

1 IN THE COURT OF COMMON PLEAS
2 OF ATHENS COUNTY, OHIO

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4 JUDITH SAVAGE, et al.,
5 Plaintiffs,

6 vs Case No. 98 CI 000217
Judge Ward

7 O'BLENESS MEMORIAL
HOSPITAL, et al.,

8
9 Defendants.

10 - - - - -

11 VIDEOTAPED DEPOSITION
12 OF ROBERT TOMSAK, M.D., Ph.D.
13 MONDAY, FEBRUARY 4, 2002

14 - - - - -

15 Deposition of ROBERT TOMSAK, M.D., Ph.D., a
16 Witness herein, called by counsel on behalf of
17 the Plaintiff for examination under the statute,
18 taken before me, Vivian L. Gordon, a Registered
19 Diplomate Reporter and Notary Public in and for
20 the State of Ohio, pursuant to agreement of
21 counsel, at the offices of Becker & Mishkind,
22 Skylight Office Tower, Cleveland, Ohio,
23 commencing at 2:30 o'clock p.m. on the day and
24 date above set forth.
25

SCANNED
11/10/04

1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

4 HOWARD D. MISHKIND, ESQ.

5 Skylight Office Tower Suite 660

6 Cleveland, Ohio 44113

7

8 On behalf of the Defendant O'Bleness Memorial

9 Hospital

10 Reminger & Reminger

11 BRANT POLING, ESQ.

12 Courthouse Square

13 505 S. High St.

14 Columbus, Ohio 43215

15

16 On behalf of the Defendant R. Mays, CRNA

17 PATRICK F. SMITH, ESQ.

18 5025 Arlington Centre Blvd.

19 Suite 250

20 Columbus, Ohio 43220

21

22 ALSO PRESENT:

23

24 Barry D. Hersch, video technician

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2 (Thereupon, TOMSAK Deposition
3 Exhibit 1 was marked for
4 purposes of identification.)

5 - - - - -

6 MR. HERSCH: We are on the record.

7

8 ROBERT TOMSAK, M.D., Ph.D., a witness
9 herein, called for examination, as provided by
10 the Ohio Rules of Civil Procedure, being by me
11 first duly sworn, as hereinafter certified, was
12 deposed and said as follows:

13 EXAMINATION OF ROBERT TOMSAK, M.D., Ph.D.

14 BY MR. MISHKIND:

15 MR. MISHKIND: Let the record reflect
16 that today is Monday, February 4, approximately
17 10 minutes of 3:00, and we are here in
18 Cleveland, Ohio, for the purposes of
19 perpetuating the testimony of Dr. Robert Tomsak
20 to be played at the trial of this matter, which
21 is scheduled to begin on Monday, February 11th.

22 The deposition is being taken
23 pursuant to notice and all counsel are present
24 on behalf of the respective defendants.

25 Q. Would you please state your name for

1 the record.

2 A. Robert Leon Tomsak.

3 Q. What is your occupation?

4 A. Physician.

5 Q. Do you have an area that you
6 specialize in as a physician?

7 A. Yes. It's called
8 neuro-ophthalmology.

9 Q. For the benefit of the jury, would
10 you please tell us what a neuro-ophthalmologist
11 does.

12 A. A neuro-ophthalmologist is a doctor
13 who specializes in dealing with problems that
14 people have that are referable to their visual
15 system, but oftentimes have a neurologic cause
16 or are related to other systemic diseases other
17 than local eye diseases.

18 Q. When you say systemic diseases, what
19 does that mean?

20 A. For example, multiple sclerosis can
21 lead to visual problems, stroke can lead to
22 visual problems, head injuries can lead to
23 visual problems, Alzheimer's disease is another
24 one where a person's nervous system can be
25 abnormal and their vision affected.

1 Q. Doctor, before we talk about your
2 background, would you please tell the ladies and
3 gentlemen of the jury who will be seeing your
4 testimony why it is that we are videotaping you
5 as opposed to your appearing in person next week
6 at trial.

7 A. Yes. Originally, I was prepared to
8 come down to Athens and speak at trial, but the
9 trial was postponed, and it so happens that next
10 week I will be speaking at a meeting called the
11 North American Neuro-Ophthalmology Society, a
12 yearly meeting that I routinely go to, and that
13 I was actually on the program prior to knowledge
14 that the trial was switched to that same week,
15 so I couldn't change my plans.

16 So I appreciate your tolerance in
17 allowing me to do it in this format.

18 Q. Where is that situation?

19 A. It's in Colorado.

20 Q. I would like to talk a little bit
21 about your background first before we talk about
22 the specifics of your involvement in the Judy
23 Savage case. Fair enough?

24 A. Yes.

25 Q. Will you tell the jury where you

1 went, first, where you went to college and where
2 you went to medical school?

3 A. I went to college at Boston
4 University in Boston, Massachusetts and I went
5 to medical school at Case Western Reserve
6 University here in Cleveland.

7 Q. And you graduated from Case Western
8 Reserve University in what year?

9 A. 1977.

10 Q. In reviewing some documents I have,
11 it appears as if you obtained a medical degree
12 in 1977; is that correct?

13 A. Yes.

14 Q. And you also obtained, apparently, a
15 Ph.D. degree at the same time?

16 A. That's correct.

17 Q. Which would explain why there is
18 M.D., Ph.D. after your name.

19 A. Right.

20 Q. Would you explain to the jury what
21 was involved in obtaining the two degrees and
22 what the Ph.D. degree pertains to, please.

23 A. Well, when I applied to medical
24 school, I thought that I wanted to be a medical
25 scientist; in other words, someone who did basic

1 research as far as medicine was concerned. And
2 I had the opportunity to come to Case to join a
3 six year program so that I was able to get both
4 the M.D. and the Ph.D. in six years as opposed
5 to eight years, which would have taken if they
6 were done one after the other. So that's sort
7 of the background as to how I got into the
8 program.

9 My area of interest at that time was
10 chemicals that cause cancer and the department
11 that I did my research in was called the
12 department of pathology, so I have a Ph.D. in
13 pathology.

14 Q. Have you had occasion to apply your
15 training as a pathologist along with or in
16 conjunction with what you do as a
17 neuro-ophthalmologist?

18 A. Well, actually, when I first went
19 into ophthalmology, I thought I might become an
20 ophthalmic pathologist. There is a subspecialty
21 of ophthalmology like that, but then I got more
22 interested in neuro-ophthalmology.

23 But to answer your question directly,
24 I think what the Ph.D. has done for me is sort
25 of taught me a way of thinking logically and

1 analyzing information in a scientific way. So
2 in that regard, I still use those skills.

3 Q. After graduating from medical school,
4 obtaining your Ph.D., you then, as a lot of
5 physicians do, attended a residency program; is
6 that correct?

7 A. Yes. I did, at that time I was able
8 to do a three year residency, which included an
9 internship, in a sense, at The Cleveland Clinic.
10 Back then it wasn't necessary to do an
11 internship and then three years of ophthalmology
12 residency -- now it is -- but to make a long
13 story short, I did my equivalent of internship
14 and residency at The Cleveland Clinic
15 Foundation.

16 Q. After finishing your residency at The
17 Cleveland Clinic, did you also then participate
18 in a fellowship program?

19 A. Yes. I was able to do a
20 neuro-ophthalmology fellowship at the Bascom
21 Palmer Eye Institute, which is part of the
22 University of Miami School of Medicine.

23 Q. How does a fellowship differ from a
24 residency program?

25 A. It's extended training. Extended in

1 subspecialized training in that particular area
2 for a year.

3 Q. I'm sorry, the name of the location
4 that you did your fellowship was?

5 A. Bascom Palmer Eye Institute in Miami,
6 Florida.

7 Q. You are licensed to practice medicine
8 in the State of Ohio; correct?

9 A. Yes.

10 Q. And I understand you were first
11 licensed, was it, in 1979?

12 A. I believe so. I can check for sure
13 by looking at my CV if you don't mind.

14 Q. That's all right.

15 (Pause.)

16 A. Yes, 1979.

17 Q. Are you board certified, doctor?

18 A. Yes, I'm board certified in
19 ophthalmology.

20 Q. Would you tell the jury how it is
21 that you first became eligible for board
22 certification, and then what was the process
23 that you had to go through to become board
24 certified?

25 A. In the United States in order to be

1 board eligible for an ophthalmology -- well, to
2 sit for the board, the American Board of
3 Ophthalmology, you have to complete a residency
4 program, which I did, as I said, at The
5 Cleveland Clinic, and then you have to take two
6 different sets of tests; one, a written exam,
7 and then if you pass the written exam, you
8 qualify the next year for the oral exam, and
9 then if you pass the oral exam, then you become
10 a member of the American Board of Ophthalmology.

11 Q. You practice here in Cleveland;
12 correct?

13 A. Yes, I practice at University
14 Hospitals.

15 Q. How long have you been affiliated at
16 University Hospitals?

17 A. Well, it's kind of been an on and off
18 relationship. Maybe I could just go quickly
19 through my professional chronology --

20 Q. That would be fine.

21 A. -- otherwise it doesn't kind of make
22 any sense.

23 When I came back from fellowship
24 training, I was employed at The Cleveland Clinic
25 as their neuro-ophthalmologist, and I did that

1 from 1980 to 1986. Then in 1986 I had a
2 slightly better opportunity to move to
3 University Hospitals as the
4 neuro-ophthalmologist there. And I spent from
5 1986 to 1992 as the neuro-ophthalmologist at
6 University Hospitals of Cleveland.

7 Thereafter, I had an even better
8 opportunity to move to Mt. Sinai Medical Center
9 in Cleveland here, and that was in 1992. And
10 then probably the jurors from Athens don't
11 though in this, but Mt. Sinai, unfortunately, in
12 a very short period of time after changing
13 hands, going from a non for profit institution
14 to a for profit institution, essentially went
15 bankrupt and closed its doors.

16 So now we are talking 1998, and at
17 that time I did not have an alternative in pure
18 neuro-ophthalmology, so I went into a private
19 practice with some doctors that I had done my
20 residency training with and spent about two and
21 a half years in Lorain, Ohio in a private
22 practice doing neuro-ophthalmology part time.

23 And then a year ago October, in
24 October 2001, I was able to resume my former
25 position at University Hospitals of Cleveland.

1 So since October 2001, I have been director of
2 the division of neuro-ophthalmology in the
3 department of neurology at University Hospitals.

4 Q. Doctor, before the deposition began,
5 we had marked as Plaintiff's Exhibit 1 a copy of
6 your curriculum vitae. And I'm just going to
7 hand you Exhibit 1 and ask you first to identify
8 whether that is, in fact, a current curriculum
9 vitae?

10 A. Yes, it is. It's my current
11 curriculum vitae.

12 Q. As of what date?

13 A. February 4th, 2002.

14 Q. And does it describe some of the
15 information that we have been talking about thus
16 far concerning your background?

17 A. Yes, it does, and it also has the
18 exact dates, which I don't remember exactly,
19 so --

20 Q. You have published a number of
21 scientific articles, book chapters, book reviews
22 and abstracts; is that correct?

23 A. Yes.

24 Q. Could you tell the jury just a little
25 bit about some of the publications and general

1 subject matter that you have had the opportunity
2 to publish on during your career.

3 A. Well, fortunately, neuro-ophthalmology,
4 clinical neuro-ophthalmology is a very
5 fascinating field and we deal with a number of
6 different problems.

7 I guess, looking back over my CV,
8 probably I've published quite a bit in optic
9 nerve diseases, a variety of optic nerve
10 diseases, and specific things that deal with eye
11 movement disturbances, but actually, it is sort
12 of a eclectic CV. I don't have one specific
13 area of interest.

14 Q. You've also published book chapters
15 or co-authored book chapters; is that correct?

16 A. Yes.

17 Q. You have also had occasion to publish
18 various book reviews, as well; correct?

19 A. Yes.

20 Q. And I understand you have been
21 invited to provide presentations in the area of
22 neuro-ophthalmology, both in Cleveland, and
23 throughout the United States; is that correct?

24 A. Yes, that is.

25 Q. Doctor, you have been called upon

1 from time to time to review articles submitted
2 by others for publication as well; correct?

3 A. Yes.

4 Q. Do you serve on any type of a review
5 board or an editorial board with regard to
6 publications by other physicians?

7 A. Yes. I'm actually book review editor
8 for a publisher that's called
9 Neuro-Ophthalmology, which is a journal devoted
10 specifically to neuro-ophthalmology, and then I
11 have been on an ad hoc review, meaning not on an
12 editorial board, but the editorial board members
13 would send me an article if they thought it was
14 something that I was able to give an opinion on,
15 and I have done that for a number of different
16 journals over the past years.

17 Q. I also note that you've received
18 various honors and awards over the years; is
19 that correct?

20 A. Yes.

21 Q. You have been acknowledged as one of
22 the best doctors in America back in the mid
23 '90s, and towards the late 19 -- it looks like
24 1998, you were acknowledged as one of the best
25 doctors in Cleveland; is that correct?

