STATE OF OHIO)
) SS.
COUNTY OF LUCAS)

COURT OF COMMON PLEAS

AUSTIN SYBERT, et al.,)
)
Plaintiffs,)
) Case No. CI0200003311
vs.)
) Judge Bates
DR. AMELIA ROUSH, et al.,)
)
Defendants.)

- - -

Deposition of DONALD I. CAMERON, M.D., a Witness herein, called by the Defendants as if upon Cross Examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kendra L. Lake, a Notary Public in and for the State of Ohio, at 27121 Oakmead Drive, Perrysburg, Ohio, on Thursday, January 24, 2002, at 6:25 p.m.

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** NOTES **

I N D E X

APPEARANCES:

On behalf of the Plaintiff:

BECKER & MISHKIND:

By: Michael F. Becker

(Via telephonic conference call)

CONNELLY, JACKSON & COLLIER:

By: Steven P. Collier

On behalf of Defendant St. Luke's Hospital:

ROBISON, CURPHEY & O'CONNELL:

By: E. Thomas Maguire

(Via telephonic conference call)

On behalf of Defendants Amelia Roush, M.D. and Today's OB-GYN:

BONEZZI, SWITZER, MURPHY & POLITO CO.:

By: Donald H. Switzer

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DONALD I. CAMERON, M.D.,

a Witness herein, called by the Defendants as if upon Cross Examination, was by me first duly sworn, as hereinafter certified, deposed and said as follows:

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CROSS EXAMINATION

BY MR. MAGUIRE:

Q. Would you state your name and professional address, please.

A. My name is Donald Ion Cameron, my professional address is 27121 Oakmead Drive, Perrysburg

Ohio.

Q. And your occupation and specialty?

A. I'm a physician, I specialize in pediatric neurology.

Q. And you're the treater of Austin Sybert?

A. Yes, and I am.

Q. What have you reviewed in preparation for this deposition, Doctor?

A. Briefly, some of my chart notes and a life care plan that was submitted to me, and that's about it.

Q. By chance, does that life care plan have the word "draft" stamped on it?

A. It is a copy of something and it has "draft" stamped on it.

MR. MAGUIRE: May I just ask a question of Mr. Becker: Is that the same plan, Mike, that you sent to me and Don?

MR. BECKER: Tom, I'm not positive, I believe it is. I will tell you that we've, in the last day or two, received another revised draft that has a very nominal -- very nominal change to it, and I don't know

that we've sent that on to Dr. Cameron or not.

MR. MAGUIRE: Okay.

MR. BECKER: So that's the best I can tell you.

Q. What's the date of the plan that we're talking about?

A. The date on my plan says, the following is based on information available to Comprehensive Rehabilitation Consultants, Inc. as of January 16, 2002. Is that what would be considered a date?

Q. Okay. How current are your notes; they go to what date?

A. Last chart entry stated here is 1-9-02. Although, those notes would be -- they are electronic records and I'm not holding the actual record in my hand, but I can get that.

Q. And what are the notes prior to 1-9-02?

A. I've got a varied -- let me see, I've got a note from 1-3-02 -- that's a chart entry that is a phone call regarding the need for specific medication. I've got a phone call from 8-8-01 and from July 17th, '01, and 4-24-01. Do you want me to go on?

Q. Just hold a minute.

A. Okay.

MR. MAGUIRE: Okay, I want the record to show that the last of the doctor's notes I have are January 13, 2000. I have, in addition to the doctor's notes, a form that's dated 7-19-01.

And, frankly, I'm going to reserve the right to continue this deposition because Counsel has not forwarded me all of the doctor's notes, as he has been asked to do on numerous occasions and -- which is the subject of the Motion to Compel.

MR. BECKER: Well, what records did you receive that we supplemented and mailed recently?

MR. MAGUIRE: I think I just told you what I have last received, and the doctor has been to '02 and he's past me even in '01. So let's go on.

Q. Doctor, on the basis of your last examination of the child have you formulated any

opinions and conclusions which are -- differ or embark from the opinions and conclusions you've held in the past?

A. Let me repeat the question as I heard it: Have I formulated any opinions and conclusions that are different as of my last visit with him from opinions that I've had in the past --

Q. Yes.

A. -- meaning from the time of your last --

Q. Yes, time of my last record from you.

A. The answer is, no different opinions and conclusions other than ongoing therapeutic decisions.

Q. Okay. I take it you last saw the child in January of '02?

A. We -- yes, that would be correct.

Q. And you did a physical and neurological exam of the child at that time?

A. It was a brief interaction primarily related to medications for spasticity.

Q. What kind of medication?

A. We were adjusting his Valium.

Q. Did you get any input from the mother or father during the time of that last examination?

A. Let's see, we had some comments, yes, from

the family.

Q. Are those recorded?

A. Yes.

Q. Can you briefly tell me what those comments are.

A. Yes, you had -- as of the time of 1-9-02 there was -- he was noted to have some tightness in his muscles, which has continued, he had no seizure activity, the main concern at that time was that he had not been sleeping well; she thought, in relationship to the tightness of the muscles.

And he had complaints of an upper respiratory infection at that time. There was also comment made that there had been some improvement with the .25 milligrams of Valium with regards to his tightness.

Q. With regard to his tightness?

A. Yes.

Q. Was it his leg tightness or body tightness?

A. The leg tightness.

Q. All right. Did you form any opinions and conclusions as a result of that interactive examination?

A. None that I haven't expressed before. He had --

Q. Okay, this was, what, an ongoing exam?

A. That's correct.

Q. On what periodic schedule do you have the child to be seen by you?

A. Well, there are two different schedules; most of our children get seen twice a year for either developmental purposes or general follow-up, and, then, currently, he is being seen on an as-needed basis as we adjust the spasticity medication.

Q. Is that in addition to the twice annual visits?

A. Yes.

Q. Okay. Are you going to have any opinions on standard of care in this case?

A. No -- are you referring to prenatal care or obstetrical care?

MR. BECKER: We're not intending to elicit any standard of care opinions from this doctor.

THE DOCTOR: Oh, sorry.

MR. MAGUIRE: All right.

