotomy and

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1 capsulotomy.
2 Q. But in terms of the literature you had reviewed for
3 purposes of your scientific journals, you did not
4 run across any such articles?
5 A. Yeah, to the best of my recollection, I did not
6 include those articles. I may have seen them, but I
7 did not include them as part of the paper.
8 Q. And can you show me the articles in binder number
9 three, that mysteriously showed up in your office,
0 that show what you believe to be an increased
1 benefit in combining the procedures?
2 A. I can't say to the increased benefit, but it does
3 show that there's combined procedures. For example,
4 article three says, for cingulotomy and capsulotomy,
5 both are done in patients with schizo-affective
6 disorder. That's --
7 Q. That's not the same as OCD, is it?
8 A. There are some components that may be in OCD, but
9 it's not the same as OCD.
0 Q. And does that show that they were combined
1 procedures simultaneously?
2 A. It does not say here. It says two surgical
3 procedures.
4 Q. Does that suggest to you they were -- you don't know
5 then if they were simultaneous or if they were

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1 consecutive?

2 A. I can't tell. It doesn't say here.

3 Q. So we can't look at that and say that that

4 article -- strike that.

5 And that article does not show any increased

6 benefit in combining the two procedures, either

7 together or separately, correct?

8 A. To me, this article, all it says is that cingulotomy

9 and capsulotomy were done in patients. That's all I

10 can say, basically. I cannot say any other

11 judgments based on what's written here.

12 Q. So you cannot use that as a basis for saying that

13 the two procedures combined would benefit the

14 patient any more than if they were done separately,

15 based on that article?

16 A. Based on this article, all that it tells me is that

17 lesions were done in these two areas for this one

18 patient, and I'm not going to make any judgments as

19 far as the benefits or side effects of these two

20 together.

21 Q. Nor does that report any benefit, any increased

22 benefit, by doing those two procedures as opposed to

23 doing one or the other?

24 A. It does not say here. It reports these two lesions,

25 but it does not discuss it further based on what's

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1 here.

2 Q. Are there any articles in this binder which provide

3 scientific support for the theory that combining

4 these two procedures simultaneously is an increased

5 benefit to the patient in terms of the likelihood of

6 success?

7 A. I did not go with a fine-tooth comb through this

8 entire article, this binder, so I don't know. I'd

9 have to review the whole thing in detail to give you

10 an answer.

11 Q. Can you cite to any one, based on your review so

12 far?

13 A. As to what, as to --

14 Q. That show a benefit to the patient in terms of

15 increased success rate by combining them in a single

16 setting. Pardon me, is this your handwriting as

17 well?

18 A. No, that's not my handwriting.

19 Q. And just for the record, I'm referring to tab seven,

20 page --

21 A. 3665.

22 Q. As well as 3666.

23 A. Here is one specific area, it says combination

24 procedures, and actually this literature and others

25 there is a combined procedure of subcaudate

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1 tractotomy, which involves a cingulotomy and a

2 modified capsulotomy, not a standard capsulotomy, so

3 that is performed simultaneously, which is not

4 exactly--

5 Q. That was not the same thing that --

6 A. It's a variance.

7 Q. But that was not what was done to Mary Lou Zimmerman

8 in this case?

9 A. I do not know the details of what was done to her.

10 I have not seen the x-rays or the lesions or the

11 details.

12 Q. Why don't you take a look at, if you would, at the

13 operative report.

14 A. Okay. This refers to anterior capsulotomy and

15 cingulotomy.

16 Q. That is not the same procedure as referenced on page

17 3668, is it?

18 A. No. It says here I was referring to limbic

19 leukotomy is a separate thing here. Limbic

20 leukotomy is a combined procedure.

21 Q. And I appreciate that. Maybe my question isn't

22 clear.

23 A. Okay.

24 Q. I'm asking now just if you know of any support in

25 this binder for combining a capsulotomy and a

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1 cingulotomy in a singular procedure like what was

2 done to Mary Lou Zimmerman?

3 A. It says here the procedures, cingulotomy, subcaudate

4 tractotomy and anterior capsulotomy have been

5 combined to provide possible better results. So

6 this indicates a combination indicating better

7 results.

8 Q. Of course, that's three different procedures, not

9 just the two?

10 A. Right. Well, I don't know which one they're

11 referring to. We have to talk to the authors. Have

12 been combined to provide possibly better results.

13 Limbic leukotomy is a combination of cingulotomy and

14 subcaudate tractotomy. That's what I was telling

15 you about. Improvements in patients' symptoms have

16 been determined for OCD and schizophrenia. 84

17 percent for OCD, schizophrenia 63 percent.

18 Cingulotomy has also been described in combination

19 with anterior capsulotomy, so that's the indication

20 of both being performed here, although improved

21 efficacy over other procedures alone remains

22 unproved.

23 Q. So that would not support -- let me just lay a

24 foundation here.

25 A. Sure.

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- 1 Q. Your thinking or your theory is that if you combine
2 these it may be of some benefit to the patient,
3 correct?
- 4 A. It potentially could because you're disrupting more
5 of the abnormal circuits in the brain causing OCD.
- 6 Q. But you couldn't say with any sort of medical or
7 scientific certainty or even probability that that
8 would be of an increased benefit to the patient,
9 correct?
- 10 A. In my practice I don't think that it would offer any
11 benefits simultaneously.
- 12 Q. And, in fact, you think it would create more risk to
13 the patient without any proven or reasonable
14 probability of improved benefit?
- 15 A. That's a potential risk, but either or alone can
16 have more of a risk than combined, so the risk is
17 very relative. I mean, you can just do a single
18 side capsule lesion and get major devastating
19 consequences, or you can do both, make seven or
20 eight lesions, and have no problems.
- 21 Q. I understand, but if you thought in your mind
22 combining them had better results with no more
23 risks, you'd be doing them, wouldn't you?
- 24 A. Most likely I would be doing them.
- 25 Q. And you don't do them because there's no proven