1 A. Yes.

2 Q. Tell the jury, if you would, whether
3 you have had occasion to write on the topic of
4 functional visual disturbance or functional
5 visual loss.

6 A. Yes. A book that I edited entitled
7 Pediatric Neuro-Ophthalmology, I wrote a chapter
8 on functional visual loss.

9 Q. And that's one of the topics that we
10 are going to be talking about today, is it not?

11 A. Yes, it is.

12 Q. Before we move into Judy Savage
13 specifically, I want to ask you just a few more
14 questions about your background for the benefit
15 of the jury. You do teaching, as well?

16 A. Yes, I do.

17 Q. Are you a faculty member up here at
18 Case Western Reserve University?

19 A. Yes, I am. I'm presently assistant
20 professor of neurology and ophthalmology at CWRU
21 and as of this summer, I will be associate
22 professor of neurology and ophthalmology.

23 Q. Do you have occasion then, doctor, to
24 teach or train future ophthalmologists or
25 neuro-ophthalmologists?

1 A. Very commonly, yes.

2 Q. And have you given lectures to
3 doctors on the topic of functional visual loss?

4 A. Yes, I have.

5 Q. In fact, doctor, most recently, can
6 you tell the jury whether you've given lectures
7 on functional visual loss within the last year
8 or two to any students or doctors?

9 A. Yes. I did give a lecture to the
10 ophthalmology residents within the past year.
11 I'm not exactly sure when it was. Probably in
12 the fall of 2001.

13 Q. Describe for the jury, please, your
14 current clinical practice. What do you do on a
15 day-to-day basis.

16 A. Okay. Four days a week, Monday,
17 Tuesday, Thursday and Friday, I see patients
18 with neuro-ophthalmologic problems who are
19 referred to me by, usually by other doctors in
20 the community or at University Hospitals. And
21 then in between that I give lectures usually
22 early in the morning or late in the day
23 depending on specific schedules. And then
24 Wednesday I have as my surgery day, when I do
25 surgery, and also time for clinical research and

1 literature review and that sort of thing.

2 Q. Tell the jury what percentage of your
3 professional time is spent in the active
4 clinical practice of medicine or in teaching.

5 A. Well, 100 percent of my time is spent
6 in something related to neuro-ophthalmology,
7 whether it's actually seeing patients or writing
8 about them or teaching residents about the
9 subject, so I'm a full-time clinical
10 neuro-ophthalmologist at this point.

11 Q. You've also had occasion to practice
12 in the area of general ophthalmology from time
13 to time, as well; correct?

14 A. Right. There is two and a half years
15 between 1998 and October 2001 were spent in a
16 general ophthalmology practice, yes.

17 Q. The next area I want to talk to you
18 about is your prior litigation experience, okay?

19 A. Yes.

20 Q. Have you been called upon in the past
21 to provide expert testimony in medical
22 negligence cases?

23 A. Yes.

24 Q. How many years, approximately, have
25 you been received as an expert in this area?

1 A. Since about 1980.

2 Q. How many times have you actually
3 testified in a courtroom?

4 A. Just once.

5 Q. Would you tell the jury whether you
6 have ever worked with me or my office before the
7 Judy Savage case?

8 A. No, I have not.

9 Q. Tell the jury whether you have ever
10 had any personal or professional relationship at
11 all with me or anyone in my firm prior to or
12 since this case?

13 A. No, I have not.

14 Q. When you have appeared as an expert
15 witness in medical negligence cases, have you
16 normally been appearing on behalf of the
17 patient, such as Judy Savage, or have you more
18 often been appearing on behalf of the defendant
19 that has been named a defendant in the medical
20 negligence case?

21 MR. POLING: Objection.

22 A. Most often for the defendant, I would
23 say, nine out of ten times.

24 Q. Doctor, I want to ask you to define
25 some terms that we are going to be talking about

1 for the balance of your testimony. Fair enough?

2 A. Yes.

3 Q. We are going to be talking about the
4 cornea. And I would like to be able to have for
5 benefit of the jury in the context of your
6 testimony and understanding of what area of the
7 eye is the cornea, and you can --

8 A. Would you like me just to show on the
9 model here?

10 Q. That would be fine.

11 A. I don't know what is going to be best
12 for -- something like this okay? You are not
13 obstructed at all? Good.

14 Well, let's just talk about the eye
15 very quickly. The eye is like a simple camera.
16 It has got an optical system, which consists of
17 the cornea, which is like a crystal on a watch,
18 and the human lens which sits in the colored
19 part of the eye called the iris. Light comes
20 through the clear front part of the eye, gets
21 focused on a light sensitive membrane that lines
22 the inside of the eye called the retina.

23 The retina is like film in a camera.
24 The retina takes light energy and turns it into
25 a form of electricity that the brain can

1 understand and that's sent from the eye to the
2 brain through the optic nerve, which is like an
3 electrical cable. So that's the eye in a
4 nutshell in terms of how it functions.

5 The cornea itself is normally clear.
6 It has a number of layers. I think we have them
7 expanded over here. It has an outer layer
8 called the epithelium. The epithelium is
9 actually a number of cells thick. It's almost
10 like a brick wall, five or six cells thick, and
11 the epithelium sits on what is called a basement
12 membranes; in a sense like the body's glue that
13 glues the epithelium to the meat of the cornea,
14 the main thickness of the cornea, which is
15 called the corneal stroma.

16 So in Mrs. Savage's case, we are
17 going to be talking about an injury to this
18 layer here, the corneal epithelium and basement
19 membrane.

20 Q. While you are still up, I'm going to
21 talk about the cornea. We are also going to be
22 talking about the term corneal abrasion.

23 Can you demonstrate for us when we
24 refer to corneal abrasion what that term means?

25 A. Yes. A corneal abrasion is an injury

1 that essentially causes the corneal epithelium
2 to be removed from the surface of the cornea.

3 Q. When one talks about an exposure
4 injury or a drying out or a desiccation to the
5 corneal, what is one referring to?

6 A. Again, we are referring to damage to
7 the corneal epithelium.

8 Q. When the cornea is injured, do
9 patients usually experience pain?

10 A. It's extremely severe pain. There is
11 some books that say that the cornea is the most
12 pain sensitive structure in the human body.

13 Q. Why is that?

14 A. Why was it made that way?

15 Q. Why is the cornea considered to be
16 one of the most pain sensitive structure of the
17 body?

18 A. Well, that's the observed fact. It's
19 because it has many sensory nerve fibers that,
20 pain sensory nerve fibers that are located in
21 this general region right here right under the
22 epithelium.

23 But if you are asking why should a
24 cornea be sensitive, well, vision is so
25 important to survival that we would want to make

1 absolutely sure that anything that touched the
2 eye with potential damage would be perceived
3 immediately by the person so that they would be
4 able to get away from that stimulus.

5 Q. Now, when we sleep, how do we protect
6 ourselves from experiencing some type of an
7 injury to the cornea?

8 A. Well, two things. One is, the
9 eyelids are usually closed during sleep. You
10 have had heard about people who sleep with their
11 eyes open; that's not a normal state of affairs.
12 Most sleep with our eyes closed. And then there
13 is this phenomenon called the Bells phenomenon
14 named after Dr. Bell who described it, that when
15 we close our eyes, our cornea actually rolls up
16 under our upper eyelid so that acts as a
17 protective effect too.

18 So in other words, if I were to close
19 my eyes real tight and pull my eyelid up,
20 chances are my cornea would be up under my lid.
21 And that's called the Bell's phenomenon, thought
22 to be a protective reflex.

23 Q. I think that probably for right now
24 is sufficient with regard to the chart. Thank
25 you.

1 I do want to have you define a couple
2 other terms that I think are going to be
3 important as relates to your testimony.

4 The term functional visual loss or
5 functional vision loss or functional visual
6 disturbance, are those terms that I have just
7 sort of mumbled through, are they all pretty
8 much interchangeable terms?

9 A. Yes, they are. And it's an
10 unfortunate case that we use that particular
11 term. I don't know exactly how it came about,
12 but it doesn't adequately convey what it really
13 means.

14 But what it means is that a person
15 has some problem with their visual function that
16 is not related to obvious persistent structural
17 damage in the visual system.

18 To give you an idea what some things
19 would be that would be persistent damage to the
20 visual system, imagine someone with a retinal
21 detachment, where the retina peeled away from
22 the inside of the eye.

23 Q. That's the back part of the eye?

24 A. The film in the camera. The analogy
25 of the film in the camera. And lost vision as a

1 result of that. Well, that would be, an
2 ophthalmologist could ascertain that the reason
3 why the person couldn't see was because the
4 retina was detached, okay?

5 Similar for macular degeneration,
6 another term that most people have heard at
7 least where there are age-related changes in the
8 most sensitive part of the retina concerned with
9 vision. And we can observe a change that
10 correlates with a loss of visual acuity.

11 In the case of a functional visual
12 disturbance, what we are saying is the person
13 can't see normally, but we can't identify a
14 particular structural problem with our
15 examination techniques; whether it be in the
16 office or using MRI or other sophisticated
17 scanning techniques, for example.

18 Q. There is a term also used in this
19 case, I believe, by the terminology of
20 nonorganic vision loss. How does that relate to
21 the term that we just talked about in terms of
22 functional vision loss?

23 A. They are synonymous, but nonorganic,
24 I think, is a little bit more descriptive of
25 what is going on. In other words, organicity in

1 medicine, when we say something has an organic
2 cause, again, it's something we can point to.
3 We can say, here is where the lesion is, we like
4 to say, here is where the lesion is, here is
5 what is the cause of the problem.

6 To give you an analogy with regard to
7 the cornea, if one has an abrasion of the
8 corneal epithelium in the central part of the
9 cornea, the part of the cornea that light is
10 coming in to be focused on the retina, the
11 central part, the person will have loss of
12 vision associated with that abrasion as well, so
13 that's an example of an organic cause for
14 corneal visual loss, for example.

15 Q. As a neuro-ophthalmologist,
16 Dr. Tomsak, is this phenomenon of functional
17 vision loss or nonorganic vision loss, is it
18 widely recognized in the area of
19 neuro-ophthalmology?

20 A. Yes, it is. In fact,
21 neuro-ophthalmologists are the doctors who treat
22 these patients.

23 Q. Would you tell the jury based upon
24 your training and experience as a
25 neuro-ophthalmologist whether there is a

1 relationship supported based upon your knowledge
2 and experience between trauma or injury to the
3 eye and functional vision loss?

4 A. Yes, there is a relationship.

5 Q. And can you explain that, please.

6 A. I can tell you what the observation
7 is. I don't know if I can explain why it
8 happens. But it's not uncommon for a person to
9 have a relatively minor injury of the eye or
10 around the eye and then subsequently develop a
11 visual loss that is not explained by that
12 injury.

13 An example would be somebody gets
14 mugged and hit around the eye. Without it
15 causing any permanent damage to the eye, I have
16 seen functional visual loss in that particular
17 case.

18 In the case of Mrs. Savage, her
19 injury was to the cornea. It was a fairly
20 substantial injury initially, but it has
21 subsequently healed. But she has developed
22 functional visual loss as a result of that, in
23 my opinion.

24 Q. Doctor, if a patient presents to you
25 with a vision loss, either a reduced vision or

1 perhaps where the visual fields are reduced in
2 terms of being able to see to the sides or
3 different areas, but you can't explain it based
4 upon the structure of the eye, how do you go
5 about diagnosing what is causing the patient's
6 problems?

7 A. Well, I think the best way to start
8 on that is to simply say that whenever we
9 diagnose a functional visual loss, we call it a
10 diagnosis of exclusion; meaning we have excluded
11 or ruled out problems that could explain that.

12 For example, a person with a visual
13 field problem could have a brain tumor. Okay?
14 So we have to make sure, for example, that they
15 don't have a brain tumor, or they could have
16 multiple sclerosis, or they could have something
17 else like this that could actually explain the
18 visual problem.

19 Again, in functional visual loss we
20 have a visual disturbance that is not explained
21 by something we can image on MRI or something we
22 can actually quantitate in the normal sense of
23 the word.

24 Q. Can functional visual loss or
25 functional visual disturbance be a disabling

1 condition?

2 A. Yes, it can.

3 Q. Are there different types of
4 functional vision loss or visual loss that you
5 encounter as a neuro-ophthalmologist?

6 A. Yes, there are. I think that the two
7 major categories are what we call hysterical
8 visual loss or hysterical functional loss,
9 whereby the person has this happen to them, but
10 they are not trying to pull the wool over
11 anybody's eyes. They are not faking it, in
12 other words. That's by far and away the most
13 common form of functional visual disturbance
14 that I see.

15 Then the other form is what's called
16 malingering. And malingering is a willful
17 deception on the part of the patient alleging
18 that they have something wrong with their
19 vision, in this particular case, but knowing
20 full well that they are faking it. The patient
21 knows they are faking it.