Q. Doctor, do you have enough information to form the opinions and conclusions you're going to State at trial?

A. Yes, I do.
Q. Now, it's my understanding that we're dealing with a 37 gestational age newborn -- 37-week gestational age newborn. Is that your understanding?
A. That's my understanding.
Q. Now, do you interpret head CTs and head MRIs?
A. Yes, I do.
Q. Do you do that on a daily basis in your practice?
A. Yes, I do.
Q. And do you interpret those EEGs and head films for other physicians?
A. No, I do not, but I do interpret the EEGs -- I will rephrase that: I do not interpret imaging studies such as CTs or MRIs for other physicians, but I do interpret EEGs for other physicians.
Q. All right, but you do interpret head CTs and MRIs for your own purposes, which aid you in diagnosing your patients; would that be a correct statement?
A. That's correct.
Q. You do not, necessarily, rely on pediatric neuroradiologists to assist you in that endeavor?
A. We, actually, do not have a pediatric

neuroradiologist available to us.
Q. Okay. Will you agree that cerebral palsy is a fixed or a static deficit of motor function?
A. That is correct.
Q. How does that definition square with your notation of remarkable improvement of neurological findings in your August 27, '99 follow-up note?
A. It, actually, squares very well, not with definitions but what we know about the neurobiology of static lesions in the brains of infants, and that is that -- the primary cause of the disorder is felt to be static and the -- but improvement occurs through the plasticity of the brain in response to a static injury. Meaning, the injury itself and the original problems are static, the adaptation of the brain is responsible for improvement of the child.
Q. Okay. Now, I see, I guess it's in your January 13, 2000 office dictation, a hypertonia (sic) described regarding the child's condition. Is that correct?
A. Yes.
Q. That's hypotonia, h-y-p-o, correct? Is that correct, Doctor, hypotonia?
A. Yes, I'm seeing that, yes.

Q. But there's no frank diagnosis of cerebral palsy by you, is that correct?
A. No, that would not be quite correct, cerebral palsy is a static encephalopathy.
Q. Say that again, I'm sorry, I missed it.
A. Cerebral palsy is a static encephalopathy.
Q. All right, you don't use the word cerebral palsy in any of your notes, correct?
A. I usually do not use it except for billing purposes or where children with medical handicaps are involved.
Q. Now, you're saying the child does have cerebral palsy?
A. That's correct.
Q. How would you style the child's cerebral palsy?
A. I think he has truncal hypotonia, with --
Q. I'm sorry to interrupt: Is that h-y-p-o, tonia?
A. Yes.
Q. Okay, go ahead, I'm sorry.
A. Yes, truncal hypotonia. But the actual description of his condition would be, quote, cerebral palsy. The nomenclature would be that of diplegia.

Q. All right. Would you call this a spastic diplegia?
A. Well, he has, I believe, a mixed -- going back to the cerebral palsy term, a mixed cerebral palsy, so he has poor trunkal control, or poor hypotonic trunk control, but has had some increase in tone that has resulted in contractures in his lower extremities, so it's a mixed cerebral palsy.
Q. All right. So the diplegia involves the lower extremities?
A. The diplegia refers to involvement of upper extremities less than lower extremities.
Q. Did you say less in the lower extremities?
A. Yes.
Q. Okay. The reason I raise this is we recently received handwritten notes, I believe from Dr. Michelle Irons, where she, if I'm reading this correctly, does describe a spastic diplegia. Are you aware of those notes?
A. No, I'm not.
Q. Okay. Would that be consistent with your diagnosis, at least, in part, if the child does have spastic diplegia?
A. Only in part. As I said, it's a mixed

cerebral palsy, so he has both spastic signs as well as hypotonic signs.

Q. All right. Now, on the Discharge Summary from St. V's the word hypertonia is used.

A. Which Discharge Summary are we referring to?

Q. It's the -- well, let me see if I can get it: It looks like it's dated 9-14-99, it would be Page 4, second paragraph is -- well, the page starts with, swollen left forearm. It's the second paragraph, fourth line down. I'll suggest to you that that may be a misprint. It says hypertonia.

A. I don't -- we're talking about a -- okay, excuse me, I'm being handed something. I believe that --

Q. Can I read the sentence, maybe I can help you out?

A. Can you hold on a second, I believe that I have something -- I believe that this is Page 4 of a Discharge Summary that is in my chart dated 8-22-99.

Q. Okay, but there's a handwritten date at the bottom, 9-14-99.

A. Okay, I do not have that reference --

Q. Okay.

A. -- but it looks to be the same record.

Q. All right. Anyway, the sentence that I'm referring to --

A. Okay.

Q. -- is the second sentence in the fourth paragraph, the physical examination showed evidence of mild generalized hypertonia. Is that a misprint; should that be hypotonia?

A. Can I, again, ask you what page that is on?

Q. Page 4.

A. Page 4?

Q. Yes.

A. I'm having a hard time locating that. Is it the paragraph that is headed, swollen left arm?

Q. Yeah, it would be the second paragraph after those words, swollen left arm, starting with, on the day of discharge.

A. Okay, it says hypertonia there, and I don't know --

Q. Should that be hypotonia?

A. I do not know, sir.

Q. Has the child ever demonstrated hypertonia?

A. Let me see -- go back to my notes. I do not have, unfortunately, any copies of my hospital consultation, if I did one. Let me see what I have in

my chart notes.

Q. Just to help you out, I don't see it, and if you can illuminate my thinking, that will be fine.

A. Okay.

Q. I'm just suggesting that may be a misprint, maybe something that the transcriber misheard, thinking it was -- appearing hypertonia as opposed to hypotonia. Can you help me out on that? Has the child ever been hypertonic as opposed to hypotonic?

A. I couldn't generalize, Mr. Maguire. I'm curious as to the description, but I am afraid I can't really clarify it. I don't see in my notes -- I don't see any specific mention of hypertonic on general examination. There again, my contention is that he has a mixed cerebral palsy picture, so I don't know if they were just picking on a particular part of his examination at that time.

Q. Okay.

A. I have no idea.

Q. Have you ever used the word hypertonic to describe the child's condition?

A. There is mention in my chart -- I have not, looking through my summaries, I have not described the child as hypertonic --

Q. Okay.

A. -- in his entirety. I just wanted to clarify a point that there is mention in my note that he had, quote, aplastotonic (phonetic) posturing, and that would be a hypertonic sign.

Q. Okay.

A. But the child is not diffusely hypertonic.

Q. All right. You will agree there are many causes, some unknown, of mental retardation, hypertonia, hypotonia and cerebral palsy?

A. Yes, that would be correct.

Q. Having nothing to do with problems during labor and delivery?

A. That is correct.

Q. You would agree that one of the Cardinal signs of hypoxia and ischemia leading to brain damage during labor and delivery is microcephaly?

MR. BECKER: What?

Objection.

A. No, I don't agree, no.

Q. You don't see that these children who have been brain damaged by hypoxia ischemia during the birthing process subsequently become microcephalic?