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- 1 benefit, and in your mind it's more risky?
- 2 A. In my practice, I don't like doing both
3 simultaneously.
- 4 Q. Again, because you don't see the benefit and you
5 think there's the possibility of more risk?
- 6 A. In my opinion, there may be increased risk of doing
7 both simultaneously.
- 8 Q. We can agree that that article says that the success
9 rates have not yet been proven, of combining the
10 procedures, correct?
- 11 A. Well, it's confusing because it says have been
12 combined to provide possibly better results on one
13 part, and another part says remains unproved, so it
14 says both things here.
- 15 Q. So which do you believe?
- 16 A. I don't know. I mean, this is the author's --
17 they're referencing various articles here, so they
18 need to be looked at in more detail.
- 19 Q. You couldn't say this article is necessarily
20 reliable medically?
- 21 A. Oh, I cannot say that. It comes from a very
22 reputable textbook, Youmans, which I wrote articles
23 in, too, Youmans textbook.
- 24 Q. So you do think the textbook is reliable?
- 25 A. This is a very famous textbook, yes.

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- 1 Q. But you've not reviewed the underlying article
2 itself to determine if, in fact, it's reliable?
- 3 MR. MALONE: You're calling it an
4 article. I think this is a chapter.
- 5 A. This is a chapter.
- 6 MR. MALONE: It's a chapter from a
7 text.
- 8 Q. Isn't it referencing articles?
- 9 A. Referencing articles.
- 10 MR. MALONE: But what he's reading from
11 is an article.
- 12 MR. LINTON: Thank you for the
13 clarification.
- 14 A. In a textbook, yeah.
- 15 Q. What I'm saying is would you look at the footnotes
16 being referenced --
- 17 A. Uh-huh.
- 18 Q. -- and tell me whether you can say if those are
19 medically reliable?
- 20 A. Oh, I don't know if I can say that. They're
21 published in journals that are -- Acta Neurochir,
22 another textbook, another textbook, another
23 textbook, 38, Surgical Technique, a postgraduate
24 medical journal. So textbooks and journals, they've
25 been published, based on the one they're referencing

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- 1 in this particular paragraph, combination
2 procedures. Let me look through some more.
- 3 Q. Excuse me.
- 4 A. Sure.
- 5 Q. You're not prepared to say that the annotated
6 textbooks and articles are, in fact, reliable, are
7 you, without reviewing those?
- 8 A. I need to review those, and these are published by
9 peer reviewed journals, so I assume that other
10 colleagues have reviewed them rigorously and decide
11 to publish or not. So I can't say at this point, as
12 to your question, I can't give you an answer to
13 that, but they have been reviewed by other
14 colleagues. Can I go through?
- 15 Q. Sure.
- 16 A. I have to go fast through all this. I wish I was a
17 speed reader.
- 18 Q. Take as much time as you need, Doctor.
- 19 MR. MALONE: You can take as much time
20 as you need.
- 21 A. It may be in other areas. I really have not gone
22 through this in detail. I've just combed it very
23 quickly, so, again, as I'm going through this, the
24 limbic leukotomy, the combined procedure, there's
25 various.

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- 1 Q. Limbic leukotomy, just so we're clear, is not what
2 was done to Mrs. Zimmerman?
- 3 A. Not from the operative note. I was talking about
4 combination procedures, which is a similar area.
- 5 Q. But in terms of her procedure, combining a
6 capsulotomy and a cingulotomy simultaneously, that's
7 what we're talking about here.
- 8 A. Okay. In this paper they performed both. It
9 doesn't say if they did it simultaneously.
- 10 Q. This paper you're referencing is tab fourteen?
- 11 A. Uh-huh.
- 12 MR. MALONE I think this is a text.
- 13 A. This is an Acta Neuro -- it's a peer reviewed paper,
14 Fodstad.
- 15 It's not here, so that's the areas.
- 16 Q. So there's nothing you've been able to point to so
17 far that shows any scientific basis for showing that
18 there would be an increased benefit for combining
19 the procedures, correct?
- 20 A. Except in that one paragraph that says may.
- 21 Q. It said it may be of benefit, but it also said it's
22 unproven, correct?
- 23 A. Right, so they're saying two --
- 24 Q. Conflicting statements?
- 25 A. Which paragraph was that; do you remember what

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- 1 number it was?
- 2 Q. It was Youmans textbook.
- 3 MR. RUF: Seven.
- 4 A. Seven. Under combination procedures, yeah, it says
5 have been combined to provide possibly better
6 results.
- 7 Q. It also talked about combining three procedures?
- 8 A. Right. It doesn't say which one in combination,
9 it's not clear, and then it says although improved
10 efficacy of cingulotomy and capsulotomy over other
11 procedures alone remains unproved, but they've done
12 it.
- 13 Q. Forget about that they've done it. There's nothing
14 in here that says it is of proven benefit?
- 15 A. In a very cursory review of this, I have not gone
16 through this in detail, so just looking at it very
17 quickly I don't see anything except that one
18 statement here, possible better results. That says
19 it's better.
- 20 Q. Have you ever taken the position at any professional
21 seminar, speech, lecture, grand rounds that you've
22 given that those two should be a combined procedure
23 done at the same time?
- 24 A. That's not what I say, no.
- 25 Q. Have you, in fact, said the opposite?