22 And normally we see malingering in
23 the setting of some fairly well defined what we
24 call it secondary gain. That could be a
25 lawsuit, for example; that could be, for

1 example, family members paying more attention to
2 patients because they are sick, so to speak, but
3 again, malingering really means a willful
4 deception on the part of the patient.

5 But it's more common, for example, in
6 the military where soldiers don't want to
7 undergo hazardous activities and this sort of
8 thing.

9 Q. As part of your assignment in this
10 case, which we are going to talk about shortly,
11 did you go about attempting to gather
12 information to be able to determine whether or
13 not Judy Savage was malingering or faking or had
14 hysterical vision loss?

15 A. Well, yes, I did. But we don't have
16 a specific test for one or the other in that
17 sense, but it really boils down to how the
18 patient responds when you start telling them
19 that there really is nothing fundamentally wrong
20 with their visual system, but yet they have the
21 visual loss.

22 A malingerer very commonly will get
23 angry about that, about being confronted that
24 there really isn't something wrong with them,
25 whereas a patient with the hysterical form of

1 functional visual loss, much like a hysterical
2 paralysis, for example, it's as real to them as
3 it would be if we stuck a needle in their eye or
4 an ice pick in their eye and they lost vision.

5 Q. And we are going to talk -- I'm
6 sorry, I didn't mean to interrupt you.

7 A. That's okay.

8 Q. We are going to talk more in
9 specifics with regard to Judy, but did you
10 arrive to a reasonable degree of medical
11 certainty as to whether Judy's functional visual
12 loss was of the malingering or hysterical vision
13 loss?

14 A. Yeah. My conclusion is that her
15 visual loss is not malingering. It is of the
16 hysterical or unintentional form.

17 Q. And we will talk more about that in a
18 moment.

19 I want to talk briefly about another
20 condition, which I believe is relevant in this
21 case, and will come throughout your testimony
22 and some of the other witnesses, some who may
23 have already testified by the time the jury sees
24 your video, as well as perhaps others, the
25 condition called recurrent corneal erosion

1 syndrome.

2 Can you tell us basically what that
3 is?

4 A. Yes. Again, going back to our -- I'm
5 kind of hooked here on the chair. There we go.

6 Going back to our diagram of the
7 cornea, if a person has a corneal abrasion in
8 the basement membrane -- I think I started off
9 by saying the basement membrane is much like the
10 body's glue that attaches the epithelium to the
11 corneal stroma. If the basement membrane is
12 damaged, what can happen is that the new
13 epithelium, which, by the way, regenerates
14 itself. So in other words, these cells here, if
15 you were to scrape them off, they grow back.
16 The body has a way of regenerating these cells.

17 The glue is not what it used to be,
18 so I used an analogy, I think in my deposition
19 like a pot hole in the street. You know that
20 pot holes are never as good as the real thing,
21 and the pot holes constantly over time will sort
22 of erode.

23 Well, in a similar way, patients with
24 recurrent erosion syndrome have episodes where
25 spontaneously they will develop tiny corneal

1 abrasions, and it is related to the initial
2 trauma that caused the major corneal abrasion.

3 Q. What are the typical signs and
4 symptoms that you as an ophthalmologist see that
5 are associated with a recurrent corneal erosion
6 syndrome?

7 A. The most common is a knife-like
8 stabbing discomfort that usually lasts seconds
9 to minutes, oftentimes associated with light
10 sensitivity, sometimes associated with tearing,
11 oftentimes occurring the first thing in the
12 morning when patients first wake up. Although
13 it can occur at different times and different
14 conditions, depending on humidity and other
15 factors such as whether they are using
16 lubricating ointments, et cetera.

17 Q. That sort of answered my next
18 question partially, but I will state it fully
19 anyway.

20 How does a patient that has recurrent
21 corneal erosion syndrome typically treat their
22 symptoms?

23 A. Well, the first line treatment is
24 ocular lubricants, usually artificial tear drops
25 and a lubricating ointment at night, so that the

1 eyelid doesn't actually pull the corneal
2 epithelium off when they open their eyes in the
3 morning.

4 Q. I've heard of like PM drops or --

5 A. There are a number of brands, like
6 Coke and Pepsi are both types of pop. Well, we
7 have got all different brands of artificial
8 tears, and they all basically do the same thing,
9 although their chemical composition is often
10 slightly different.

11 Q. Why would a patient use drops at one
12 time and ointment at another time?

13 A. Well, drops are more convenient.
14 They don't blur the vision as much, but they are
15 shorter lasting. So that's why normally during
16 the day people use drops and at nighttime when
17 they don't really have to be worried about
18 vision, they are just worried about protection,
19 they use the ointment.

20 Q. In your experience, when a patient
21 has recurrent corneal erosion syndrome, how
22 frequently in a range, if you will, do they
23 experience the type of symptoms that you have
24 just described?

25 A. Well, it could be up to daily, but

1 it's often once or twice a month or once or
2 twice a year. It depends on a number of factors
3 that we really can't put a handle on.

4 Q. Can you have a corneal erosion
5 syndrome even if the cornea by examination
6 appears to be entirely healed?

7 A. Yes. I think the analogy I used in
8 my deposition was that if a person awakens, for
9 example, and has the symptoms of a corneal
10 erosion and then calls your office and makes an
11 appointment and comes in later in the afternoon,
12 it might be entirely likely that you saw no
13 abnormality on the cornea at the time of the
14 exam.

15 So really the diagnosis is, and the
16 way I have come to the diagnosis in
17 Mrs. Savage's case is based on symptoms, number
18 one, and number two, an underlying cause that
19 would indicate that those symptoms are, you
20 know, fit, let's put it that way, those symptoms
21 fit with the underlying trauma.

22 Q. Okay. Now, if you want to put the
23 chart down, we are going to get into the next
24 area that I would like to talk to you about with
25 the jury, and that is the material reviewed and

1 your involvement in this case. Okay?

2 A. Yes.

3 Q. First, I thank you for giving us the
4 background on some of the medicine that I think
5 is relevant to your opinions, but so there is no
6 question, at my request, you reviewed certain
7 information relative to Judy Savage; is that
8 correct?

9 A. Yes.

10 Q. And you also examined Judy Savage at
11 my request?

12 A. Yeah, on two occasions.

13 Q. Do you remember when those occasions
14 were?

15 A. I can tell you, if I can refer to my
16 notes, I can tell you exactly.

17 Q. Sure, absolutely.

18 A. The first exam was done while I was
19 in my Mt. Sinai phase of my career and that was
20 done on March 26th, 1998. And the most recent
21 exam was done at University Hospitals on January
22 8th, 2001.

23 MR. POLING: Objection. Off the
24 record.

25 MR. HERSCH: We are off the record.

1 MR. POLING: I have never been
2 advised that there was a subsequent exam. This
3 is news to me. If I had known of a subsequent
4 exam, I would have procured discovery relative
5 to that additional exam. I'm not sure what is
6 going to be said about the subsequent exam. I
7 don't have a report from the subsequent exam.
8 I'm quite surprised to hear this on video so I
9 want to state that on the record.

10 MR. MISHKIND: For the record, when
11 you came back into the case, which was I think
12 in January of 2001, I sent to you and I have the
13 correspondence, with a copy of the report from
14 Dr. Tomsak for that exam.

15 I provided Pat with a copy of it, as
16 well. I also provided the adjustor with a copy
17 of the report. So I'm happy to show you the
18 correspondence, but there is no doubt in my mind
19 that the reports were referenced and they may
20 even be indicated. And I don't have my trial
21 brief handy right now, but I know that both
22 examinations have been referenced, and I'm happy
23 to give you, if you don't have a copy of the
24 report with you right now, I'm happy to give you
25 a copy of the report, but there is no doubt in

1 my mind that it was sent.

2 I can't explain why you be don't have
3 it, but --

4 MR. POLING: I don't have it. I
5 don't know what else to say. If you have it, I
6 would like to look at it now before we go any
7 further.

8 MR. MISHKIND: Pat, you have a copy
9 of the report, do you?

10 MR. SMITH: No, not in the packet of
11 materials that I have.

12 MR. MISHKIND: Well, I will go back
13 to correspondence, because --

14 MR. SMITH: I think what we are
15 saying, why don't you just make us a copy of the
16 report and you can continue on with your
17 deposition.

18 MR. MISHKIND: Sure. But I want the
19 record to reflect that there is no doubt in my
20 mind that the supplemental report was produced.
21 I hear what both of you are saying, but there is
22 no doubt prior to or back in January of last
23 year that the report -- in fact, Dr. Mauger at
24 the time of his deposition in December had both
25 reports. So I think that you may be mistaken

1 with regard to that. He did mention the two
2 reports.

3 (Recess had.)

4 MR. POLING: I will withdraw the
5 prior objection.

6 MR. MISHKIND: Obviously, you have,
7 although you have remained silent, which is
8 surprising, so far, I can certainly show you
9 documentation where you had the report as well.
10 I presume that you have no objection?

11 MR. SMITH: No objection.

12 MR. MISHKIND: Thank you.

13 MR. HERSCH: Back on the record.

14 Q. I think before we had our discussion
15 off the record, you had identified the two dates
16 that you examined Judy. One was back in 1998.

17 A. Correct.

18 Q. And then the second one was in
19 January of 2001?

20 A. Correct.

21 Q. Have you also had occasion to review
22 the results of other doctors that have examined
23 Judy in this case, including the findings of
24 Dr. Mauger who examined Judy just most recently
25 in October of 2001 at the request of the defense

1 in this case?

2 A. Yes, I have.

3 Q. Would you tell the jury briefly what
4 material you were provided in this case in order
5 to arrive at certain opinions.

6 A. Can I just page through it and talk
7 about it as I encounter it?

8 Q. If that's the easiest way for you,
9 that's fine.

10 A. Okay. The first thing I have on my
11 pile is some records from a Dr. Baker,
12 apparently, an optometrist who had seen
13 Mrs. Savage in, I think it was '91. I'm sorry,
14 '91 or '97. One date is here is 1-17-91, it
15 appears, and the other one is 1-17-97.
16 Optometrist.

17 Then I have records from O'Bleness
18 Hospital, which include a number of different
19 things. Should I go through them or --

20 Q. No.

21 A. Okay. This is a duplicate of the
22 hospital records. I have an MRI report. I have
23 some progress notes from the surgeon who did the
24 parotid surgery, and I have Dr. McAdoo's notes,
25 including his hospital consultation while

1 Mrs. Savage was in the hospital.

2 I have originals of my files, my two
3 office files that were alluded to before, some
4 extra copies of Dr. McAdoo, a letter from
5 Dr. Carl Asseff, an ophthalmologist in town, and
6 some visual fields of his. This is dated June
7 5th, 1997.

8 I have the deposition testimony of
9 Dr. McAdoo, the letter from Dr. Mauger dated
10 October 22nd, 2001, some corneal topography
11 tests dated 11-19-01, Dr. Mauger's office
12 records, office notes. Dr. Mauger's deposition,
13 and my deposition.

14 Q. And then you have also had the
15 benefit of examining Judy on the two occasions?

16 A. Correct.

17 Q. Would you tell the jury essentially
18 what was your assignment in connection with this
19 case, as you understood it.

20 A. My understanding was to examine
21 Mrs. Savage to come to a diagnosis as to the
22 cause of her visual problems and try to
23 determine if there was a cause for that
24 specifically, and what the prognosis was for her
25 future.

1 Q. And based upon your examinations and
2 the review of the records, have you arrived at
3 certain opinions in this case?

4 A. Yes.

5 Q. And the opinions that we are going to
6 talk about during the balance of your direct
7 examination, are those opinions all to a
8 reasonable degree of medical probability?

9 A. Yes. If they are not, I'll let you
10 know.

11 Q. Let's talk about your first exam in
12 March of 1998, please. I would like you to tell
13 the jury what history you obtained at that time.

14 And you can certainly feel free to
15 refer to your report or your notes or whatever
16 will help you with that.

17 A. I'm going to be referring both to my
18 jotted down office notes that I did personally
19 and my report letter, if that's okay.

20 I saw her on 3-26-98. Her chief
21 complaint was, quotes, a haze over her eye,
22 meaning her right eye.

23 She told me that she had had a tumor
24 removed in her neck, and then subsequently
25 developed a corneal abrasion sometime around the

1 time of surgery or in the early postoperative
2 period.

3 Shortly thereafter, she had a little
4 bit of a facial nerve weakness, we call a 7th
5 nerve palsy. And then she began to develop
6 problems of discomfort. She described some of
7 these as if there was glass in her eye.

8 An ophthalmologist treated her in the
9 hospital, and then she had been seen by him for
10 on a number of visits thereafter. She mentioned
11 her visit to Dr. Asseff and a fact that an MRI
12 was done, which was normal. She also mentioned
13 that in addition to the sharp pain, she had a
14 toothache-like pain almost all the time. And
15 the aforementioned haze in her vision.