A. No, Mr. Maguire, it's a matter of degree --

Q. Okay.
A. -- that determines whether or not they become microcephalic or not.
Q. In any event, there's no evidence of microcephaly in this case? I think you direct your attention to that --
A. Yes, I have a head circumference curve here that indicates that he has a normal head circumference.
Q. All right. Now, we can do this the easy way or the hard way: I want to refer to the first arterial blood gases run at St. Luke's Hospital. Do you have any record of that?
A. No, I do not. Let me see -- unless it's in that report, I would not.
Q. All right. Well, let me ask you to assume -- and I've taken this from the lab values, that the first arterial blood gases run 20 minutes after birth at 4:45 showed a 6.67 Ph, PCO2 of 129, a PO2 of 25, a base excess of minus 23, and a bicarb of 15.1.
Further, let me ask you to accept, for purposes of these questions, that the Apgar at five minutes was one for the heart. Okay?
A. Could you repeat the blood gases for me.
Q. Sure. The St. Luke's records show that 20

minutes after birth at 4:45 the draw -- the blood gases, arterial blood gases, were drawn and the Ph was 6.67, the PCO2 was 129, the PO2 was 25, the base excess was minus 23 and the bicarb was 15.1. Okay?
A. Yes.
Q. And the Apgar was one at five minutes, the one being for the heart. All right?
A. Yes.
Q. Now, with those blood gases and that Apgar you would expect a prolonged depressed newborn after birth, would you not?
A. Well, I'm not a neonatal medicine expert.
Q. So you have no opinion on that?
A. No, I do not, sir.
Q. But you, however, noted in your notes a rapid resuscitation in this case, correct?
A. In my notes? I don't know that I could have noted that, because I don't have any -- did I note that in one of my hospital notes?
Q. Let me see if I can find it. Let me withdraw that because I can't seem to locate it. Let me refer you to your August 27, '99 follow-up note: You say that the child had severely impaired Apgar at birth and had all the classical signs of neonatal asphyxia.

Do you see that?
A. I'm looking, Mr. Maguire, I seem to have --
Q. It's your August 27 follow-up note.
A. Unfortunately, with all the photocopying I seem to have misplaced that note. Let me just see if I can locate it.
Q. It's in your office notes, Doctor.
A. Yeah, I do believe you, except that my office notes, as I look at them here, are totally out of order, so I do know that we can get them out of the computer. Here, I found it. Now, tell me what --
Q. The second sentence in the notes.
A. Remarkably, however, the child has had very rapid --
Q. No, the second sentence, Doctor, first paragraph.
A. Okay, the child had severely impaired Apgars at birth and had all the classical signs of neonatal asphyxia.
Q. Okay, that's what I just read to you, right?
A. Yes.
Q. And you do remark in the next paragraph that, remarkably, the child has had a very rapid turnaround of his neurological findings?

A. Yes.
Q. But you do not -- are you able to say one way or the other whether the child had a rapid resuscitation after birth to the point of being stabilized?
A. I don't see anything in any notes to that effect, no.
Q. All right. Are you aware of the nuclear red blood cell count within 24 hours after birth?
A. No.
Q. You are not?
A. No.
Q. If I gave you a figure of 17, would that mean anything to you standing alone?
A. No, I'm afraid not.
Q. All right. Do you get into nuclear red blood cells in your practice?
A. Not really. I vaguely recall that --
Q. All right. You wouldn't have any opinions one way or the other on the meaning of 17 NRBCs --
A. No, I wouldn't.
Q. -- run close to the time of birth?
A. No.
Q. No?

A. No.
Q. All right. You're not going to be testifying, I take it, about the significance of the blood gases at the time of birth?
A. No.
Q. All right. Can we say that seizures generally follow a hypoxic ischemic brain injury at the time of birth?
A. They don't always follow, but it is a frequent sequelae.
Q. Now, the July 23rd, '99 EEG interpretation states that there was no epileptic form activity despite the occurrence of clinical jerks. Do you see that?
A. This is in -- during the hospital stay --
Q. Yes.
A. -- still.
Q. Yes.
A. Let me see, I don't know -- let me see if I have that record. What was the date again, I'm sorry?
Q. 7-23.
A. 7-23. I actually may not have that if it was during his hospitalization, because I wouldn't have been sent that as a matter of course, let me just check again. I'm afraid I don't see that in my records. I

may have been the one who dictated it, however, I -- that would be a part of his hospital -- wait a minute. No, I'm sorry, I do see it.
Q. This is your finding, your impression.
A. I do see a note, I'm sorry, it says 7-24 --
Q. I'm sorry, the day of the procedure is 7-22, I guess it was dictated on the 23rd.
A. Right.
Q. Do you see that impression at the bottom?
A. Yes, this is -- begins by, this is a dramatically abnormal electroencephalogram?
Q. No, at this time no distinctive epileptic form activities were noted despite the occurrence of clinical jerks. Do you see that?
A. I think I have a different --
Q. Last sentence in your report.
A. Hold on, I have a -- is this on Page 2?
Q. Page 1 of 1.
A. Oh, Page 1. The letter appears -- I'm reading here, the latter appeared to persist for one second or a fraction of a second following the jerking.
Q. I'm looking at your impression at the bottom of the page. There is a remarkably abnormal electroencephalogram due to absence of any discernible

recognized activities, and then the sentence in question, at this time no distinctive epileptic form activities are noted despite the occurrence of clinical jerks. Do you see that?
A. I'm having a hard time because I have a different impression on my -- this is rather odd, let me just verify with your colleagues.
Q. The St. Vincent's Mercy Medical Center EEG report.
A. Right, and it's the same --
Q. Procedure, 7-22-99.
A. I don't know how to explain this, but I have two different -- I have a completely different impression, and I'm trying to figure out --
MR. COLLIER: For the record, Mr. Switzer has handed me a copy of, Tom, the page that you have and I provided it to Dr. Cameron and he is now comparing it to his own chart.
A. There's some discrepancies between our records. My record says, date and time, typed, 7-24, 1999 at 12:13 a.m. Yours says, 12:34 a.m., and the date time dictated it says, 7-23-99, 5:55 p.m. for mine and

5:50 p.m. for yours, and the impressions are different --
Q. Right.
A. -- and I can't account for the difference between the two of them.
Q. Okay.
A. I would be happy --
Q. Let me ask you this: With respect to the one I'm referring to, specifically, the language, at this time no distinctive epileptic form activities are noted despite the occurrence of clinical jerks.
A. Yes.
Q. Those might simply mean that there's no seizures really being observed or --
A. That means that the jerking activity that was present was, likely, not a seizure.
Q. Okay. Well, we got about that the hard way, all right. Now, it's noted in the chart that you saw a spike pattern on the first EEG. That's 7-24, Physician Progress Notes.
A. Okay.
Q. Okay?
A. Yes.
Q. But at that point in time would you agree

that hypoxic ischemic brain damage would manifest itself by way of a first suppression pattern on the EEG?