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- 1 A. My reference is do staged procedures.
- 2 Q. Okay. And staged meaning?
- 3 A. Meaning do one and then do the other.
- 4 Q. But you, yourself, have not even done staged
5 cingulotomy and capsulotomy, correct, you
6 personally?
- 7 A. Correct. I don't recall doing that. I'm not a
8 hundred percent sure, but I don't recall. It's been
9 many years.
- 10 Q. You don't train your residents to do a combined
11 simultaneous procedure, do you?
- 12 A. Not in my practice, no.
- 13 Q. And you have not written in any professional journal
14 or paper or article that those two procedures should
15 be combined simultaneously in the same setting?
- 16 A. To the best of my knowledge, no.
- 17 Q. If, in fact, a neurosurgeon was going to perform a
18 procedure where there would be a combination
19 cingulotomy and capsulotomy where there was unproven
20 benefit and possibly increased risk, would that
21 require, in your opinion, additional informed
22 consent?
- 23 A. I think that's up to the neurosurgeon. I mean, this
24 is how I practice, and others do it differently,
25 other colleagues around the country, and actually in

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- 1 Europe there may be colleagues who do it
2 simultaneously, and in their opinion it may be the
3 right thing to do to help these end stage patients.
- 4 So it's really a judgment call of each
5 individual person. For me, personally, I don't do
6 that, but when you have a patient that's so severe
7 end stage suicidal, nothing more to do, some
8 colleagues want to do the best they can, and they
9 may be wanting to do simultaneous lesions to try to
10 offer the best hope for the patient.
- 11 Q. But you also cause irreversible permanent brain
12 damage when you do the lesions, correct?
- 13 A. Yes.
- 14 Q. There's no turning back the clock once you've done
15 damage to the brain?
- 16 A. No.
- 17 Q. So doesn't it make more sense to, at the very least,
18 do them in staged procedures so that you can see the
19 benefit of doing one to see if a second is, in fact,
20 necessary?
- 21 A. In my mind, that's how I think about it, but I'm
22 saying that whenever you have a patient that's so
23 severely incapacitated, some colleagues may say,
24 okay, I'll do them both at the same time to give you
25 the maximum chance. And at that point, I think that

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1 has to be explained to the patient, the potential
 2 risks and benefits of the surgery.
 3 Q. Tell me, a patient presents to you with
 4 long-standing OCD and says, Doctor, I want you to
 5 tell me what my options are here at The Cleveland
 6 Clinic, what do you tell them are their options?
 7 MR. MALONE: This is 2001?
 8 A. 2001?
 9 Q. Correct.
 10 A. Yeah, today I would tell the patient options are
 11 gamma knife, capsulotomy or radio frequency
 12 cingulotomy, radio frequency capsulotomy or deep
 13 brain stimulation.
 14 Q. And what would you say are the advantages and
 15 disadvantages of the different procedures?
 16 A. Oh, that's a very complex question. I think the
 17 advantages of the deep brain stimulation is that it
 18 is fully reversible in 2001 and is adjustable over
 19 time. You can adjust the pacemaker to maximize the
 20 benefit for the patient, so you're not destroying
 21 brain, you're modulating brain. So I think that's
 22 the most advantageous.
 23 Regarding lesioning, in my opinion lesioning
 24 provides a one shot deal, so you just make a
 25 destruction of the abnormal circuits. You know

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1 exactly where you are with radio frequency lesions.
 2 With gamma knife, you may have what we call
 3 runaway lesions or after burn lesions where it may,
 4 down the line, it's unpredictable, but you may have
 5 a lesion just exploding and causing catastrophe in a
 6 patient. So that has to be explained to each
 7 patient. It's rare but can happen. So I would tell
 8 the patient about lesions, you see the results, it's
 9 a one shot deal, and it's irreversible.
 10 Gamma knife is progressive versus radio
 11 frequency, and it may go into a runaway state so
 12 it's unpredictable, blossoming. And I say to them
 13 if there is a side effect it may be permanent
 14 because you're burning the areas, whereas with a
 15 stimulator you're not destroying the areas, so you
 16 can have the chance of being fully reversible.
 17 Q. Now, are you presently doing DBS, in fact, with a
 18 patient?
 19 A. We have a protocol at the Clinic for deep brain
 20 stimulation for OCD.
 21 Q. If a patient came in and wanted the DBS, you could
 22 perform that?
 23 A. Per our protocol with the FDA, yes.
 24 Q. Now, back in 1998 the other procedures were
 25 available; were they not?

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1 A. Yes.
 2 MR. MALONE: At The Cleveland Clinic?
 3 He wasn't there.
 4 A. I don't know about The Cleveland Clinic. That's a
 5 good question.
 6 Q. Certainly the neurosurgical community there was the
 7 gamma knife, capsulotomy and the radio frequency
 8 cingulotomy and capsulotomy?
 9 A. In 1998 where I was practicing, other areas, those
 10 can be available all together, gamma knife and radio
 11 frequency.
 12 Q. And I assume the success rate in 1998, based on what
 13 you told us at your last deposition, was basically
 14 the same as it is now in 2001 for those procedures?
 15 A. Again, this is a very tricky area as far as success
 16 rate is concerned. The literature, it takes on many
 17 different outcome scores, many different definitions
 18 of what success is. Percent improvement can be a
 19 small or large degree, so it's really very difficult
 20 to comb through literature and come up with some
 21 sense of exact percent of success.
 22 Q. Maybe my question is not clear. Let me see if I can
 23 clarify. I'm not talking about trying to state a
 24 success rate right now, I'm just talking about in
 25 terms of the overall success of the procedure it's

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1 pretty much the same today, 2001, as it was in
 2 1998?
 3 A. I would say, yes, that it has not changed
 4 significantly.
 5 Q. And the outcomes have not changed significantly
 6 either, as far as you know?
 7 A. There's no studies that I know that have shown
 8 radically different outcomes.
 9 Q. So you would expect the same success today as you
 10 would have expected in 1998 in those other
 11 procedures, those being gamma knife, capsulotomy or
 12 radio frequency cingulotomy and capsulotomy?
 13 A. Most likely, correct.
 14 Q. Now, the DBS patient comes to you, you have a
 15 written protocol, you have a written consent form
 16 that they have to sign, correct?
 17 A. Yes.
 18 Q. Do you also have a written consent form a patient
 19 has to sign if they do another type of psychosurgery
 20 here at the Clinic in 2001?
 21 A. Everybody at the Clinic for any procedure has to
 22 sign a consent form, so it's a standard consent
 23 form.
 24 MR. MALONE: Don't say something you
 25 don't know.