16 Q. Did you then examine Judy?

17 A. Yes, I did.

18 Q. Would you tell the jury what tests
19 you used and what your findings were?

20 A. Okay. Well, perhaps I will just go
21 through it sequentially; in a sense outline what
22 we normally do.

23 Q. That's fine.

24 A. When we examine a patient for a
25 neuro-ophthalmologic cause, or for a

1 consultation, we first check their visual
2 acuity. Visual acuity is what we measure when
3 the patient is in the exam office and looks at
4 the eye chart.

5 We are going to be talking about
6 visual field exam. That's something slightly
7 different. So I want everybody to understand
8 that visual acuity is eye chart vision,
9 basically. And we always aim for best corrected
10 acuity.

11 In other words, I happen to be
12 nearsighted, which means I can read comfortably
13 at this distance without glasses but I can't see
14 real clearly in the distance. So my best
15 corrected acuity is what's most important.

16 So when I put my glasses on, if I was
17 in the examining room, I would be able to read
18 on the 20/20 line on the eye chart. If I take
19 them off, I can't. But nothing happened to my
20 eyes, I just took my glasses off.

21 So the point is it's important
22 whenever we check people to arrive at their best
23 corrected acuity so we know exactly what their
24 best potential is.

25 We usually do that at distance and at

1 near. At near we use a little card that's
2 standardized for distance of 14 inches. So then
3 we can compare distance vision and near vision.

4 And I'm also what we call presbyopic.
5 I have my nearsighted correction and I have to
6 have some lenses on the bottom, a bifocal in a
7 sense, so I can see clearly up close. So in
8 other words, some people need glasses for
9 distance and for reading, some people just need
10 them for distance, et cetera.

11 But whenever we measure patients, we
12 always get a best corrected acuity. So that's
13 one thing that I did with Mrs. Savage.

14 I then did a test of her side vision,
15 both using my fingers -- that's called a
16 confrontation test -- and also using a special
17 machine called a perimeter, which measured her
18 ability to see off to the sides in both eyes.

19 I analyzed how her eyes were moving.
20 I analyzed how her pupils were reacting to
21 light. I looked at her eyes carefully with a
22 microscope that we call the slit lamp and I
23 looked inside her eyes carefully with some other
24 optical tools to make sure that -- just to do
25 the complete exam. I'll leave it at that.

1 I also measured her intraocular
2 pressure; in other words, did a glaucoma test.

3 Q. Did your examination show any
4 abnormalities of the cornea or other structures
5 in the eye?

6 A. No.

7 Q. Did your exam show any abnormalities
8 with regard to her visual field or her vision
9 itself?

10 A. Yes. Her visual acuity was subnormal
11 in her right eye, both at distance and near.
12 And her visual field, her side vision with the
13 right eye was abnormal.

14 Q. What was the vision in her right eye?
15 Now, the right eye is OD; correct?

16 A. Yeah. That stands for ocular dexter,
17 latin for right eye.

18 Q. Her vision in her OD was what in the
19 right eye?

20 A. 20/200, and the equivalent of 20/100
21 at near.

22 Perhaps I should amplify on our 20/20
23 system.

24 Q. Please.

25 A. Normally, in an ophthalmologist's

1 office, we measure distance acuity at 20 feet.

2 That's where the one 20 comes from.

3 The man who designed this scale did
4 it back in the middle of the 19th century. His
5 name was Dr. Snellen. And he essentially made a
6 scale that was of different sized objects, and
7 his equivalent for normal was he termed 20/20,
8 meaning that a normal person saw it 20 feet, the
9 20 sized optotype line. The little figures are
10 the optotypes.

11 When a person is 20/200, that
12 basically means that a normal person could see
13 at 200 feet, but this person would have to be 20
14 feet away to see. At near, because we are only
15 measuring at 14 inches, we don't usually use a
16 20 system, because we are not at 20 feet away,
17 only at 14 inches away, so we have a number of
18 systems that can equate to distance acuity and
19 one is called the Jaeger scale. To make a long
20 story short, J-10 vision is equivalent to 20/100
21 distance vision, but it's a near measurement.

22 Q. Now, when you did the confrontation
23 visual field, how was that done?

24 A. Well, when we do visual field
25 testing, whether it's by machine or by

1 confrontation, we always do one eye at a time.
2 So in this setting, I covered her left eye, I
3 sat across from her at about two or three feet
4 away, I had her look at the center of my nose,
5 and then I presented fingers of different
6 quantities, in what we call the quadrants of
7 visual field.

8 As she was looking at my nose, I held
9 up five fingers here, one finger here, two here,
10 five down here. A normal person can look
11 centrally and pick up those different fingers
12 accurately, okay? She did normally with her
13 left eye, but with her right eye she couldn't
14 see in the quadrant up, and towards her nose we
15 call that the upper nasal quadrant.

16 If you think of our visual field like
17 a pie, circular, we think of our eye chart
18 vision as the center of that, then everything
19 else is peripheral vision or visual field. Our
20 visual field is not quite circular, but for our
21 purposes we can consider it circular.

22 Q. The 20/200 in her right eye, was that
23 with or without correction?

24 A. That was best corrected, yeah.

25 Q. So that at 20 feet, she was seeing

1 what people with 20/20 vision can see at 200
2 feet?

3 A. That's correct.

4 Q. Her left eye, did she have any visual
5 acuity deficits?

6 A. No.

7 Q. In her left eye, did she have any
8 visual field deficits?

9 A. No.

10 Q. Did your exam also look at her -- the
11 cornea and the optic nerve?

12 A. Yes.

13 Q. And in looking at the cornea and the
14 optic nerve and the lens, what were you looking
15 for?

16 A. Well, I was looking for abnormalities
17 that would explain her visual loss.

18 Q. And were you able to find any
19 structural abnormalities to explain her visual
20 loss?

21 A. No.

22 Q. You also did, I believe, a test
23 called an automated perimeter test?

24 A. Yes.

25 Q. What's that?

1 A. Well, this is a more sensitive and
2 sophisticated way of testing a person's side
3 vision. Essentially, they sit in front of a
4 special machine, which is like a half dome, we
5 call it a hemisphere, literally half of a
6 sphere. And lights are projected at different
7 points inside this bowl, and with a patient
8 looking straight ahead, it's ascertained how
9 bright they have to get and at what location
10 before the patient can see then. When they see
11 them, they indicate by beeping, a little beeper
12 that they hold in their hand.

13 And there are all different ways of
14 doing this. In other words, the machines that
15 are sold have all different programs, so you can
16 sort of do a number of different types of tests.

17 But to make a long story short, with
18 regard to Mrs. Savage, I initially did one using
19 what's called the Octopus perimeter -- that's
20 the brand name -- and I used a method that is
21 very sensitive for visual field abnormalities.
22 And there were abnormalities in her right eye
23 but not her left eye.

24 Q. Where were the abnormalities in her
25 right eye on this automated perimeter test?

1 A. I don't know if the photographer can
2 actually tell -- whether this is in focus or
3 not? Close?

4 There are four different scales here
5 that are actually telling us different things.
6 But if we just look at this area here, this is
7 the gray scale. Wherever you see dark, that's
8 abnormal in a sense.

9 And unlike the confrontation visual
10 field which suggested that she had a problem up
11 and towards her nose, this automated test showed
12 that she had a problem off towards her ear. So
13 there was an inconsistency between the
14 confrontation testing and the automated testing.

15 Q. And of what significance were these
16 results from the confrontation test as well as
17 the automated perimeter test in terms of your
18 final diagnosis?

19 A. Well, ultimately, it was very
20 consistent with the diagnosis of a functional
21 visual loss.

22 Q. Why is that, doctor?

23 A. Well, it just happens to be that
24 people with functional visual loss have
25 irregularly reproducible visual fields, so in

1 measuring them ten times in a row, very commonly
2 you will get ten different results. I can't
3 tell you why that is, but that's the observed
4 fact clinically.

5 Q. When you looked at her cornea on the
6 examination, you did not see any evidence at
7 that time of any abnormality of the cornea;
8 true?

9 A. That's correct. I looked
10 specifically for evidence of small corneal
11 abrasions and I didn't find any.

12 Q. If everything looked okay on your
13 exam, how then can a patient like Judy Savage
14 have these visual deficits and visual field
15 abnormalities that you discovered during your
16 exam in March of '98?

17 A. I'm not sure I understand your
18 question. When you say how can she --

19 Q. I guess I'm trying to understand
20 physically, if the test results in terms of
21 looking at the cornea, looking at the lens, if
22 they, if there is no evidence of any problem
23 with the eye, how then could she have the visual
24 field deficits and the visual acuity deficits
25 that you just described?

1 A. Well, I think that's what we had been
2 talking about earlier; that this basically boils
3 down to a functional visual disturbance, and
4 then the differential is, is she malingering, is
5 she faking it or is this hysterical loss of
6 vision.

7 Q. When you refer to hysterical as
8 opposed to malingering, can you amplify that a
9 little bit in terms of what you are talking
10 about?

11 A. Again, that's a term carried on from
12 the last century, and again, it used to refer to
13 the womb actually. Like hysterectomy refers to
14 having your uterus taken out, it used to be
15 thought that women were more hysterical than men
16 and that it had something to do with the uterus
17 playing a role.

18 Obviously, now a days, we don't go
19 into those explanations, because obviously men
20 can have hysterical visual problems or
21 hysterical paralysis, for example, just as well
22 as women can.

23 So it's one of these terms carried
24 over, but basically it means that it's as if the
25 person had a stroke, for example, in terms of a

1 hysterical paralysis or had some damage to their
2 eye, and for them, they can't see even though
3 there is no structural reason why they can't
4 see.

5 Q. As a neuro-ophthalmologist, is this a
6 common finding that you see in the clinical
7 setting?

8 A. In a clinical neuro-ophthalmology
9 practice we have more than our share of patients
10 with functional visual loss, and mainly that's
11 because -- and I'm being totally frank about
12 this -- patients with this problem take a long
13 time to diagnose, because as I mentioned before,
14 it's a diagnosis of exclusion.

15 So, for example, in my private
16 practice days, when I was in a busy practice
17 where maybe we would see 50 patients a day, one
18 functional visual loss patient that might take
19 an hour would ruin your entire day. You just
20 couldn't take that amount of time. So the
21 doctors that see this in private practice tend
22 to refer to neuro-ophthalmologists, who by
23 definition have and set aside in their schedules
24 more times to deal with these sorts of problems,
25 that's one reason.

1 The other reason is it's not a very
2 satisfying condition to diagnosis and treat in
3 the sense that oftentimes the treatment or the
4 ultimate prognosis is poor. So no matter what
5 we do, we can't really help the patient. So
6 it's frustrating for the patient and frustrating
7 for the doctor.

8 But to make a long story short, they
9 gravitate toward neuro-ophthalmology, so that's
10 part of our reason for being, dealing with
11 patients with functional, in this case,
12 functional visual loss.

13 Q. In addition to reduced vision, and
14 reduced visual fields, are there other signs and
15 symptoms that are commonly seen in patients that
16 have functional visual disturbance?

17 A. Well, in this case, and especially in
18 the setting of eye injuries in general, and this
19 particular injury, the corneal abrasion, pain
20 and commonly chronic pain is a concomitant and
21 thought to be a functional component.

22 Q. Even though there is no objective
23 evidence that you can show that the cornea is
24 continuing to show signs of injury?

25 A. Correct. Maybe some of the jurors

1 have low back pain, which is a chronic condition
2 and oftentimes -- I have it myself, so I can
3 speak from personal experience. And it's
4 something that is there to some degree every day
5 of my life and I try to work through it. But
6 it's sort of a gnawing exacerbating problem, and
7 oftentimes there is no real reason why it
8 happens and there is not really always a
9 treatment for it, so it's kind of like that.

10 Q. Based upon your exam in March of
11 1998, having interviewed Judy, having obtained a
12 history from her, what was your diagnosis, your
13 full diagnosis as of March 1998? And feel free
14 to again refer to your findings.

15 A. I thought she had two basic things.
16 I thought she had a functional visual
17 disturbance manifesting as the loss of visual
18 acuity and visual field and I thought she had
19 symptoms of a recurrent coronary erosion
20 syndrome.

21 Q. Now, the symptoms of corneal erosion
22 syndrome, we talked about earlier. Yet I want
23 you to assume that for purposes of your
24 opinions, Dr. McAdoo, who is Judy's
25 ophthalmologist, will or may have already

1 testified that Judy's cornea has healed 100
2 percent going back to some time in 1997, after
3 the injury.

4 The fact that the cornea has healed,
5 according to his examination, is that consistent
6 or inconsistent with the existence of a
7 recurrent corneal erosion syndrome?

8 A. Well, in my opinion, it's still
9 consistent.

10 Q. Explain to the jury, please.

11 A. I think we went into a little before
12 where I said that given the example of someone
13 who awakens with symptoms of a recurrent erosion
14 syndrome and calls the office and you get them
15 in in the afternoon and you find out that you
16 can't find an abnormality.

17 So I realize in Mrs. Savage's case
18 she has been to numerous doctors and none of
19 them have seen evidence of an epithelial defect.
20 However, her symptoms are consistent with a
21 recurrent erosion syndrome, and the corneal
22 abrasion, the insult that is consistent with a
23 cause for it.