A. A severe anoxic (sic) ischemic insult of advanced degree would manifest -- could manifest itself by a birth suppression pattern. The -- but it's not the only manifestation that one could see. That is, indeed, the most severe and classical abnormality, I would agree.

Q. Well -- all right, okay. Now, with respect to the initial CAT scans run on the second day of life, they show no -- the interpretation indicated no edema narrowing the lateral ventricles. Agree?

A. Let's see, what date are we talking about?

Q. Well, my note refers to the Discharge Summary, second page. You can refer to what you wish.

A. Okay, back to the Discharge Summary?

Q. Yeah.

A. Okay, let's see: I'm on Page 2, and what line is that, Mr. Maguire?

Q. Just a second, I'll grab it. Well, I guess I've editorialized; Page 3, the first line it says, the CT brain scan on the second day of life was reported normal. Do you see that?

A. Yes, I do see that.

Q. Can you agree with that?

A. I don't know what -- what am I supposed to agree with?

Q. Well, that the CT scan on the second day of life was normal?

A. I don't have any recollection of that, Mr. Maguire. If it's reported as that, I'm happy to --

Q. Well, do you have the CT interpretation of the second day of life with you?

A. No, I do not. I would believe that would be part of his hospital record.

Q. Okay. Well, I would like you, for the purposes of my next question, to accept my statement that there is nothing noted about edema narrowing the lateral ventricles. Okay?

A. Yes.

Q. Such edema which would narrow the lateral ventricles would be a telltale sign of a hypoxic ischemic brain injury, you will agree with that?

A. It would be the telltale sign of a severe anoxic (sic) ischemic injury, of the most advanced degree.

Q. Let me take this a little further.

A. Yeah.

Q. There is no later evidence of enlargement of the lateral ventricles in the 8-20-99 and the 12-20 MRIs? Agreed?

A. Again, let me see if I have those records -- those would be post-discharge? I have records of 12-20-99 which show prominence of the ventricles. Let me see if I have 8-20-99. 8-20-99 I do have, and the one by 8-20 did not show ventricular system enlargement, according to the radiologist.

Q. Have you looked at those MRIs?

A. Not recently. I presume that I would have looked at them at that time.

Q. You don't see any enlargement of the lateral ventricles on those MRIs do you, Doctor?

A. Well, I don't know, because I haven't looked at them recently, but the report states that there wasn't any in August. There was some in December. I would appreciate the opportunity of looking at them if you so wish.

Q. Okay, well, let's go by way of the interpretation at present: There's no evidence of enlargement of the lateral ventricles in August or December?

A. No, in December there is.

Q. It says, prominence, it does not say enlargement; correct, Doctor?

A. It's -- it says prominence; prominence means enlargement.

Q. Do you know whether the lateral ventricles are abnormally enlarged, or is the enlargement within normal parameters, or can you answer that question at this point?

A. I cannot since I don't have the films to comment on.

Q. In any event, you would agree that abnormal enlargement of the lateral ventricles in August and December of '99 would be a telltale sign of hypoxic ischemic brain damage around that time and date, correct?

A. Well, I would like to correct your statement by saying that it is not a telltale sign of hypoxic ischemic insult, but patients who have hypoxic ischemic insults may have loss of peripheral white matter that leads to prominence of the ventricles, but it's not a pathognomonic sign of hypoxic ischemic insult.

Q. All right. Now, if there were a hypoxic ischemic event around the time of birth sufficient to cause brain damage, you would expect systemic organ

damage to be manifested in the lab reports? That's established in the literature. Would you not agree?

A. I beg to disagree, there are two parts to your question.

Q. All right.

A. One is that it is established in the literature; the literature examines severe cases of anoxic (sic) ischemic injury, and in severe cases of anoxic (sic) ischemic injury there have been reported to be alterations of organ systems, including liver, heart, muscle.

I would not equate that with a statement of if hypoxic ischemic injury occurs, that there will be organ damage, because there are very simple ways, for instance, of causing localized hypoxic ischemic damage, and I will just simply site one and that is strangulation.

So you can locally cause cerebral flow to have changes without causing systemic changes. You can cause spasm in patients without causing peripheral injury. So I agree with part of your statement, that the literature supports that with an advanced ischemic insult that there may be peripheral organ damage, and that would be a correct statement.

Q. Okay. Are you aware of any systemic organ damage in this case around the time of birth?

A. It would be out of my purview to ascertain that there was no organ damage, but I'm not aware of any major organ damage sustained on this patient.

Q. Have you been informed that there will be placental pathological evidence of central nervous system damage days, weeks, before birth?

A. I'm sorry, could you rephrase that.

MR. BECKER: C'mon, Tom, let's get to it; how could he be informed of that when we haven't been informed of that?

MR. MAGUIRE: Well, I'm just asking him the question.

MR. BECKER: Let's get to it.

A. Can you repeat the question.

Q. Let me ask it this way: Would it surprise you that there will be placental pathological evidence of central nervous system damage days, weeks, before birth, Doctor?

A. Again, I don't understand the question. What does the placenta have to do with the central

nervous system? I guess I can't answer that question.

Q. You can't answer the question?

A. No, I cannot.

Q. Now, will you agree that damage to the thalami can lead to cerebral palsy and mental retardation?

A. Do I agree that damage to the thalami can lead to cerebral palsy? What I could agree with is that damage to the brain that would include the thalami would be found and could be found in cerebral palsy. The issue of the mental retardation I would disagree with because thalamic injury does not equate with mental retardation, no.

Q. All right. Would you agree that the thalami are less sensitive to damage by hypoxia ischemia --

A. No.

Q. -- than is the basal ganglia in a 37-week fetus?

A. Well, the thalami are part of the basal ganglia and, indeed, thalamus, globus pallidus and putamen are sensitive indexes of ischemia and hypoxia, and, indeed, in the neuropathological cases that I've been involved with as a fellow in neuropathology, those would be target areas that we would look for evidence of

hypoxia.

Q. Well, let's see if you can answer my question: If you can't, you can't. In a 37-week fetus would you agree that the thalami are less sensitive to damage than are the basal ganglia? I'm sorry, hypoxic ischemic damage than the basal ganglia?

A. You're referring to -- see, the basal ganglia include the thalami, but I think I'm going to be able to answer your question.