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1 THE WITNESS: Okay.

2 MR. MALONE I mean, you can talk about

3 your area, but don't tell them about hearts

4 because you don't know. There are no informed

5 consents. Be careful what you say, because you

6 just said something that's just simply not

7 true.

8 THE WITNESS: Fair enough.

9 Q. You're just talking about neurosurgery?

10 A. From my surgeries, we have to have consent for every

11 procedure I do. It's a consent form.

12 Q. It's a written consent form?

13 A. Yes.

14 Q. And that's been the case since you've been here at

15 the Clinic?

16 A. Yes.

17 Q. And that would include for anybody getting a

18 cingulotomy or a capsulotomy or a combined

19 capsulotomy/cingulotomy?

20 A. For any kind of procedures I've been involved with

21 it's required, consent.

22 Q. Now, why have none of the 10 or so patients that

23 you've seen not had the surgery done?

24 A. Because we have not started the protocol.

25 Q. So even if somebody wanted the DBS today, they could

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1 not yet have it done?

2 A. Once the protocol is underway, yes, they can. We're

3 dealing with the FDA, and there's a lot of different

4 groups that we're working with for this protocol.

5 Q. What do you tell a patient today who wants it in

6 terms of when they can reasonably expect to have the

7 surgery?

8 A. We say these are your options, if you wish to go

9 ahead with the deep brain stimulation you have to

10 wait until the protocol is fully ready to go from

11 the FDA and other parties and then we can proceed.

12 Q. Aside from the materials in the binder that showed

13 up on your desk, have you reviewed any other

14 literature or records in connection with this case

15 or your deposition to prepare for your deposition?

16 A. No.

17 Q. I assume that as part of your normal practice, you

18 make it a habit of staying current with the

19 literature in your field?

20 A. Uh-huh, yes.

21 Q. And in particular, since one of your specialties is

22 psychosurgery, staying current with the

23 psychosurgery literature?

24 A. Yes.

25 Q. How do you do that; how do you stay current?

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1 A. I read papers and journals, I also review papers

2 submitted -- I'm the editor, so I review papers for

3 journals submitted regarding surgery for psychiatric

4 disorders.

5 Q. Have you reviewed -- strike that.

6 In your efforts to stay on top of the

7 psychosurgery literature, have you seen anything

8 since the time of your last deposition as it relates

9 to psychosurgery and success rates?

10 A. Yes.

11 Q. What specifically have you seen?

12 A. I don't recall the exact details and numbers, but

13 I've seen several articles that have been submitted

14 for publication.

15 Q. Have any actually been published?

16 A. Yes, there have been articles that have been

17 published on surgery of psychiatric problems.

18 Q. In what journals?

19 A. I don't recall.

20 Q. You are editor of Neurosurgery Clinics of North

21 America, and specifically is it an article entitled

22 Neurosurgery for Psychiatric Disorders?

23 A. It's a book I'm editing for psychiatric disorders.

24 Q. That's to be published in 2002?

25 A. 2002, 2003. These things take a long time.

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1 Q. Have you actually started to type a manuscript?

2 A. I have many authors working on papers, yeah, yes.

3 Q. Are you going to publish a separate chapter in that

4 book?

5 A. Something that I am writing?

6 Q. Yes.

7 A. Yes.

8 Q. And what is your topic?

9 A. It's a topic about the evolution of psychiatric

10 neurosurgery and requirements for centers conducting

11 surgery for psychiatric disorders.

12 Q. What sort of requirements?

13 A. It's basically the requirements that our group is

14 putting together, has put together --

15 Q. And --

16 A. -- as state of the art from 2001 on, at this point

17 what we recommend.

18 Q. And have you started to write that yet?

19 A. It's in the outline stages and so on, so it's no

20 definitive form, no. It's many colleagues, so it's

21 not just me.

22 Q. Who are the other contributing authors?

23 A. The authors are from other universities, Brown

24 University.

25 Q. Dr. Rasmussen?

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1 A. Yes.
 2 Q. Who else?
 3 A. Dr. Greenberg, Rasmussen, a few other colleagues.
 4 Q. What other colleagues?
 5 A. Dr. Newton. I don't recall the names. There's a
 6 lot of people. They may have brought other
 7 colleagues, because this is not done yet, so each
 8 group is providing their input, and then we're
 9 putting it all together.
 10 Q. When are you to submit your manuscript to the
 11 editor?
 12 A. As soon as I get a chance. I am the editor.
 13 Q. I'm sorry. Do you have to submit it to -- who do
 14 you submit it to, the publisher?
 15 A. I review it with other editors, the two other
 16 editors for this, and we submit it to the publisher,
 17 right.
 18 Q. So what are the requirements now, 2001, for research
 19 centers performing psychosurgery?
 20 A. It's a complex issue that's being -- that's
 21 evolving. Does it have anything to do with this
 22 case or what was done in 1998?
 23 Q. It may or may not.
 24 A. I mean, basically we have to have a patient who's
 25 intractable for several years, must have had several

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1 medications and has not responded to medications,
 2 must have been deemed completely end stage
 3 refractory by a psychiatrist, must be very severely
 4 affected despite optimization of medication therapy
 5 or behavioral therapy, psychotherapy, and we're
 6 recommending a board to see each patient.
 7 Q. The multi-disciplinary board we talked about?
 8 A. To see patients and decide whether there's any other
 9 avenues and options and so on, and also the patient
 10 has to understand risks and benefits clearly and
 11 options, have ethicists involved. That's basically
 12 in a nutshell. It's much more complex than that.
 13 I'll send you an article when it comes out.
 14 Q. Okay. When do you expect it to be published?
 15 A. We're writing an editorial to the Neurosurgery
 16 journal regarding this, so probably by early next
 17 year, a variation of that, because it's a book.
 18 Q. Has that been submitted to the Neurosurgery journal?
 19 A. It's sitting on my desk.
 20 Q. Which journal is that?
 21 A. Neurosurgery. It's called Neurosurgery.
 22 Q. The requirements you just walked through, are those
 23 right now in any written form?
 24 A. Some shape and form, not finalized.
 25 Q. Just in a draft form?