24 So I'm basing my opinions on those
25 two major signs and symptoms, basically.

1 Q. In a moment, doctor, I want to talk
2 about your January 2001 exam, but I want to ask
3 you first, based upon your review in this case,
4 do you have an opinion to a reasonable degree of
5 medical certainty after reviewing the medical
6 records and hospital records and after having
7 examined Judy as to the most likely or probable
8 cause of her functional visual loss.

9 A. Yes, I do.

10 Q. And what is your opinion?

11 A. I think it is directly related to the
12 corneal abrasion she suffered while in the
13 hospital.

14 Q. How do you normally treat patients
15 that have functional visual loss?

16 A. Well, there is not a whole lot of
17 literature on this condition, but what there is
18 suggests that the best treatment is reassurance;
19 assuring them that there is not something
20 seriously wrong with their visual system and
21 that there is a possibility for improvement.

22 And this works some of the time and
23 it doesn't work some of the time. And if we
24 lined up a hundred people with functional visual
25 loss, we would have a hundred different

1 experiences as to their ultimate prognosis.

2 Q. Would you tell the jury whether the
3 majority of patients that have functional visual
4 loss stay visually impaired or get better over
5 time?

6 A. In my personal experience, they tend
7 to stay visually impaired.

8 Q. What is your opinion to a reasonable
9 degree of medical probability as to the
10 prognosis for Judy Savage with regard to her
11 functional vision loss?

12 A. Well, looking back, this is now about
13 five years, I think --

14 Q. It is.

15 A. -- since the initial corneal
16 abrasion. She has seen a number of doctors who
17 all have essentially confirmed that she is in
18 discomfort and she has got a problem with her
19 visual function on the right. And it really
20 hasn't changed much. It's waxed and waned.

21 There have been times where her
22 vision was measured better than at other times,
23 but on the other hand if we drew a graph showing
24 on balance what the average was, there has
25 really been no change whatsoever, so I think

1 that's an indication that in all likelihood this
2 is not going to improve.

3 Q. Do you have an opinion to a
4 reasonable degree of medical certainty as to
5 whether her functional vision loss is permanent?

6 A. Well, as I say, based on her past
7 track record, I would say it is permanent.

8 Q. Let's talk briefly about the second
9 exam, January of 2001. What were your findings
10 at that time, both with regard to the functional
11 vision loss, and to the recurrent corneal
12 erosion syndrome?

13 A. Again, the findings were very similar
14 to the exam in '98 in the sense that her best
15 corrected acuity was 20/200 again in the right
16 eye. And J-16 Jaeger, again Jaeger scale 16
17 means that it was worse than the J-10. J-16 is
18 roughly 20/400 vision at near.

19 There were no signs of any corneal
20 staining or damage and her visual field on that
21 side was again abnormal. And if I can, I would
22 like to show the visual fields.

23 This is her normal left eye and this
24 is her abnormal right eye. And I think you
25 might remember that the visual field I had shown

1 from the visit three years earlier was, quotes,
2 better than this. This is a different pattern
3 again, and I did say that it's very common to
4 get a different result every time you measure
5 patients with a functional visual disturbance.

6 So in essence, the findings were the
7 same. And my opinion was essentially the same.

8 Q. What history did Judy give to you
9 when you saw her on January 8th?

10 A. She told me that she had knife-like
11 pains and at times her eye throbbed like a
12 toothache. She said her eye felt dry.

13 She told me that the knife-like pains
14 occurred every day, three to four times a day,
15 it lasted a few minutes. She denied tearing at
16 that time. The throbbing pain she described as
17 a bad toothache. She said at times her eye felt
18 hot; that this would occur two to three times a
19 day and last minutes. Then she told me
20 something about her schedule of using eyedrops
21 and ointment.

22 I believe there is some additional
23 information. She told me that she didn't use
24 oral pain killers except for Excedrin, Tylenol,
25 and that her vision blurred. Her blurred vision

1 really had not gotten any better.

2 She told me that because of this, she
3 was having trouble driving. She didn't drive at
4 that time. She said that she couldn't read
5 recipes and that she oftentimes bumped into
6 things off to the right.

7 She further stated that she used to
8 work at school, but she -- as a volunteer, but
9 she couldn't do that anymore. And that she had
10 to rely on her family to, as she put it, haul
11 her everywhere.

12 Q. Did you do a refractive exam when you
13 saw her in January?

14 A. Yes, I did.

15 Q. And I'm not sure that we talked
16 specifically about a refractive exam, but what's
17 involved when you do that?

18 A. Well, refraction literally means
19 putting lenses in front of a person to see if
20 you can improve their vision, and --

21 Q. So that's when you sit in front of
22 the machine and the doctor slides different
23 lenses in?

24 A. Right. That is refraction. A
25 refraction can be done with hand held lenses.

1 It doesn't have to be done with that machine.

2 Q. Fair enough.

3 A. But a refraction is again a
4 subjective test, meaning that the patient has to
5 tell you what they see. However, we can fairly
6 objectively determine a refractive error. In
7 other words, whether a person is nearsighted,
8 farsighted, whether they have astigmatism or not
9 by using a technique called retinoscope, where
10 we essentially have a special instrument that
11 shines a beam of light in their eye, and based
12 on the way that light moves in relation to the
13 way the instrument moves, we can essentially
14 tell whether they are nearsighted or farsighted.

15 So it's possible to objectively
16 neutralize, as we say, refractive error and then
17 find out if that improves their vision. And I
18 did that with her and it didn't improve her
19 vision in her right eye.

20 Q. Her right eye in January of 2001 even
21 after refraction was what?

22 A. 20/200.

23 Q. And her vision in her left eye with
24 refraction was what?

25 A. Actually better than our standard of

1 normal. 20/15.

2 20/20 is what we call normal, but the
3 fact of the matter is practically everybody has
4 20/15. 20/15 is actually normal vision, but for
5 the purposes of this discussion, we can say that
6 20/20 is also considered normal vision.

7 Q. You also did on that date, did you
8 not, a Humphrey automated perimetry test?

9 A. That's the test that I held up that
10 showed that tubular visual field or tunnel
11 vision.

12 Q. So essentially, doctor, so I have an
13 understanding, when you refer to tubular tunnel
14 vision, can you explain out of the right eye
15 what Judy is seeing in terms of her visual
16 field?

17 A. Again, I can't tell you what she is
18 seeing. The only one who can tell you what she
19 is seeing is what she is seeing, but I could
20 tell you what this would equate to, and that is
21 it would be as if I was looking through a soda
22 straw or down a tube, a gun barrel tunnel and I
23 could only see the central area and everything
24 else was missing.

25 Q. No peripheral vision?

1 A. Right. That's correct, no peripheral
2 vision with the right eye.

3 Q. And is that in addition to seeing at
4 a 20/200 visual acuity?

5 A. That's correct.

6 Q. So she has two different visual
7 defects in her right eye?

8 A. Correct.

9 Q. Your diagnosis in January of 2001,
10 was it any different than your diagnosis back in
11 1998?

12 A. No.

13 Q. In 2001, doctor, would you tell the
14 jury whether the pain that she was experiencing,
15 the knife-like pains, whether or not -- and the
16 throbbing pains that you described, whether or
17 not you associated those pains to the functional
18 vision loss, to the recurrent corneal erosion
19 syndrome or to both?

20 A. Okay. Well, I think that the sharp
21 pains are consistent with the recurrent erosion
22 syndrome. And I think I stated that.
23 Especially given the fact that she had a
24 significant corneal abrasion in the past.

25 The dull throbbing pain I think is

1 more along the lines of the pain associated with
2 the functional visual disturbance, which is a
3 pain that we really can't get a better handle
4 on, but it's related to it in the sense, but the
5 same underlying cause for the functional visual
6 loss is the cause for the pain.

7 MR. MISHKIND: Off the record for
8 just one moment.

9 MR. HERSCH: We are off the record.
10 (Pause.)

11 Q. Doctor, a patient with functional
12 vision loss like Judy, should this patient in
13 your professional opinion be seen from time to
14 time by a neuro-ophthalmologist?

15 A. I think it's reasonable, perhaps
16 every year.

17 Q. And what would be the purpose of such
18 visits?

19 A. Well, I think the purpose is really
20 to document her visual function, and if there is
21 a change for the better, I would encourage her
22 that that's the case. In other words, to provide
23 some positive reassurance.

24 And then, of course, as we say in
25 medicine, a dog can have ticks and fleas. In

1 other words, it's possible to have another
2 illness that starts that's unrelated to anything
3 we have talked about, so you know, given that, I
4 think it's reasonable to see her on a yearly
5 basis.

6 Q. Did you at any time during your
7 examinations get the sense that Judy was trying
8 to trick you or pull the wool over your eyes or
9 in some way exaggerate her findings or her
10 symptoms?

11 A. No, I never got that feeling.

12 Q. As a neuro-ophthalmologist, is that
13 one of the things that you look at when you are
14 seeing these type of patients?

15 A. Most definitely, because that's sort
16 of how I would clinically differentiate between
17 a malingerer and someone with a hysterical form
18 of visual loss.

19 Q. Do you have an opinion, doctor, in
20 this case to a reasonable degree of medical
21 certainty as to whether Judy will or will not
22 always be impaired with her visual acuity and
23 have pain and reduction in her visual fields in
24 the future?

25 A. I do. And as I mentioned before,

1 it's based on her five year track record of
2 basically being exactly the same, with some
3 fluctuations in terms of discomfort, in terms of
4 visual loss. So I don't see any signs of that
5 improvement is occurring.

6 Q. And when you say permanent, what do
7 you mean by that?

8 A. Well, it could be for the rest of her
9 life.

10 Q. Do you have an opinion to a
11 reasonable degree of probability as to whether
12 it's likely that she will have these symptoms
13 for the rest of her life?

14 A. I do. I think it's most probable
15 that that will be the case.

16 Q. After this case is over, doctor --
17 it's been going on -- well, the injury was five
18 years ago, but after the trial is over with, do
19 you have an opinion to a reasonable degree of
20 medical certainty as a specialist in the area of
21 neuro-ophthalmology as to whether Judy's
22 eyesight and the pain is likely to improve?

23 A. After the trial?

24 Q. Yes.

25 A. I don't see why that would have any

1 effect whatsoever.

2 Q. Why is that?

3 A. I just don't see the relationship.
4 Unless I'm missing something.

5 Q. Most patients that have functional
6 vision loss, do they improve over time or do
7 they get worse or do they stay the same?

8 A. As I said, if we lined up a hundred
9 people, we would have a hundred different
10 scenarios. But by and large, adults, when they
11 have a history of an injury like this that seems
12 to be at the basis for the functional visual
13 loss tend not to improve.

14 Q. Do you have an opinion to a
15 reasonable degree of medical certainty as to
16 whether Judy will require continued use of
17 ointments and/or drops in her eyes on a
18 continuous basis in the future?

19 A. Yes, I do. And my opinion is that
20 she will need drops or ointment to some degree
21 as long as her symptoms of discomfort persist.

22 Q. Now, doctor, you have had a chance to
23 look at the hospital records in this case; true?

24 A. Yes.

25 Q. And you also had a chance to see, I

1 believe, the records that describe the corneal
2 abrasion in this case?

3 A. Dr. McAdoo's consult note, yes.

4 Q. Yes. Based upon your experience as a
5 neuro-ophthalmologist looking at the records
6 from O'Bleness Hospital, do you have an opinion
7 to a reasonable degree of medical certainty as
8 to the most likely cause of the corneal abrasion
9 on February 6th, 1997?

10 MR. POLING: ~~Objection.~~ *lv*

11 Q. You can go ahead.

12 A. Yes.

13 Q. What is your opinion?

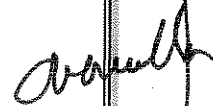
14 A. From the pattern of the abrasion, the
15 location being in the inferior third of the
16 cornea, that is a location that we most commonly
17 see with what we call exposure, where the eyelid
18 is open for a prolonged period of time.

19 I can't tell you exactly what the
20 magic number is, but let's say, now, more and
21 more as a round figure.

22 MR. SMITH: Off the record. I'm
23 going to make a motion to strike that last
24 testimony. The reason is because this doctor
25 had a discovery deposition taken of him and he

overruled

1 did not express those particular reasons as
2 being the basis of any opinion that he has.
3 This is the first time that I have heard that
4 this doctor has indicated that the eyelid in his
5 opinion was open for more than one hour; that
6 there was exposure and that it involved the
7 inferior third. For these reasons that these
8 are new opinions and new explanations, I would
9 move to strike his testimony.



10 MR. MISHKIND: And just for the
11 record, your associate took his deposition and
12 asked him at the time of his deposition what his
13 opinion was in terms of what was the most likely
14 cause for the injury, and he testified at that
15 time -- and we can get to the exact page or we
16 can -- bear with me for one second.