Q. Okay.

A. The thalami and basal ganglia are sensitive to hypoxic injury. I am not aware whether that at 37 weeks, specifically, one would be less likely to get injury to one or the other.

Q. You just don't know?

A. I do not -- I'm certainly not aware of it.

Q. Okay, but when you say you're not aware of it, does that mean you just don't know?

A. Well, I'm speaking as a person who used to do neuropathological examinations, so I am certainly not aware of anybody specifically coming up with that evidence. And I may just be out of touch of a field that I have not touched in many years so --

Q. Now, on the 12-20-99 MRI it is noted that

the thalami and basal ganglia are damaged, correct?
A. It says, punctuated abnormalities, yes, in the basal ganglia and thalami.
Q. Do you have those films with you, Doctor?
A. No, I do not.
Q. Are you able to tell from the description, the interpretation, whether the up-take on the thalami and the basal ganglia on those films is the same or different?
A. Let me see: The neuroradiologist who interpreted these did not make any --
Q. Okay.
A. -- differentiation between the two.
Q. Now, I note that the interpreter of the 12-20-99 MRI said that the pattern he sees was consistent with causes other than hypoxia ischemia. Do you see that?
A. The statement made is, may relate to the patient's acute episode of lack of oxygen, however, abnormal signal within the deep brain matter, more typically, is related to one of the torched infections with calcifications or HIV.
Q. So, in answer to my question, you do see that, correct?

A. I do see that.
Q. Okay. And, of course, there are brain abnormalities which the interpretor says are due to the prematurity. Do you see that?
A. Could you refer to which line that is in.
Q. I'm sorry, I didn't hear your question.
A. Could you refer me to the line in the report.
Q. Oh, yeah, hold on. Yeah, it's the -- I may have said 12 but I guess I should refer to the 8-20 MRIs: Do you see the second paragraph dealing with findings where it talks about prematurity and gestational age?
A. And your question was what, I'm sorry?
Q. Well, let me change the question since we're referring to a different interpretation: On the 8-20-99 MRI interpretation there is reference to abnormalities which should be correlated with the patient's prematurity and gestational age. Do you see that?
A. I see that statement, yes.
Q. Okay, and also on the 7-23 CT there is a statement, I guess this is, really, what I was referring to about poor opercularization upon the sylvian fissure

which may be related to a premature gestational age at birth. The sulci appear slightly thick, which may also reflect prematurity. Do you see that, Doctor?
A. I actually do not have the CT scan report. The MRI report that I have makes mention of the CT of 7-23-99.
Q. And how would those findings affect the child?
A. The report that I have -- and I'm not gonna refer to the CAT scan you're talking about since I don't have it in front of me, but the report that I have comments on the diffuse signal in the periventricular white matter, which suggests a lack of -- there must be a typo there of myelination, and their comment is that one should consider that finding in correspondence to whatever degree of prematurity or gestational age of the patient.
Q. Okay. Now, do you interpret that to mean that these findings are as a result of the prematurity of the child as opposed to any hypoxic ischemic insult?
MR. BECKER: Let me just object to the question. If you understand it, Doctor, please feel

free to answer.
A. The -- I understand the question, I -- first of all, I don't have the films in front of me, but I do -- I believe that the radiologist is questioning whether or not -- how to explain the abnormality of signal and the -- you will note that the reason for exam is stated as, a premature male infant.
And so the radiologist is saying, we've got an abnormal signal in the white matter, consider this in relationship to prematurity to whatever gestational age the child has. As it turns out, the child is not premature, so that the radiologist's report must be interpreted in that light.
Q. So what you're really saying is that if the radiologist is interpreting the films to be related to prematurity, that's wrong, because, in your judgment, the child is not premature? Is that correct?
MR. BECKER: Objection.
You may answer, Doctor.
A. That's correct.
Q. I'm sorry, I didn't hear your answer.
A. That is correct.
Q. Did you say correct, Doctor?
A. That is correct.

Q. Okay. Now, in your August 27, '99 letter -- do you have that in front of you?
A. Okay, hold on a second, I need to recoup -- excuse me, Mr. Maguire, while I do a little housekeeping here, I won't take long.
Q. I called it a letter, it's a follow-up note on the 27th, typewritten.
A. The one that we were previously referring to?
Q. Yeah.
A. I'm trying to locate it because, as I recall, it was out of order so -- okay, I have that letter now.
Q. Yeah. You say, sixth paragraph, MRI of the brain is reported to show some periventricular white matter changes, the significance of this is unclear at this time. Do you see that, Doctor?
A. Yes, I do.
Q. You're saying that you see periventricular leukomalacia?
MR. BECKER: Objection.
A. No, I did not say that.
Q. Does the child, in your opinion, have periventricular leukomalacia?

A. I don't know that I have termed it that in any of my notes, so I would have to punt on that.
Q. You will have to what?
A. I'm going to have to pass on that statement because I have not actually mentioned periventricular leukomalacia in any of my reports.
Q. Are you going to be interpreting these films at trial, Doctor?
MR. BECKER: We will not be asking this doctor to interpret the films.
Q. Doctor, you've looked at these films and you have a lot of notes: Does this child have PVL?
A. Periventricular leukomalacia is an entity related to prematurity. At least, we commonly -- or, specifically, tend to use it in relationship to the white matter diseases of prematurity. He has -- this child does have white matter disease, but I have refrained in my notes to use the term periventricular leukomalacia because of its association with prematurity.
Q. You do see PVL in term babies, however, which occurred prior to term, correct?
A. We see -- I'm being very specific about this

because the term -- and there's considerable controversy about the nomenclature, I'm specifically steering away from the use of the word periventricular leukomalacia to ensure that my words and statements are not interpreted as the fact that the white matter disease present is related to -- in any way to the prematurity related periventricular white matter.
Q. But you will agree that PVL does not occur beyond the 35th week of gestation? That's established in the literature, correct?
MR. BECKER: Objection.
A. Periventricular leukomalacia is, in my nomenclature, a disease of prematurity.
Q. Are you acquainted with the medical articles of K-u-b-i-n and M-e-n-k-e-s which address this matter?
A. I am aware of Dr. Menkes as a child neurologist, and Dr. Kubin. I am not sure what articles you're referring to so --
Q. These are authoritative positions in the area of PVL and cerebral palsy?
MR. BECKER: Objection.
A. To be honest, it's an area that I don't regard myself as a literature expert on, so I will pass on whether or not they are experts. Dr. Menkes, I

believe, is a metabolic specialist and genetic specialist, not a perinatologist or neonatal neurologist.
Q. Will you agree that PVL does not occur beyond the 35th week of gestation?
A. Beyond the what?
Q. 35th week of gestation.
A. The only thing I'm willing to agree to, Mr. Maguire, is that periventricular leukomalacia is a disease of the premature brain. Prematurity is defined as 37 -- younger than 37 weeks gestation.
Q. Okay. And you, of course, will see this in a newborn of more than 37 weeks gestation, but the PVL has occurred no later than the 35th week, right? Is that as far as you will go?
A. The -- I'm being very specific again: The term periventricular leukomalacia I use exclusively, as do others, in relationship to a description of white matter disease occurring in the premature. The specific reasons why the distinction is made, Mr. Maguire, have to do with the neuropathological findings, as well as the putative etiology of the white matter disease in that age group. Hence, the convenience of using the term periventricular leukomalacia in relationship to

prematurity. If your question is, does white matter disease occur in children other than prematures? The answer is yes.