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1 A. Draft form, right.
 2 Q. What must be done to make sure the patients
 3 understand the risks and benefits of the procedure?
 4 A. I think you just explain basically what the surgery
 5 is about, what they're about to undergo, what
 5 potential complications can happen, and what are the
 7 benefits of the procedure.
 8 Q. And then there are also --
 9 A. Risks, benefits, alternatives.
 10 Q. And there also then has to be the multi-disciplinary
 11 review board we talked about?
 12 A. The review board's role is different. Consent is
 13 with the patient and surgeon, predominantly. The
 14 board's role is different in terms of patients'
 15 candidacy and so on.
 16 Q. But the surgery cannot go forward until the patient
 17 consents and both the board approves, correct, under
 18 your proposed -- under your current requirement?
 19 A. Under the current requirement, 2001, yes.
 20 Q. On the current panel that's in place at The
 21 Cleveland Clinic, are they employees that sit on the
 22 board or people from outside the Clinic?
 23 A. The current panel --
 24 MR. MALONE: Let me show an objection.
 25 THE WITNESS: Sorry.

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1 MR. MALONE: I'm going to object.
 2 We're getting way far field now. Go ahead.
 3 A. It's mainly people from the Clinic. They may have
 4 other appointments, other institutions, but they're
 5 at The Cleveland Clinic.
 6 Q. Who are the lawyers that are on the panel?
 7 A. I don't recall the names.
 8 Q. How about the bioethicists?
 9 THE WITNESS: Do I have to give names
 10 of these people for confidentiality relations?
 11 MR. MALONE: I think this is
 12 confidentiality. This is far field. This is
 13 what's going on now. It had nothing to do with
 14 '98.
 15 A. It's basically confidential and we have not made it
 16 public yet, so I'd like to disclose it once we get
 17 going with the protocol. The board is being
 18 assembled and all that at this time. Maybe in a few
 19 months it will be all public record, but at this
 20 time I would like to --
 21 Q. When will we know once it's in the public record?
 22 A. Once we start with the protocol, once we get going
 23 with the protocol.
 24 Q. Okay.
 25 A. They'll be within Cleveland Clinic records and so

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1 on.

2 MR. LINTON: I think that, and Jim, we

3 can talk about this, I think that this is

4 relevant. I think we're entitled to it. I'm

5 more than happy to enter into a confidentiality

6 agreement to make sure this is not disclosed

7 outside of the purpose of this lawsuit.

8 MR. MALONE: Well, it's certainly not

9 relevant. Whether -- I guess the standard is

10 whether it leads to something that's

11 discoverable that might be relevant or

12 admissible. Quite frankly, I am taxed even in

13 my imagination, but you're always ahead of me

14 on creativity and imagination, and perhaps you

15 can manufacture some reason for it.

16 MR. LINTON: It will not be

17 manufactured, but there is a good reason, I

18 assure you.

19 MR. MALONE: Tell me what it is right

20 now and perhaps I can respond now.

21 MR. LINTON: I guess the overall

22 question is --

23 MR. MALONE: He's not going to tell you

24 because he considers it confidential. Whether

25 or not -- I don't know anything about that. I

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1 don't know what it is, but you're talking about

2 how we do things and how we are planning to do

3 things in the future as we sit here on

4 September 14th, 2001, and the case at hand, I

5 believe, involves surgery that was done in

6 1998.

7 MR. LINTON: All right.

8 MR. MALONE: Roughly three years ago.

9 Q. Just so I'm clear, Doctor, you're not willing to

10 answer these questions; is that correct?

11 A. Because our protocol is still confidential and

12 involves our group, we're not disclosing it, yes.

13 Q. Is that's right?

14 MR. MALONE: He just asked if you're

15 willing or not willing.

16 A. I prefer not to at this point because it's not

17 public yet.

18 Q. Unless we get a Court order or work it out with

19 counsel, you're not prepared at this point?

20 A. No.

21 Q. It would be a waste of time --

22 MR. MALONE: He may not tell me

23 either.

24 Q. Just so I'm clear, it's going to be a waste of time

25 to get into the details of that because you're not

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1 willing to reveal that information at this point,

2 correct?

3 A. As far as details of the board, who they are and so

4 on, no, I'm not going to disclose who they are.

5 Q. Protocol, documents, et cetera?

6 A. Absolutely, yes, for sure. I'll be glad to give it

7 to you at a later point, some point.

8 MR. MALONE: You just answer his

9 questions. Geez.

10 THE WITNESS: Okay, fine.

11 Q. Have you taken any steps to continue your efforts to

12 try to put together a worldwide web in terms of a

13 database on neurosurgical procedures like you had in

14 New York where you can track patients?

15 A. Explain that again.

16 Q. Okay. Is there any system in place currently, aside

17 from the FDA project, to track patients who have

18 psychosurgery here at The Cleveland Clinic?

19 MR. MALONE: What FDA project are you

20 referring to?

21 MR. LINTON: The one that he doesn't

22 want to talk about.

23 MR. MALONE: That's not even in place

24 yet.

25 A. Right.

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1 MR. MALONE: That's not even started.

2 Q. Right. But I assume -- strike that.

3 I'm talking about other patients who have

4 undergone psychosurgery at The Cleveland Clinic.