17 MR. SMITH: To help you, counsel,
18 it's the bottom of page 45 and the top of page
19 46. And if you read carefully his answer,
20 particularly beginning on line 11, he says, so,
21 given those facts, my opinion is that his
22 corneal problem originated during the surgical
23 procedure. I understood that to be the doctor's
24 testimony.

25 The basis of my objection, Howard, is

1 because the facts that he is referring to in his
2 answer on page 46 are not those facts that he
3 just articulated in his answer. And that reason
4 is the basis of my objection. Had he testified
5 consistent with the factual basis that he gave
6 in his deposition, I wouldn't have made the
7 objection.

8 MR. MISHKIND: I understand that, but
9 obviously he was asked questions where he
10 indicated that he felt that the corneal abrasion
11 was secondary to exposure and I'm not sure that
12 his opinions are new opinions; they may be
13 extended in terms of factual statements, but I'm
14 not sure that simply because additional
15 questions weren't asked of him at the time of
16 the deposition to find out more specifics that
17 that necessarily is a basis to exclude him.
18 It's not as if he is coming up with a new
19 opinion in terms of the exposure injury as being
20 the cause of it.

21 I understand your objection.
22 Certainly we can deal with that with the judge,
23 but I don't think that there is a new opinion
24 being expressed by the doctor in any way based
25 upon what he has said nor what he said in this

1 deposition. Okay?

2 MR. SMITH: I don't agree with your
3 argument, but I understand what you are saying,
4 so we can go back on the record for the rest of
5 the deposition.

6 MR. MISHKIND: Okay.

7 MR. HERSCH: Back on the record.

8 Q. Doctor, do you recall at the time
9 that your deposition was taken that you were
10 asked whether or not one can cause a corneal
11 abrasion by rubbing the eye in the recovery room
12 or rubbing one's eye after surgery?

13 MR. POLING: Objection.

14 Q. Do you recall that question being
15 asked of you at the time?

16 A. I recall something about that and I
17 believe it was posed hypothetically, but I don't
18 remember the exact nature of the question, the
19 detail of the question.

20 Q. I want you to assume that there may
21 be testimony in this case that in the recovery
22 room, shortly after emerging from anesthetic,
23 that Judy was observed in the recovery room with
24 an IV in her arm, a blood pressure cuff in her
25 arm, and IV in her right arm, and at least one

1 of the nurses may testify that she was
2 repeatedly reaching up to try to rub, actually,
3 both eyes over a period of time in the recovery
4 room.

5 First, based upon your review of the
6 records in this case, the sworn hospital record
7 that was created at the time, do you see any
8 evidence that would support that hypothetical
9 statement?

10 MR. SMITH: Objection.

11 MR. POLING: Objection.

12 A. Do I answer?

13 Q. Yes.

14 A. No, I don't. And I think that's what
15 I was alluding to when I mentioned the location
16 of the, location and shape of the corneal
17 abrasion. Assuming Dr. McAdoo's rendition is
18 accurate, that is the classic picture of lower
19 one-third corneal exposure injury.

20 If the patient, Mrs. Savage had
21 scraped her eye with her thumbnail or her, some
22 piece of clothing or whatever, normally the
23 scrapes or the appearance of abrasion for that
24 tends to have a different appearance, tends to
25 be linear as opposed to oval, and so I think

1 that that's highly unlikely.

2 I would argue probably just the
3 opposite; that she was trying to rub her eyes
4 because her eyes were uncomfortable. That I
5 think is a lot more logical than the other way
6 around.

7 Q. If, in fact, she was rubbing her eye
8 in the recovery room, hypothetically, and she
9 had sustained the corneal abrasion that is
10 described by Dr. McAdoo in his description, do
11 you have an opinion to a reasonable degree of
12 medical probability as to whether rubbing the
13 eye in the recovery room can exacerbate or
14 aggravate a corneal abrasion?

15 MR. POLING: Objection.

16 A. Well, theoretically it's certainly
17 possible that rubbing a corneal abrasion could
18 make it worse. On the other hand, because of
19 the pain that's involved in doing that, it would
20 be highly unlikely for a patient to do that.

21 And let me give you just an example.
22 When we do eye muscle surgery on children, very
23 commonly we don't patch their eyes at all after
24 surgery, we put a little ointment on. And the
25 mothers ask what if he or she rubs their eyes,

1 and the doctor says, don't worry about that;
2 they are not going to go near their eye if it
3 hurts; they won't rub their eye if it hurts.
4 And that's a child who can't think about what is
5 going on.

6 So I would say it would be extremely
7 unlikely that at least that was the proximate
8 cause of her corneal abrasion.

9 Q. Again, I want you to assume that
10 there is testimony to the effect that she was
11 over a ten minute period rubbing the eye after
12 the corneal abrasion, whether that is, in fact
13 what happened or not.

14 Would that be a sufficient, in your
15 professional opinion, contributing factor to
16 aggravate the underlying corneal abrasion?

17 MR. POLING: Objection. Asked and
18 answered.

19 A. Again, going back to what I said,
20 because corneal abrasions are so painful, that
21 there is absolutely no logic to rubbing a
22 painful eye to make it more painful.

23 The body just doesn't like to do
24 that, you know. It's like if you ever hit your
25 thumb with a hammer or closed it in a door. You

1 don't go squeezing your thumb, you shield it,
2 try to do something to protect it, but you don't
3 go grabbing it and try to manipulate it.

4 And so it is with the eye.

5 Q. Based upon your review in this case,
6 in terms of Judy's underlying medical
7 conditions, is there anything that you see as a
8 neuro-ophthalmologist that would explain from a
9 medical standpoint some other condition that
10 could be causing or contributing to her
11 continued visual deficits and visual field
12 problems?

13 A. No.

14 Q. When you examined Judy, did you see
15 any evidence of blepharitis or rosacea?

16 A. I have no notes of that.

17 Q. What is blepharitis?

18 A. Blepharitis is a chronic eyelid
19 irritation or infection. I tell people it's
20 like crab grass in some ways. Once you have it,
21 you tend to have it to some degree, but it waxes
22 and wanes depending on treatment or how clean
23 you keep your eyelids, but I didn't make a note
24 of significant blepharitis in either of my
25 visits.

1 Q. You have had a chance to review the
2 findings of the examination of Dr. Mauger;
3 correct?

4 A. Yes.

5 Q. And that was just in October of this
6 past year; correct?

7 A. Yes.

8 Q. Dr. Mauger is not a
9 neuro-ophthalmologist, is he?

10 A. As far as I know, he is not, no.

11 Q. I want you to assume that Dr. Mauger
12 is of the opinion that the irritation in her
13 eye, at least part of the irritation in her eye
14 that she was complaining of is related to
15 rosacea and blepharitis.

16 In your professional opinion, do you
17 agree or disagree with that?

18 MR. POLING: Objection.

19 A. Well, the way you phrased it, part --
20 what part? Are we talking one percent, 90
21 percent, 50 percent?

22 Q. Do you believe that any rosacea or
23 blepharitis is a substantial factor in terms of
24 causing Judy's ongoing irritation in her right
25 eye?

1 A. No.

2 But let me qualify that. Again, I
3 didn't see her the same day Dr. Mauger saw her,
4 so with that caveat, I would say no.

5 Q. Assume Dr. Mauger has no opinion
6 whether or not the corneal injury is the
7 proximate cause of her functional vision loss,
8 do you agree or disagree with that opinion?

9 MR. POLING: Objection.

10 A. Do I agree that he has no opinion?

11 Q. Well, do you agree that -- well, is
12 the functional vision loss in your professional
13 opinion directly and proximately related to the
14 corneal injury?

15 A. That's my opinion, yes.

16 MR. POLING: ~~Objection.~~

17 Q. Now, I want you to assume that
18 Dr. Mauger indicated that Judy was cooperative,
19 did not seem to be difficult during the exam or
20 angry, and that he did not get the sense that
21 she was trying to exaggerate her symptoms during
22 that examination in October of 2001.

23 Assuming those facts to be what
24 Dr. Mauger will testify to, do you have an
25 opinion as to whether those findings are

1 significant with regard to the type of
2 functional vision loss that Judy Savage has?

3 MR. POLING: ~~Objection.~~

4 Q. First, do you have an opinion?

5 A. Yes, I do.

6 Q. What is your opinion?

7 MR. POLING: ~~Objection.~~

8 A. They are consistent with the
9 hysterical form of functional visual loss and
10 inconsistent with the malingering form.

11 Q. And just very briefly, why do you say
12 that?

13 A. Well, that's just the way people
14 behave who malingers; they tend to be easy to
15 anger and don't tend to go along with the
16 program. They don't tend to go along with what
17 the doctor tells them; they tend to go along
18 with what they want the doctor to tell them.
19 And if there is a difference between those two
20 things, then it comes out in just the
21 interpersonal interaction.

22 Q. Your examinations of this patient in
23 terms of the testing that you did on the two
24 different occasions, were you satisfied that you
25 performed sufficient testing on the two visits

1 to be able to have arrived at the diagnosis that
2 you described for the jury?

3 A. Yes.

4 Q. And do you believe that there is any
5 more likely explanation for her functional
6 vision loss than what we have talked about in
7 terms of the injury that she sustained at the
8 time of the surgery back on February 6th, 1997?

9 A. Not with the facts available to me.

10 MR. MISHKIND: Doctor, thank you very
11 much. I have no further questions for you.

12 THE WITNESS: You are welcome.

13 MR. HERSCH: Off the record.

14 (Recess had.)

15 EXAMINATION OF ROBERT TOMSAK, M.D., Ph.D.

16 BY MR. SMITH:

17 Q. Thank you, doctor. My name is Pat
18 Smith and I represent Mr. Mays in this case.
19 Doctor, on this, I listened very carefully to
20 the questions and your answers.

21 You indicated that basically this
22 woman suffers from two problems in your opinion;
23 correct?

24 A. Yes.

25 Q. And you examined her on two

1 occasions; correct?

2 A. Yes.

3 Q. Once in 1998 and once in 19 -- I'm
4 sorry, once in 1998 and once in 2001; correct?

5 A. Correct.

6 Q. Doctor, if you could hold up the
7 chart that you were using on direct examination.
8 On both of those occasions, am I correct that
9 you went and you did a physical examination on
10 her; correct?

11 A. Yes.

12 Q. And looking at the -- let's start at
13 the cornea, itself. The cornea on both
14 occasions was normal; correct?

15 A. Correct.

16 Q. The pupil, the pupil was normal;
17 correct?

18 A. Yes.

19 Q. And if you could point on the chart
20 as we talk about each one of these items, can
21 you show on the chart the lens.

22 A. This is the human lens here.

23 Q. Normal; correct?

24 A. Yes.

25 Q. The aqueous humor, could you point on

1 that?

2 A. The aqueous forms the space, fills
3 the space between the cornea and the iris.

4 Q. Normal; correct?

5 A. Yes.

6 Q. The vitreous humor, could you point
7 to that?

8 A. It's like jello that fills the inside
9 of the eye. Normal.

10 Q. Normal, correct?

11 A. Correct.

12 Q. On both examinations?

13 A. Correct.

14 Q. Looking at the retina, can you show
15 the jury the retina?

16 A. Like film in the camera, the inside
17 lining of the eye.

18 Q. Absolutely normal?

19 A. Correct.

20 Q. The optic nerve?

21 A. Normal.

22 Q. On both occasions?

23 A. Yes.

24 Q. And doctor, looking at the
25 epithelium, which is the layers of the cornea,

1 the epithelium is normal from your examination;
2 correct?

3 A. Well, the epithelium is one layer of
4 the cornea.

5 Q. And was that normal?

6 A. Yes.

7 Q. In fact, all the layers from your
8 examinations were normal on both occasions;
9 correct?

10 A. Correct.

11 Q. And the bottom line is we try to
12 figure out in terms of was there any structural
13 abnormalities to explain either of her vision
14 problems, you could find absolutely no
15 structural abnormality to explain it; correct?

16 A. No persistent structural abnormality.

17 Q. And doctor, with respect to the
18 occasions that you saw this patient, on both of
19 the occasions that you saw this patient, it was
20 at the request of her attorney; wasn't it?

21 A. That's correct.

22 Q. You were not, you were not seeing
23 this patient as a referral from a physician;
24 correct?

25 A. Correct.

1 Q. Now, on both of the occasions in
2 which you saw this patient, you did not really
3 provide any care and treatment to her, did you?

4 A. That's correct.

5 Q. But doctor, you mentioned to this
6 jury that the one aspect in terms of the
7 treatment that would be provided to someone who
8 would have this type of problem would be
9 reassurance; am I right?

10 A. Yes.

11 Q. Now, on this, when you saw the
12 patient on the first examination in 1998, did
13 you reassure this patient?

14 A. I don't believe I did.

15 Q. And when you saw this patient in
16 2000, did you reassure this patient?

17 A. I don't believe I did.

18 Q. Doctor, in your deposition when I
19 took it, or when it was taken back in July of
20 2000, you indicated that in patients that have
21 this problem, when you treat those patients,
22 you, yourself, provide them reassurance, don't
23 you?