Q. Okay, but, periventricular leukomalacia does not occur beyond the 35th week of gestation, I think we can agree on that, can we not?

MR. BECKER: Objection, asked and answered, he has given you his best answer. Let's move on, Tom.

Q. Can you answer the question, Doctor?

A. I have specifically said that periventricular leukomalacia is a disorder that we -- is a nomenclature that we use to describe white matter disease in the premature of a specific neuropathological description and pathophysiology.

Q. All right. Now, correct me if I'm wrong, but were any frank seizures found at St. V's Hospital where the child was admitted on transfer from St. Luke's?

A. I don't know if I can correct you, let me see what is in the records. My note, but I'm referring to my note, exclusively, of August 27th, 1999, makes reference to some seizure activity being observed. I cannot reference you to the actual description.

Q. Did you observe any frank seizure activity, Doctor?

A. Not during the time that I saw the child.

Q. Not during the time you saw the child?

A. No, but then, that would be, of course, a very limited amount of time.

Q. All right, and what seizure activity would you require to call it seizure activity? I mean, what would be the sequence, the classic chronic movements?

A. Well, the spectrum of newborn seizure activities is quite vast, as I'm sure you're aware. Seizure activity in a newborn can be limited to lip smacking, chewing, jerking, generalized tonoclonic activity, bicycling movements of the legs, unusual eye movements, apnea has been described as a manifestation of seizure activity. So there's quite a spectrum, yes.

Q. All right. Have you ever observed any seizures in this child, Doctor?

A. I have not personally observed seizures in the child, no.

Q. Now, there's a history of thyroid problems in the mother; how does that manifest itself -- or how can that manifest itself in a fetus and newborn, do you know?

A. Could you clarify your question? Are you asking whether or not the hypothyroidism in the mother has an effect on --

Q. I'm just saying, there's reference to a, quote, thyroid problem --

A. Okay.

Q. -- end quote, in the mother. And I appreciate this is very generalized and maybe you can't, or don't choose to answer it, but how can a thyroid problem in the mother manifest itself in the fetus in a newborn?

A. It's not a problem that I encounter as a neurologist, I'll be honest. If I recall, in clinical endocrine presentations they can actually present, depending on what type of problem she had with either irritability from hypothyroidism or, more likely, a goiter from interference with whatever caused the mother's --

Q. Was there anything anywhere in the literature that hyper or hypothyroidism in the mother can manifest in the fetus and newborn by way of mental retardation and cerebral palsy?

A. If the mother -- I'm, certainly, not aware of cerebral palsy being associated with thyroid

problems, no.

Q. Doctor, will you agree there are several anomalies with respect to the signs and findings in this child which are difficult to relate to hypoxic ischemic encephalopathy around the time -- occurring as a result of the birthing process?

A. I'm not certain what you mean by that, what kind of signs or --

Q. Well, I'm just asking whether -- are there signs and findings in this child which do not relate to hypoxic ischemic injury around the time of birth?

A. Oh, that is an excellent question: Unfortunately, I don't have -- and perhaps you do have access or I could be given access to, my neurological examination at that time, when I would have considered such an issue. I don't have that in front of me at this time. But I normally would consider if there are any discrepancies, and I'm not saying that there aren't any, I'm just saying at this time I don't have in front of me material that would clarify your question.

Q. Would you agree that the child's condition may be caused, at least, in part, by the events occurring days to weeks before birth?

MR. BECKER: Objection.

A. I'm sorry, unfortunately, your voice cut out there for a minute, Mr. Maguire: Do I agree that -- and then I heard, before birth.

Q. Okay, let me try it again: Will you agree that the child's condition, at least in part, may be caused by events occurring in utero days, weeks, prior to birth?

A. Are you asking me to speculate?

Q. No, I'm asking you if you can answer the question? If you can't, you can't. If you have no opinion, you have no opinion.

A. It's not that I don't have an opinion, it's just that I'm trying to understand the question. There are, obviously, multiple causes of white matter injury, mental retardation, developmental delays and so on. So if I'm asked -- if the question is, are there other causes of cerebral palsy that are not -- that could have occurred in the time before the delivery? The answer is yes.

Q. Okay. This may be a hard question or, perhaps, in your mind, impossible, but can you give us a rough estimate of the child's IQ, Doctor?

A. That's a great question, let me see if I --

Q. What's happening?

A. Yeah, I'm thinking through --

Q. Okay.

A. -- because I don't usually make an IQ note. Let me preface my comment by stating that Austin -- not for Austin only, but when we state IQ in a young infant this age, we're really referring to a gross estimation of IQ. IQ being the ratio of his achieved potential and -- achieved proficiency in developmental skills over what it should be, so we commonly refer to a certain number of points over 100.

Well, that kind of official test is not done in this age group, so having -- what I'm doing now is I'm projecting -- I'm going to project his current developmental skills, state what percentage they are of his age, and relate that to his final IQ.

Q. Okay.

A. And so the -- Austin is, currently, a little over two years, he's about two-and-a-half years of age. He has -- his motor skills are those of a four- to eight-month of age infant, so that that would be, roughly, a quarter of his stated age, for argument sake. His alertness, his social skills, are probably at the level of a 10- to 11-month-old in some instances, so, extrapolating, I would say that his IQ is probably

not lower than 40, and the -- but, at this point in time, without some of that recovery that we see from brain plasticity, I wouldn't be able to place him at more than an IQ of 50.

Q. And what would be, quote, normal?

A. Normal would be 100.

Q. All right.

A. And realize, of course, that I have to make some allowances and extrapolations here.

Q. I understand. Is that going to improve, or can you say, Doctor?

A. Well, that is one of the reasons -- I appreciate that question: One of the reasons we don't measure IQs is that so many developmental skills that he may or may not have can be developed over time in response to this brain plasticity I talked about, so that, ultimately, this may be an underestimate of his potential.