5 A. I haven't done any. I don't know any that have had

6 psychosurgery at the Cleveland Clinic. Since I've

7 been here, I have not seen anybody that has or know

8 of anyone that has done any.

9 Q. Now, you don't know of any scientific evidence,

10 Doctor, that there is a 70 percent success rate of

11 positive results in patients that have undergone

12 cingulotomy for OCD?

13 A. Actually, there are in this binder.

14 Q. This is the binder that mysteriously showed up in

15 your office?

16 A. In the binder that was along with the, what's it

17 called, the transcript.

18 MR. MALONE: The deposition

19 transcript.

20 A. The deposition transcript.

21 Q. It came from the legal department, Vicki Bokar?

22 MR. MALONE: He said he doesn't know.

23 A. These were together on my desk along with many of

24 the papers.

25 Q. Tab 8 it says Vicki Bokar, office of general

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1 counsel.
 2 A. Okay.
 3 MR. MALONE Is that your question, or
 4 are you showing you can read upside down?
 5 MR. LINTON: I'm showing that for the
 6 record.
 7 MR. MALONE: What's the significance to
 8 that; is there some significanceto it? I
 9 thought if you put it on the record it had to
 10 be significant. I guess it's not.
 11 A. Can you repeat your question earlier again as far as
 12 percentage of --
 13 MR. MALONE: 70 percent success for
 14 cingulotomywas the question.
 15 A. So again, the literature always has many different
 16 success rates reported, so just going through this
 17 binder and many other papers, you see ranges
 18 anywhere from 20 percent to 90 percent for various
 19 procedures, and that's based on each person, the way
 20 they look at outcomes, what score they use, how many
 21 month follow-ups, so it's very diverse and variable.
 22 MR. MALONE: Okay. That's well and
 23 good, Dr. Rezaï, but, please, listen to this
 24 man's question. He asked you a very specific
 25 question. Is there anything in this binder or

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1 that you know of that demonstrates a 70 percent
 2 success rate for cingulotomyfor
 3 obsessive-compulsive disorder patients? I
 4 think that's the question. Is that the
 5 question or not?
 6 MR. LINTON: Correct.
 7 A. Okay. I did see a high -- I have to look through
 8 this whole binder again. As I was going through it,
 9 there are reports of, for example, 62 percent
 10 improvement with cingulotomies here reported.
 11 Q. What report is that from?
 12 A. From a 1987 report, from a retrospective study of
 13 190 patients who went through cingulotomy.
 14 Q. And that would be more reliable than your 2000 CNS
 15 Spectrum article?
 16 A. This may be -- this is looking at different papers
 17 of different individuals.
 18 Q. So that would be more --
 19 A. I did not includethat in my paper because the
 20 significant level would be different from these and
 21 others. I used my own significant levels based on
 22 my experience.
 23 Q. So you're not suggesting that that article is more
 24 reliable than your article?
 25 A. This article is published in a peer reviewed

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1 journal.
 2 Q. Are you saying that that's --
 3 A. I don't compare it to my article in that regard.
 4 Colleagues have reviewed, for example, the 70
 5 percent reporting in this paper.
 6 Q. That was the one Mr. Malone just pointedto?
 7 A. The one I put a cross, a box on.
 8 Q. I'm sorry, is this your writing?
 9 A. That's my writing. It's my writing.
 10 Q. And where does that 70 percent number come from?
 1 A. Fromthe paper published 2000, July, 2000, Modern
 2 Neurosurgeryfor Psychiatric Disorders.
 3 Q. And who publishedthat?
 4 A. Neurosurgery, 70 percent improvement.
 5 Q. Do you know the basis for that number?
 6 A. No. It says significant improvement, so again
 7 significant can be five percent improvement, it can
 8 be 99 percent improvement. That's why I'm going
 9 through this. You find 20 percent, 30 percent, 50
 10 percent, 60 percent.
 1 Q. Doctor, when you see a patient, you try to give them
 2 the most accurate rates that you know of based on
 3 your thorough review of the literature and your
 4 clinical experience, correct?
 5 A. Uh-huh.

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1 Q. Isn'tthat right?
 2 A. Correct.
 3 Q. And it would be misleading if you suggested to a
 4 patient that the success rate was 70 percent or 80
 5 percent or 90 percent, wouldn't it?
 6 A. From my own practice.
 7 Q. Absolutely.
 8 A. I say based on what I know and what I think and what
 9 I believe in.
 10 Q. Exactly.
 1 A. But any physician can say anything. Like for
 2 example, a doctor can look at this paper X here and
 3 quote these numbers.
 4 Q. But that wouldn't be accurate to selectively quote
 5 one study to a patient that was at the high end when
 6 there was overwhelming literature that it was much
 7 lower, correct?
 8 A. Right. For my practice I use different numbers.
 9 Q. Right. You use what you think are the most accurate
 10 numbers out there, correct?
 1 A. Based on my experience, yes.
 2 Q. And it would be misleading in your practice and in
 3 your experience and in your judgment to quote a high
 4 number of 70 and 90 percent, correct?
 5 A. In my practice, I do not quote a 70 to 90 percent.

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- 1 Q. Right. You don't even quote just **70** percent or **70**
 2 to **75** percent, correct?
 3 A. In my practice, no.
 4 Q. That would be inaccurate and misleading, based on
 5 your experience and your thorough review of the
 6 literature?
 7 A. Based on my experience, my practice, I don't quote
 8 those high numbers.
 9 Q. Because that would be inaccurate and misleading,
 10 wouldn't it, based on your experience?
 11 A. Based on my experience. But others can look at the
 12 literature and peer reviewed journals and --
 13 Q. Just your experience, Dr. Rezai. That would be
 14 based on your experience, right?
 15 A. Right.
 16 Q. Because there is overwhelming literature out there
 17 that conflicts with the one article ~~or~~ two articles
 18 you showed me that suggests a **70** percent improvement
 19 rate, correct?
 20 A. There are more than one or two articles, but they
 21 are conflicting. And this was my whole point
 22 earlier, is that there's -- they say significant
 23 improvement. That can be a five percent improvement
 24 in your symptoms or **90** percent. Significant is
 25 arbitrary depending on each person.