24 A. I do.

25 Q. And in fact, when you provide a

1 patient like that reassurance, you indicate to
2 them that what you have is essentially we have
3 excluded any real serious cause in your case;
4 correct?

5 A. Did I say that or are you quoting me?

6 Q. When you explain to your patients and
7 give reassurance, do you tell them that you have
8 excluded anything real serious in their case?

9 A. I'm asking, are you quoting me?

10 Q. Yes, on page 38 of your deposition,
11 beginning on line 14.

12 A. Could I look at that, please?

13 Q. Absolutely.

14 A. Good. One more time.

15 Q. If you turn to your deposition on
16 page 38, line, beginning on line 14.

17 A. Okay.

18 Q. My question to you, doctor, is when
19 you are explaining to your patients and
20 providing them reassurance, do you tell your
21 patients that you have excluded anything real
22 serious in your case?

23 A. Well, that's what I said in my
24 deposition, so, yes.

25 Q. And do you tell your patients --

1 A. But let me correct. Let me amplify
2 that, if I could.

3 Q. Excuse me, I just want to find out
4 what you tell your patients.

5 Do you tell your patients we are
6 certain that you can get better? Is that what
7 you tell your patients when you give
8 reassurance?

9 A. It depends on the situation.

10 Q. And do you tell your patients that
11 your vision can come back?

12 A. I sometimes do.

13 Q. Okay. Doctor, in this particular
14 case, even though you did not give any advice or
15 any reassurance to Mrs. Savage, did you in turn
16 contact her treating doctors and provide them
17 with your recommendation that reassurance was
18 the way to treat her?

19 A. No, I did not.

20 Q. Did you at any time after you saw
21 this patient, either on the first or the second
22 occasion, did you ever contact the treating
23 doctors and have any discussions with them
24 whatsoever?

25 A. No.

1 Q. How about before you saw the patient
2 in 1998 or in the year 2000, did you contact the
3 treating doctors and have a discussion with
4 them?

5 A. No.

6 Q. At any time since you have been hired
7 in this case as an expert witness by the
8 attorney for the plaintiff, have you ever
9 contacted the treating doctors and have any
10 discussions with them?

11 A. No.

12 Q. Doctor, in your treatment of this
13 case, did you do any type of psychological
14 testing whatsoever?

15 A. No.

16 Q. Did you see that any psychological
17 testing had been done?

18 A. No.

19 Q. At any time in this case, have you
20 contacted Mr. Savage to ask him questions about
21 his wife and how she was getting along?

22 A. I don't believe so. I don't believe
23 he accompanied her at either of her visits.

24 Q. And did you have any contact at any
25 time in this litigation with any of her children

1 to find out how she was getting along?

2 A. No.

3 Q. Did you contact any of her friends to
4 discuss how she was getting along?

5 A. No.

6 Q. Doctor, with respect to this
7 particular case, did you identify for the jury
8 all the information that you have reviewed prior
9 to offering your opinions in this case?

10 A. I believe I have.

11 Q. One of the things that I saw that or
12 I was listening for that I did not see that you
13 mentioned, you never reviewed the deposition of
14 my client, Mr. Mays, did you?

15 A. No, I did not.

16 Q. You were not given that information,
17 were you?

18 A. No, I was not.

19 MR. SMITH: Thank you, doctor. At
20 this time, I don't have any other questions.

21 THE WITNESS: You are welcome.

22 MR. POLING: Off the record.

23 MR. HERSCH: We are off the record.

24 EXAMINATION OF ROBERT TOMSAK, M.D., Ph.D.

25 BY MR. POLING:

1 Q. Dr. Tomsak, my name is Brant Poling.
2 I represent O'Bleness Memorial Hospital and the
3 nursing staff there.

4 You have not reviewed any deposition
5 transcripts of nursing staff from the hospital;
6 correct?

7 A. Correct.

8 Q. And you do not have firsthand
9 knowledge of Mrs. Savage's eyesight or her
10 optical condition since you were last
11 examination of January 2001; correct?

12 A. That's correct.

13 Q. So any conditions that she may have
14 developed subsequent to that, you would not have
15 personal knowledge of; correct?

16 A. With the caveat of Dr. McAdoo --
17 rather, Dr. Mauger's report. But no firsthand
18 evidence, correct.

19 Q. Because it's now February 4th, 2002,
20 and your last examination was January 8, 2001.
21 It's been just over a year, an entire year since
22 you have had the opportunity to examine Mrs.
23 Savage; correct?

24 A. That's correct.

25 Q. All right. She has not unilaterally

1 decided to return to you for any medical advice
2 or optical treatment; correct?

3 A. Correct.

4 Q. All right. And I believe we have
5 established that you are not a psychologist or a
6 psychiatrist; correct?

7 A. Correct.

8 Q. But when we talk about functional
9 vision loss, that's essentially a psychological
10 problem, is it not?

11 A. Yes, it is.

12 Q. And I believe you said earlier there
13 can be two causes of functional vision loss.
14 One is malingering; correct?

15 A. Yes.

16 Q. And malingering is a patient who is
17 consciously faking vision loss for some gain,
18 usually financial; correct?

19 A. That's right.

20 Q. And eye exams can be somewhat
21 subjective depending upon the person being
22 examined; correct?

23 A. Absolutely.

24 Q. All right. It would be difficult
25 though for a person to make their vision better

1 than it actually is, better than it actually is
2 on examination; correct?

3 A. Correct.

4 Q. But a person could report vision
5 worse than it actually was on examination;
6 correct?

7 A. Yes.

8 Q. All right. And the second cause of
9 functional vision loss as you have defined it is
10 hysterical vision loss; correct?

11 A. Yes.

12 Q. And that's the psychological problem
13 that we made reference to throughout today's
14 deposition; correct?

15 A. Correct.

16 Q. And functional vision loss has not
17 been well looked at from a psychiatric or
18 psychological standpoint, even though it has its
19 roots in psychological disturbances; correct?

20 A. That's right.

21 Q. Psychologists and psychiatrists
22 aren't really interested in studying this
23 phenomenon, are they?

24 A. I don't think they are.

25 Q. And if I understood your testimony,

1 both by Mr. Mishkind and Mr. Smith, the only
2 thing in your experience that seems to have any
3 positive effect in curing this alleged condition
4 is reassurance?

5 A. That's right.

6 Q. You are not aware whether Mrs. Savage
7 has ever undergone any sort of reassurance
8 treatment from any physician; correct?

9 A. I'm not aware of that, correct.

10 Q. You would agree with me that health
11 care is a two-way street, correct? Patients
12 bear some responsibilities, as well as
13 physicians?

14 A. Yes.

15 Q. So patients are obligated to do what
16 is necessary in following their doctor's advice
17 in order to make themselves better; correct?

18 A. I think it helps, yes, it helps if
19 that's the case.

20 Q. And the people who are not receptive
21 to reassurance simply will not get better;
22 correct?

23 A. In this particular case in functional
24 visual loss?

25 Q. Yes.

1 A. Yes.

2 Q. People who are receptive to this
3 reassurance, telling them that they can get
4 better and their vision will return, they do get
5 better; correct?

6 A. They can get better. Not everyone
7 does, but, yes, it's certainly the case.

8 Q. But the ones who are receptive to
9 reassurance get better under your scenario and
10 philosophy; correct, doctor?

11 A. Right. It's not my philosophy. It's
12 based on my personal experience and what's
13 written in the literature.

14 Q. Based upon what you see in those
15 people who are subject to simple reassurance,
16 you can get better, your eyesight will return,
17 then do get better; correct?

18 A. Yes.

19 Q. And you have not made a referral for
20 Mrs. Savage for any psychological or psychiatric
21 consult; correct?

22 A. Correct.

23 Q. And she has had no psychological or
24 psychiatric care for this hysterical vision
25 loss; correct?

1 A. Not that I know of.

2 Q. You have not been provided with any
3 medical records from a psychologist or
4 psychologist --

5 A. Right.

6 Q. -- psychologist or psychiatrist;
7 correct?

8 A. Correct.

9 Q. And doctor, going back to the anatomy
10 of the eye, when you saw Mrs. Savage on both
11 occasions in March of '98 and January of 2001,
12 you didn't see any evidence at the time of your
13 examinations, physical evidence of recurrent
14 corneal erosion syndrome; correct?

15 A. I did not see any corneal epithelium
16 defects, correct.

17 Q. And you can see evidence of corneal
18 erosion syndrome on examination if there is
19 actually an acute process going on at the time;
20 correct?

21 A. Yes.

22 Q. Or there may be a scar to a certain
23 portion of the cornea; correct?

24 A. Yes.

25 Q. Because of the recurrent ongoing loss

1 of cornea; correct?

2 A. Well, I would have to qualify that in
3 terms of what is the genesis for the erosion
4 syndrome. In other words, there are people who
5 develop it because they have a dystrophy of the
6 basement membrane, and those people we commonly
7 see abnormalities at that level in the cornea.
8 And I don't know if that answers your question.

9 Q. Well, some patients who have corneal
10 erosion syndrome can have a small scar of the
11 anterior stroma of the cornea; correct?

12 A. Yes.

13 Q. You didn't see that in Judy Savage's
14 case?

15 A. I did not.

16 Q. On neither occasion did she present
17 in your office with symptoms of intermittent
18 stabbing pain; it's only by her report to you
19 that she experiences these symptoms that you
20 were able to conclude that she has this
21 diagnosis; correct?

22 A. Correct.

23 Q. So if her history was wrong, then
24 your diagnosis could be wrong; correct?

25 A. Yes.

1 Q. And doctor, just a little bit of
2 housekeeping. You're charging for your
3 testimony here today?

4 A. Yes.

5 Q. How much are you charging, sir?

6 A. Well, I have charged Mr. Mishkind
7 \$250 an hour for review of records and for the
8 deposition I'm charging him \$500 an hour.

9 Q. How many hours do you have in
10 preparation from beginning of the case to end of
11 the case before coming here today?

12 A. I really don't know. I would imagine
13 between ten and 15.

14 Q. Between 10 and 15 hours for review
15 and preparation?

16 MR. POLING: Thank you, doctor. No
17 more questions.

18 EXAMINATION OF ROBERT TOMSAK, M.D., Ph.D.

19 BY MR. MISHKIND:

20 Q. Doctor, just a couple questions.

21 You were asked by Mr. Smith when we
22 were talking about page 38 in terms of no
23 persistent structural abnormalities and you
24 wanted to explain that. Do you recall that?

25 A. Yes.

1 Q. Would you explain what it is that you
2 wanted to say?

3 A. Yes. Because I believe Mr. Smith was
4 quoting, excerpting a bit of my testimony,
5 deposition testimony, and quoted on a couple of
6 occasions and then I went and read the whole
7 paragraph and I didn't have a chance to rebut
8 his question or statement.

9 So I would like maybe if you could
10 read back for me --

11 Q. Sure.

12 A. That interaction, if that's possible.

13 MR. MISHKIND: Let's go off the
14 record for one second.

15 (Record read.)

16 A. What I was attempting to say was that
17 there are some people who have functional visual
18 loss superimposed on organic disease, and in
19 those cases I would not categorically say we
20 have excluded anything real serious in your case
21 and I just wanted to make that absolutely clear.

22 Q. Okay. Now, you were asked questions
23 about psychological testing and whether or not
24 psychologists do or do not or have or have not
25 studied this area in terms of functional vision

1 loss. You are not a psychiatrist, are you?

2 A. No.

3 Q. You are a neuro-ophthalmologist;
4 correct?

5 A. Correct.

6 Q. You have studied, have you not, the
7 topic of functional vision loss?

8 A. Yes, I have.

9 Q. And you are familiar with what
10 functional vision loss is and is not?

11 A. Yes.

12 Q. And is there any question in your
13 mind after considering all of the information in
14 this case that Judy Savage has functional vision
15 loss?

16 A. No, there is no question.

17 Q. Is there any question in your mind as
18 to whether or not there is a direct causal
19 relationship between the corneal abrasion that
20 she sustained at the time of her surgery in
21 February 6th, 1997 and her functional vision
22 loss?

23 A. No, no question.

24 Q. Now, you did not read Mr. Mays'
25 deposition transcript. Mr. Smith asked you

1 about that; correct?

2 A. I have never seen it.

3 Q. Did you have sufficient information
4 from the sworn record to be able to appreciate
5 what the nature of the injury was that Judy
6 Savage sustained at the time of her surgery
7 without reading deposition testimony?

8 MR. SMITH: Objection.

9 A. I have Dr. McAdoo's notes and follow
10 up, and that's sufficient for me in terms of the
11 fact that the patient did have a corneal
12 abrasion. I don't have information specifically
13 on what the issues are around how that might
14 have occurred.

15 Q. Before Judy Savage entered the
16 hospital on February 6th, 1997, was there any
17 evidence that she had a corneal abrasion?