Q. In your opinion, is the child's -- is the child -- well, strike that. Do you recognize Herbert Grossman as an authority on life expectancy?

A. Mr. Grossman and myself have been on opposite ends of the spectrum of understanding, but I -- so I would say I recognize the name, I know his

interests and his publications on life expectancy. My personal experience over 18 years has been dramatically different than his.

Q. All right. Are you going to be giving any opinions with respect to the child's life expectancy?

A. If asked, I could give an opinion as to the life expectancy, yes.

Q. Your answer is yes?

A. Yes.

Q. I take it you have not read Mrs. Sybert's deposition?

A. No, sir.

Q. She describes the child as unable to roll over but is able to sleep, unable to sit up, is not toilet trained, is unable to feed himself, unable to communicate or respond to communication. That's her testimony. Is that your understanding of the child's condition?

A. I haven't really addressed those issues most recently, so I don't know what stage in development she was describing him at.

Q. If those are the facts, would those be important to you in determining -- making a determination of the child's life expectancy?

A. No, sir.
Q. That indicates to me that you do not subscribe to the Grossman studies --
A. That is correct.
Q. -- would that be accurate?
A. That is correct, Mr. Maguire.
Q. But you recognize Dr. Grossman as an authority on life expectancies?
MR. BECKER: Objection, it's been asked and answered.
Q. Can you answer the question, Doctor?
A. In past testimony I've actually commented on it; I think that Dr. Grossman is to be admired for doing the work of an academic and publishing his interest in the area of life expectancy in patients who are mentally retarded or handicapped or otherwise impaired. I happen to disagree quite strongly, and, in fact, there is more recent evidence published by other authors that contradicts him. So we -- I disagree with him, yes.
Q. Are you referring to Dr. Strauss?
A. No, you know, the name escapes me at this point in time.
Q. All right.
A. I seem to remember a more ethnic name than

that, but --
Q. All right.
(Whereupon, a discussion was held off the record.)
Q. I'm a little unprepared here so -- and Don may have to take over because I don't have your most recent report, Doctor, only your notes, but let me try it this way: On the basis of your most recent examination, what were your physical and neurological findings?
A. Austin had poor trunk control, he has contractures at his ankles and wears ankle braces for that. He has some mild degree of facial hemiatrophy, or weakness on one side. And his motor skills at this point in time would be deemed to be poor and primitive.
Q. Elaborate a little on that, would you, before I forget.
A. Well, as you mentioned earlier, his mother talks about his difficulty with trunk control and getting around. Austin is a young man who cannot support himself, needs to be placed in the elevated position, has poor neck control and very limited function, voluntary function, at this point in time in his upper extremities and lower extremities, but his

lower extremity involvement is, clearly, more profound than is the upper extremity involvement with regards to motor control and strength.
In addition, the psychomotor findings are that he is interactive, he is sociable in the sense that he appears to be attentive to personal interactions. He can smile or look fearful in response to stimuli; if you try and frighten him or interact with him positively there is an appropriate response. And those were the findings that we had.
I did not see, at the last exam, the spasms that mom was concerned about, but I was -- those tend to occur more when the child is trying to sleep. That's pretty much the extent of my last interaction with him.
Q. Well, you may have answered this, but what do you mean by interaction, the child is interactive, can you give me some examples?
A. Yes. He will track you visually in the room, he will smile or express fear at a friendly or, alternatively, noxious interaction with him.
Q. And what conclusions can you draw from this interaction which you observed, Doctor, anything?
A. Well, the only thing that -- from a physician's perspective, the person who is taking care

of him, it gives me some degree of hope that what we term higher cortical functions, his -- for you, I guess, his intellectual skills may be relatively spared, perhaps, in relationship to his motor impairments.
Q. But you can't say that with any medical probability, right?
A. I cannot be certain at this point that it's going to translate into a more promising IQ than what I've delivered to you, no.
Q. All right. In other words, you can't say whether or not the child's intellectual ability, his ability to communicate, his abilities to receive communication, are going to improve, correct?
A. Based on my exam, you mean?
Q. Yes.
A. No, I cannot say that they'll improve based on my exam.
Q. All right. Is the child toilet trained?
A. I do not believe so, he was wearing diapers the last time I saw him.
Q. Can the child feed himself?
A. To my knowledge, no. I would be -- in fact, from a neurological point of view, I would be quite amazed.

Q. Has there been any consideration of a gastrostomy?
A. No.
Q. Do you know whether or not that will be contemplated in the future?
A. At this point in time my understanding is that he needs to be fed, but I have not been made aware of any specific feeding difficulties.
Q. And how frequent are the child's respiratory infections?
A. I think you might want to refer that to his primary care pediatrician. I am not aware of pulmonary complications according to my notes.
Q. Would that be important to you in determining the child's life expectancy?
A. Not life expectancy, no.
Q. All right. Can the child roll over?
A. To my knowledge, he does not roll over independently.
Q. All right. And he cannot sit, correct?
A. That's correct.
Q. Obviously, he cannot walk, cannot stand?
A. That's correct.
Q. What kind of movement does the child have

with his hands and arms?
A. He can move both arms.
Q. Can he grasp and hold objects?
A. He can grasp within his reach. He does not, to my knowledge, make undue -- he's not able to make undue efforts towards reaching an object out of his reach, and he cannot manipulate that object with any skill with his hands.
Q. Do you believe that he's reaching by way of intellectual motivation, as it were; that if he sees something he wants that he grabs it, or can you tell?
A. Are you asking me if he has reached that stage, developmentally, where he might want to do it?
Q. Yeah.
A. Yes, he manifests interest in objects around him.
Q. Okay. And what does that interest mean to you, does that translate into intellectual ability, or can you just not say?
A. It does translate into intellectual ability, yes, that was the reference that I made between the discrepancy between motor skills and intellectual skills at this point.
Q. What can a child with an IQ do or not do

intell -- IQ of 40, do or not do intellectually, Doctor, maybe I can get it that way?
A. Yeah, that's a great question: I think that the -- an IQ of 40 would be considered severely retarded, of course, and a child in that age group would be dependent, but a great amount of the issue here with regards to his quality of life is going to center around his motor skills, whether or not he has some degree of motor skills that allow us -- or allow him to interact more productively with his environment.
So that, in answering your question, I would say, I guess, I've had patients with IQs of 40 to 50 who are wandering around the place being a comfortable member of their families who are dependent entirely for their needs, but, on the other hand, the -- their quality of life would be infinitely better than that of a child who has motor skill impairments and that degree of intellectual impairment. I hope I've answered your question.
Q. All right. Is there going to be any improvement in any of these areas that we've discussed, or can you say?
A. It is my belief that there will be improvement, I cannot predict how much improvement there