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- 1 Q. And shouldn't the patient know there's a range out
 2 there that's wide and varied?
 3 A. A patient should know that; however, the problem is
 4 that the literature is -- it's, again, full of
 5 nonstandardized outcomes, and it's very difficult to
 6 sift through and look at different outcomes and
 7 percentages. But myself, I have very
 8 conservative -- I, myself, am very conservative when
 9 I talk to my patients.
 10 Q. And why do you want to be conservative when you talk
 11 to your patients?
 12 A. Because I tend to go on the low end.
 13 Q. And why do you want to go on the low end and be
 14 conservative with your patients?
 15 A. Because I believe they have to understand basically
 16 the minimum is what I want them to understand, the
 17 minimum improvement. That's personally what I like
 18 to communicate to the patients, so I am very
 19 conservative.
 20 Q. Because, again, it would be misleading and
 21 inaccurate for a patient to walk into a surgery
 22 thinking there was a **70** to **75** percent success rate
 23 and not being told about the other literature out
 24 there suggesting it's far, far lower?
 25 MR. MALONE: Well, I'm going to show an

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- 1 objection. The application we review all
 2 medical literature with patients before they
 3 undergo a procedure is simply inappropriate
 4 here. I don't know that any doctor anywhere
 5 has ever given the whole body of medical
 6 literature to a patient contemplating a
 7 surgery. Having said that, he may answer, as
 8 he sees fit.
 9 - - - -
 10 (Pager interruption.)
 11 - - - -
 12 Q. Do **you** need to take that page?
 13 A. Go ahead. I'll answer the question.
 14 MR. LINTON: Read back the question,
 15 please.
 16 - - - -
 17 (Thereupon, the requested portion of
 18 the record was read by the Notary.)
 19 - - - -
 20 MR. MALONE: Note the objection, Laura,
 21 of course, but you can go ahead.
 22 Q. In your judgment, Doctor.
 23 A. In my practice I do not quote those high numbers,
 24 but others may well do it.
 25 Q. Because you don't believe the literature supports

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- 1 it, based on your best information and your
 2 experience and your judgment?
 3 A. Based on my experience and my judgment, I think
 4 those numbers are not reflective of what I think it
 5 should be.
 6 Q. Or what it's reported to be, if you look at the
 7 entire body of literature?
 8 A. Other literature reports it up to **80**, **90** percent.
 9 Q. But if you look at the entire body of literature?
 10 A. Right, there's a big range. There's a range from **20**
 11 percent to **90** percent.
 12 Q. Right. And the patient is entitled to know there's
 13 a range?
 14 A. And it also depends on what study the physician
 15 knows of and what study the physician is quoting,
 16 sure. I mean, I agree with you because you're
 17 saying, you know, it's impossible to know all the
 18 literature. There's just so many papers out there,
 19 thousands and thousands of journals and papers
 20 coming out, so there may be a paper that came out
 21 that I don't know about.
 22 Q. Okay.
 23 A. But based on my experience, yes, this is my
 24 experience.
 25 Q. Now, aside from what you pointed to in the white

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1 binder --

2 A. Yes.

3 Q. --what other medical literature or scientific

4 studies are you aware of that would suggest that

5 there's a 70 to 75 percent success rate for

6 cingulotomy?

7 A. So --

8 Q. I'm talking about aside --

9 A. -- aside from this?

10 Q. Aside from this.

11 A. Other than the papers here, I do not know of

12 literature, to the best of my knowledge.

13 Q. Do you need to answer that page?

14 - - - -

15 (Thereupon, a recess was had.)

16 - - - -

17 Q. Doctor, when you used the term success rate, we're

18 talking about what you perceive or the likelihood of

19 positive results in a patient from your proposed

20 surgery?

21 A. Uh-huh.

22 Q. Correct?

23 MR. MALONE: You've got to say yes.

24 A. Yes. Sorry. Yes. I'm getting the lingo here.

25 MR. MALONE: Well, there are a lot of

1 unproven benefit and there's nothing in the

2 literature that establishes with any degree of

3 probability that it has a better result, and, in

4 fact, it has a possibility of worse side effects

5 than doing either one by themselves, don't you have

6 to tell that patient that as part --

7 MR. MALONE: This is a hypothetical

8 question, of course?

9 Q. -- as part of the informed consent process?

10 A. I think, first of all, the improved benefits, that's

11 up to question based on that one paragraph, at

12 least, and it needs to be looked at in more detail.

13 I tell the patient based on my experience, my

14 practice, I do not prefer to do two lesions

15 simultaneously in one setting.

16 Q. When you say two lesions, do you mean bilateral

17 or --

18 A. I mean bilateral on two different sites, capsulotomy

19 and cingulotomy.

20 Q. So it would really be four lesions?

21 A. Right, yes, four lesions, yes. Different location

22 is what I meant.

23 Q. But assuming that there's no scientific literature

24 or studies out there that show with any degree of

25 probability that combining these two, in fact, has

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1 things going on. I understand if you don't.

2 Q. And just so I'm clear, you, yourself, have not

3 performed a cingulotomy or a capsulotomy since

4 you've come to The Cleveland Clinic, correct?

5 A. Correct.

6 Q. And to your knowledge, nobody else at the Clinic has

7 since you came here?

8 A. I don't know the answer to that.

9 Q. But do you have knowledge of any other --

10 A. Not that --

11 Q. -- doctor --

12 A. Not that I know of, not that I know of.

13 Q. So you don't know of any other doctor here at the

14 Clinic who has performed a cingulotomy or a

15 capsulotomy or any type of psychosurgery since you

16 came here, correct?