18 A. There was no evidence.

19 Q. Prior to February 6th, 1997, was
20 there any evidence that Judy Savage had any
21 visual deficits before she was put under
22 anesthetic and underwent the surgery on February
23 6th, 1997?

24 A. No. In fact, other than glasses, her
25 vision was normal in both eyes based on two

1 different reports.

2 Q. And prior to the surgery in February
3 of 1997, is there any evidence that she had any
4 visual field deficits prior to undergoing the
5 surgery on February 6th, 1997?

6 A. There is no evidence of that.

7 Q. You indicated on, I think Mr.
8 Poling's questions that there was no evidence of
9 recurrent corneal erosion syndrome when you
10 examined the patient. The fact that you did not
11 see any evidence when you examined the patient
12 of decreed current corneal erosion syndrome,
13 would you tell the jury whether or not that
14 alters the opinions that you hold in this case
15 as to the existence in your professional opinion
16 of recurrent corneal erosion syndrome in Judy
17 Savage's case?

18 A. Well, I think I answered that
19 question by saying I did not see any evidence of
20 a corneal epithelium defect, which would be the
21 active equivalent of a corneal erosion syndrome,
22 which I think that's how I answered the question
23 and that's how I meant it to be answered.

24 But the fact that I did not see that
25 on two occasions does not in any way change my

1 opinion that that is I believe she suffers from
2 a decree current corneal erosion syndrome.

3 Q. Can patients have a current corneal
4 erosion syndrome and be examined on multiple
5 occasions by different doctors and not have
6 evidence on examination of the cornea of any
7 erosive episodes at that time?

8 A. That is possible, yes.

9 Q. And in fact, from a probability
10 standpoint, do patients that have recurrent
11 corneal erosion syndrome that use drops and
12 ointments in their eyes, do they more often than
13 not unless they are symptomatic at the time do
14 they not show evidence of recurrent corneal
15 erosion at the time of exam?

16 A. Right. If they are using drops and
17 ointment and not symptomatic when the
18 ophthalmologist examines them, they do not
19 usually show evidence; correct.

20 MR. MISHKIND: Doctor, I don't
21 believe I have any further questions for you.
22 Thank you.

23 EXAMINATION OF ROBERT TOMSAK, M.D., Ph.D.

24 BY MR. SMITH:

25 Q. Doctor, my name is Pat Smith. And in

1 follow up, sir, let me go back to page 38 of
2 your deposition, because I want to make sure in
3 all fairness that the answer, the question was
4 asked and your complete answer is before the
5 jury, so that nothing is viewed as being taken
6 out of context. Is that fair?

7 A. I would like that.

8 Q. Okay. If I can, why don't I read the
9 question that was asked on page 38, and why
10 don't you read your complete answer to that
11 question. Is that fair?

12 A. Sounds fine.

13 Q. If you could turn to page 38. The
14 question was asked at that time, and what is
15 your experience in terms of their, I guess,
16 their prognosis. And your complete answer was?

17 A. Well, how about going back to the
18 former question so we can frame it? No?

19 Q. That's fine. Doctor, if we go back
20 to the former question on line 3, the question
21 was, have you had patients in your practice with
22 the diagnosis of functional vision loss before,
23 sir, and your answer?

24 A. I said, yes, yes, I have.

25 Q. And then the next question was, and

1 what is your experience in terms of their, I
2 guess, their prognosis, what is your complete
3 answer, please?

4 A. I said, it's really variable and the
5 only thing in the literature and also I could
6 echo that with my personal experience that seems
7 to have any positive effect is reassurance in
8 the sense that what you say is essentially we
9 have excluded anything real serious in your case
10 and, you know, we are certain that you can get
11 better, your vision can come back, we just don't
12 know the time frame. It may be tomorrow, it may
13 be a week, it may be a month. And the people
14 who are receptive to that will get better and
15 the people who are not receptive to that -- and
16 I don't mean that in a malicional way -- won't.
17 And it's just one of those things we don't have
18 a handle on. It's kind of like trying to pick
19 up a drop of mercury, functional visual loss.
20 It's very difficult to pin it down from a
21 scientific standpoint.

22 Q. Thank you, doctor. Did you have a
23 chance to read then the complete answer just
24 now? Did you read the complete answer?

25 A. Yes, I did.

1 Q. And doctor, on the question that
2 Mr. Mishkind asked, as it related to the
3 anything real seriousness part of your answer, I
4 believe that you wanted to qualify that or
5 amplify that, and if I'm correct, you were
6 saying that if a patient did have some sort of a
7 structural defect along with functional vision
8 loss, that in that situation, you wouldn't be
9 able to tell the patient that there was nothing
10 real serious going on; correct?

11 A. Exactly. In other words, there is a
12 form of, which we didn't go into until just now,
13 of organic disease with functional symptoms
14 superimposed on that, and I just wanted to make
15 it clear to everybody that in those cases I
16 would never tell the patient that there is
17 nothing wrong with you, if indeed I found
18 evidence that there was organic damage.

19 Q. With functional vision loss, it can
20 occur, in your opinion, where there is a
21 structural abnormality; correct?

22 A. And in fact I think that's the basis
23 of this case, the initial corneal abrasion.

24 Q. And it can occur without there being
25 a structural abnormality; correct?

1 A. Absolutely.

2 Q. In Mrs. Savage's case, through your
3 examination and the exam you conducted on both
4 occasions, you did not see a structural
5 abnormality; correct?

6 A. At the time of my exam, I did not.

7 Q. And doctor, in terms of providing
8 reassurance to a patient such as Mrs. Savage, in
9 your opinion, you would tell her, am I correct,
10 that there was nothing real seriousness in her
11 case?

12 A. Oh, I don't think I would go that
13 far.

14 Q. Doctor, with respect to Mrs. Savage,
15 am I correct that on both occasions that you
16 examined her, you did not see any evidence of a
17 structural abnormality; correct?

18 A. That's correct.

19 Q. And you did not, and with respect to
20 Mrs. Savage, that the only treatment that she
21 would have in your opinion would be reassurance;
22 correct?

23 A. How about if I tell you what I would
24 tell Mrs. Savage if she were my patient if I was
25 treating her.

1 Q. That's fine. Go ahead.

2 A. Okay. I would say, Mrs. Savage, I
3 don't find any evidence for a structural
4 abnormality in your cornea or your visual system
5 and I would say, and given that, I'm hopeful
6 that this, your problem will improve given that.

7 Q. And doctor, with respect to the
8 reassurance that you would give to Mrs. Savage,
9 in your opinion, that is the appropriate medical
10 treatment that should be given to her; correct?

11 A. Yes.

12 Q. And doctor, do you hold that opinion
13 to a reasonable degree of medical probability?

14 A. Yes.

15 Q. Doctor, I think we went over this on
16 the first part of my cross-examination. But you
17 did not, either in 1998, provide her
18 reassurance, did you?

19 A. No, I did not.

20 Q. And in the year 2001, you did not
21 provide her reassurance, did you?

22 A. I did not. Can I explain why?

23 Q. Go ahead.

24 A. I simply did not do that because I
25 was not seeing her in the normal doctor/patient

1 treating relationship. I was examining her at
2 Mr. Mishkind's request for a medical/legal
3 consultation.

4 Q. And doctor, with respect to the
5 treatment of reassurance, I believe we went
6 over, you did not write a letter to any of her
7 treating doctors telling them that reassurance
8 was the treatment modality that should be given,
9 did you?

10 MR. MISHKIND: ~~Objection. Asked and~~
11 ~~answered.~~ ✓

12 A. I did not, no.

13 Q. And doctor, understanding that you
14 were hired by Mr. Mishkind, with respect to what
15 is in the patient's best interest, in terms of
16 getting better, the treatment modality that
17 someone, some physician at some point should
18 have explained to her, is that of reassurance;
19 correct?

20 A. I would agree with that.

21 Q. Because without that, she has not
22 been given the opportunity to have the treatment
23 modality that could effectuate an improvement in
24 her vision; correct.

25 MR. MISHKIND: ~~Objection~~ w/D

1 A. Well, I don't know if she has or
2 hasn't. All I know is what the records state.

3 In other words, I don't know, when a
4 doctor and a patient interact with one another,
5 a lot of things are said that are not written
6 down, so unless I misunderstood your statement,
7 I thought you were making a statement that she
8 has not had this. I don't know whether she has
9 had this or not, but she certainly hasn't had
10 that from me.

11 Q. From your review of the records it
12 did not appear that she had it in any of the
13 treating doctors, did it?

14 A. I would agree with that.

15 Q. And even knowing that the records do
16 not reflect that, did you specifically ask her
17 whether any of the treating doctors had provided
18 her such reassurance?

19 A. I doubt it. I don't recall.

20 MR. SMITH: Thank you, doctor. I
21 have no other questions.

22 THE WITNESS: You are welcome.

23 MR. POLING: No more questions.

24 MR. MISHKIND: I have a couple
25 questions.

1 EXAMINATION OF ROBERT TOMSAK, M.D., Ph.D.

2 BY MR. MISHKIND:

3 Q. You reviewed Dr. Mauger's records;
4 correct?

5 A. Yes.

6 Q. You reviewed Dr. Mauger's deposition;
7 correct?

8 A. Yes.

9 Q. Did you see any evidence that
10 Dr. Mauger provided any reassurance to Judy
11 telling her that in time she would get better?

12 MR. POLING: Objection.

13 A. You know, I would have to go back and
14 look. Would you like me to?

15 Q. Do you see any evidence from the
16 record itself that you reviewed?

17 A. The deposition or medical records?

18 Q. The records.

19 A. No.

20 MR. POLING: Move to strike.

21 Q. We talked about your not seeing any
22 structural abnormalities when you examined the
23 patient.

24 Did Judy Savage have a structural
25 abnormality which in your professional opinion

1 is the direct and proximate cause of her
2 functional vision loss?

3 A. Yes.

4 MR. POLING: ~~Objection~~

Overruled

5 A. Yes, the corneal abrasion that
6 occurred on February 6, 1997.

7 Q. And doctor, based upon everything
8 that you have reviewed, can you tell the jury
9 whether you believe that with reassurance
10 provided at this point that the functional
11 vision loss after five years would improve and
12 would no longer be permanent?

13 A. Would you mind asking that again?
14 It's getting late.

15 Q. Sure. If she were to be provided
16 with reassurance at this point after five years
17 with her functional vision loss, you testified
18 previously as to your opinion concerning the
19 permanency of this condition --

20 A. Yes.

21 Q. Would that in your professional
22 opinion alter the outcome given what has
23 transpired to date?

24 A. I doubt it.

25 Q. And why is that, doctor?

1 A. Just because it's gone on for five
2 years and it's sort of been cemented and
3 solidified in her personality so to speak.

4 MR. MISHKIND: Thank you very much.
5 Nothing further.

6 EXAMINATION OF ROBERT TOMSAK, M.D., Ph.D.
7 BY MR. SMITH:

8 Q. One follow up, doctor. Had the
9 reassurance been provided earlier in time, it
10 would have a much better chance of being
11 successful than it would today; correct?

12 MR. MISHKIND: Objection.

13 A. I think that's fair.

14 MR. MISHKIND: Thank you. No other
15 questions.

16 MR. POLING: No questions.

17 MR. MISHKIND: Doctor, would you
18 waive the requirement of reading the deposition?

19 THE WITNESS: Sure.

20 MR. MISHKIND: And will you waive the
21 requirement of reviewing the videotape so we can
22 get this filed?

23 THE WITNESS: Sure.

24 MR. MISHKIND: Both counsel, I
25 assume, you will waive the requirement of the

End

1 doctor reading the transcript and viewing the
2 tape?

3 MR. SMITH: Yes.

4 MR. MISHKIND: As far as filing it,
5 we will go ahead and file the transcript.

6 MR. SMITH: I will let you know this
7 as far as I'm concerned with respect to the
8 videotape how old, if you want to keep the
9 original and then bring that down to court and
10 play it, that's fine, you do not have to go
11 through the formality of filing anything one day
12 before trial.

13 With respect to the depositions and
14 as long as it is, what is good for the goose is
15 good for the gander, that's fine. With respect
16 to any depositions that have been taken in this
17 case, any depositions can be used for any
18 purpose, allowed under the law.

19 In other words, you do not need to
20 file the deposition to use the deposition at
21 trial as long as that's good for me, it is good
22 for you, we are fine.

23 MR. MISHKIND: I think all the
24 depositions have been filed anyway.

25 MR. SMITH: What do you want to take

1 in terms of your position? In other words, I am
2 saying you don't need to file this deposition to
3 be able to use it at trial.

4 MR. MISHKIND: I'm going to have to
5 file it because the judge wants it for purposes
6 of objections anyway, so let's leave it at that.

7 MR. SMITH: That's fine.

8 - - - - -

9 (Deposition concluded at 5:10 p.m.)

10 (Signature waived.)

11 - - - - -

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CERTIFICATE

State of Ohio,

SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named ROBERT TOMSAK, M.D., Ph.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 5th day of February, 2002.



Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

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