17 A. Correct.

18 Q. Now, help me with the concept of informed consent.

19 Obviously, you have --you're trying to help the

20 patient. You also have research interests, but

21 ultimately it's the patient who has control over

22 their own body, correct?

23 A. Absolutely.

24 Q. And if there is a procedure out there, like a

25 combined capsulotomy and cingulotomy, that has

1 an increased benefit and there is a possible risk,

2 increased risk, when you combine them, don't you

3 have to explain that to a patient?

4 MR. MALONE: Objection.

5 Q. In your judgment?

6 MR. MALONE: Objection.

7 Q. You can answer, Doctor.

8 A. In my judgment, again, I prefer -- I tell the

9 patient not to do simultaneous surgeries in one

10 setting. That's what I tell them because I am not

11 comfortable in my practice to do two bilateral

12 lesions.

13 Q. And that's because of the risk or that's because

14 there's a lack of proven benefit or both?

15 A. I think more so, in my opinion, it would be because

16 of the potential risk.

17 Q. There's nothing that you have seen so far to

18 establish a proven benefit?

19 A. There may be a potential proven benefit and there is

20 proven benefit of a staged bilateral, so if you do

21 it separately --

22 Q. We're talking about simultaneous.

23 A. Other than that, I don't know of others, in my

24 judgment. To my best recollection, I haven't seen

25 others.

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- 1 Q. Doctor, help me out, if you can. When a patient has
 2 a cingulotomy/capsulotomy combined, that requires
 3 there to be four bur holes that are drilled into the
 4 skull, they're bilateral?
 5 A. Bilateral, **four**. You can do it through the same bur
 6 hole. You don't have to have different bur holes.
 7 You don't have to. You can do it through four or
 8 two bur holes, depending on the surgeon's preference
 9 or technique.
 10 Q. Let's say you decide you're going to go with **four**
 11 bur holes. You have to actually, obviously, go
 12 through skin, go through skull to get to the brain,
 13 correct?
 14 A. Correct.
 15 Q. And you insert an electrode that kind of looks like
 16 a knitting needle, for lack of better words --
 17 A. Yes.
 18 Q. --that actually heats or cooks, according to Dr.
 19 Barnett, the brain cells?
 20 A. Correct.
 21 MR. MALONE: I don't think it has a
 22 hook on it like a knitting needle.
 23 MR. LINTON: You're talking about
 24 crochet, and I'm talking about knitting.
 25 MR. MALONE: I misunderstood. I can't

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- 1 imagine a hook on the thing. I don't do
 2 either, do you? Do you crochet a lot?
 3 MR. LINTON: I'm a knitter, not a
 4 crocheter, Jim.
 5 MR. MALONE: I'm trying to pick up
 6 needlepoint, but I haven't had any luck with
 7 it.
 8 Q. That the patient develops, Doctor, a deep brain
 9 abscess. First of all, have you ever heard that
 10 occurring from any form of psychosurgery?
 11 A. To the best of my knowledge, I haven't seen that.
 12 Q. Okay. Let's assume further that it happens, a deep
 13 brain abscess, and then it tests positive for **two**
 14 organisms, one is a staph aureus, the other is
 15 something called klebsiella oxytoca.
 16 A. Uh-huh.
 17 Q. Have you ever heard of that organism, the klebsiella
 18 oxytoca?
 19 A. Klebsiella, yes; oxytoca strain, no.
 20 Q. Do you know where klebsiella typically comes from,
 21 where in the body?
 22 A. Klebsiella can be either the urine, enteric, can be
 23 in the oral cavity.
 24 Q. Okay.
 25 A. It's a gram negative.

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- 1 Q. Right.
 2 A. Many areas. Same as staph.
 3 Q. Right. Now, assuming that occurs, how does that
 4 sort of infection happen; what are the possible
 5 causes or sources of a contamination?
 6 MR. MALONE: I'm going to show an
 7 objection. I don't think he needs to go into
 8 this, Bob. This is a guy who wasn't here in
 9 1998, never laid eyes or hands or Mrs.
 10 Zimmerman, and for you to attempt to turn him
 11 into an expert witness feeding him
 12 hypotheticals in a chart he has never looked a
 13 at, it's simply out of bounds and
 14 inappropriate. He's answered your questions so
 15 far, but we're not going to answer a
 16 hypothetical based on her care.
 17 Q. Doctor, you're not answering that question?
 18 MR. MALONE: I've instructed him not
 19 to.
 20 Q. Okay. And you're not answering any -- you do know,
 21 based on your neurosurgical practice and your
 22 training and education and your experience, you
 23 would certainly have opinions on what the potential
 24 sources of an infection like that would be in this
 25 type of surgery, correct?

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- 1 MR. MALONE: You don't need to answer
 2 that. Objection. He's not --
 3 MR. LINTON: Excuse me, Jim. Am I
 4 wasting my time getting into this line of
 5 questioning?
 6 MR. MALONE: Yes.
 7 MR. LINTON: We'll go back to the
 8 Court, if necessary.
 9 MR. MALONE: Okay, good.
 10 MR. LINTON: If I can have just a
 11 minute.
 12 - - -
 13 (Thereupon, a discussion was had off
 14 the record.)
 15 - - -
 16 MR. LINTON: That's all the questions I
 17 have at this time. Thanks.
 18 MR. MALONE: Okay.

ALI REZAI, M.D.

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CERTIFICATE

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

I, Laura L. Ware, a Notary Public within and for the State of Ohio, do hereby certify that the within named witness, ALI REZAI, 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 was reduced by me to stenotype in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative counsel or attorney of either party, that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D), or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 29th day of September, 2001.

Laura L. Ware, Ware Reporting Service
21860 Crossbeam Lane, Rocky River, Ohio 44116
My commission expires May 17, 2003.

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