will be.
Q. You can't quantify or qualify it?
A. That's correct.
Q. All right. Are the child's -- let me try it this way: I guess you've answered the question, but is the child's condition permanent?
A. That is a very tough question, Mr. Maguire. I think I've answered it earlier in the sense that --
Q. You can't say?
A. Well, the injury, obviously, has caused some permanent neurological damage, and that's what we refer to as the static encephalopathy.
Q. Yeah.
A. The brain plasticity that he has will enable him to make progress beyond what we can assess today, but we cannot say to what degree, and I'll be happy to give you an example. If you take out the speech area of the brain of a child less than one year of age, you would, intellectually, perhaps, assume that since you've taken out the speech area, that person will not talk and should not be able to talk.
Brain plasticity, however, allows a child going through those conditions of damage from whatever cause, and acquire language that, between the ages of

six and eight, is indistinguishable from its peers, that of its peers, except through some very sophisticated testing, and that is related to brain plasticity. The problem, Mr. Maguire, is that I cannot predict, nor can anybody else predict, the amount of brain plasticity that is left in this young man's brain.

Q. Okay. So we don't know what the future is gonna hold for him?

A. We do not.

Q. Correct?

A. That's correct.

Q. Okay. Is the child hearing impaired?

A. You know, I don't --

Q. Can you tell?

A. We can normally tell. I am sure that we had a brain stem auditory vocal response study done on him, I do not have that in front of me at this point.

Q. Is the child sight impaired?

A. He does not appear to have obvious site impairment, no.

Q. Is the child in pain, or can you tell?

A. Well, he's not in constant pain, the only -- I'm assuming and interpreting that the difficulty he has in going to sleep is a reflection of his discomfort from

his spasms. And so that I -- yes, he is uncomfortable from time to time. I -- if your question is, is he in pain all the time, I have no idea, nor do I have any evidence to support that.

Q. Okay. And you really don't know, having said that, whether pain is caused or -- pain or discomfort is causing him a problem with sleeping, correct?

A. My assumption is -- I can't ask him, for obvious reasons. My assumption is that he has discomfort from the spasms causing him difficulty sleeping, that's why my earlier comments were made as to the nature of his last visit or interaction with us, we were attempting to improve his sleeping by decreasing the discomfort putatively.

Q. Did you try to stimulate him with pain, such as with a pinch or pinprick?

A. Have I tried to use a pin prick? No, we wouldn't use that. Have I stimulated him -- excuse me one second. Can I answer this call?

Q. Sure.

(Whereupon, a discussion was held off the record.)

A. I'm sorry, the question about pinching --

the pain --

Q. Stimulate him with pain.

A. Yeah, I mean, routinely, when we try and make the children -- when we want them to move their legs, that's how we assess their function, we will pinch their toes to see if they have withdrawal and so on. I would hardly put that at the level of a sophisticated sensory test. Am I clear enough?

Q. Well, yeah, but what kind of -- I'm the layman here, what kind of sensory test do you -- or have you applied to the child to determine whether or not he can feel or react to that stimulus?

A. Very simple, just pinch his toes and you'll see him move them away. The pinch --

Q. He will do that?

A. I'm sorry?

Q. He will do that?

A. Oh, yes.

Q. Okay, just like any other child who is not neurologically impaired, correct?

A. Well, the --

Q. No different from any other child, right?

A. I can't say that, because I have no way of testing the subjective component of --

Q. Okay, in --

A. -- discomfort.

Q. -- other words, you don't know whether he comprehends pain, even if stimulated, right?

A. At this point in time I have no way of understanding his -- whether he has an insight into his plight, no.

Q. And I take it the child does not appreciate his predicament?

A. That -- my comment exactly just now, I do not know that he can appreciate his plight, I do not know.

Q. Does he laugh or cry?

A. He cries. He laughs or smiles in response to stimuli. I would interpret that with caution.

Q. Okay, what kind of stimuli makes him laugh?

A. Well, the stuff that I do in the office is pretty simple, you know, tickling him.

Q. All right.

A. Just making faces. I don't -- I think your question is directed as to whether or not he comprehends that and I can't --

Q. And you don't know?

A. I don't know.

Q. Okay. Based upon what we've been discussing here for the past 20 minutes, Doctor, do you have an opinion with respect to the child's life expectancy?
A. Yes, I do.
Q. You would agree that it is severely limited?
A. No, I do not.
Q. Would you say that he will live less than 20 years?
A. No, my opinion about his life expectancy is simply that I don't see anything, neurologically, that is specifically going to curtail his life.
Q. So what's your opinion as to life expectancy, just so we can get it out?
A. Oh, you mean in terms of actual numbers of years?
Q. Yes.
A. Perhaps I misspoke earlier, then, when I said I had an exact number of years; I have no idea how many years he's going to live.
Q. All right. You have no opinion on it then?
A. No, my opinion is that there's no neurological impairment that would curtail his life expectancy, but I can't tell you whether he's going to live 60 years or 65 years, that's an actuarial issue.

Q. Are you going to testify about the cost of caring for the child or will you leave that to others?
A. I think that my only expertise would be to comment or assist in pointing out what items of care are the usual and customary items in the care of a child with developmental impairments or neurological impairments. I have no concept as to the cost themselves, although, I could give you a ballpark figure for some things, but that's not my area of expertise so --
Q. Well, you've looked at the life care plan, have you not, Doctor?
A. I have looked at the life care plan, yes.
Q. That's rather detailed and involved, correct?
A. Could you repeat that, please.
Q. It's rather detailed and involved and subjective well into the future, right?
A. Yes, that's correct.
Q. And you're not prepared to say whether or not all of those needs are required of the child, particularly, with the fact that you don't know what the prognosis is, correct?
A. There's some items in there that you can't

comment on because they are putative; such as, you know, hip surgeries and so on. My comments refer specifically to, are these the kinds of interventions that may occur or might occur in the course of the life of a child with static encephalopathy?
Q. Yeah. And that's my point: You can't say with any probability the child is going to need everything that's described in that life care plan? That's a fair statement, is it not?
A. I think that's a fair statement.
Q. All right. Is the child going to need surgery or is that open to question at this point?
A. That would be open to question.
Q. Now, you're aware, are you not, Doctor, that all disabled children in the United States do have access to Federal and State entitlement?
A. That is correct.
MR. BECKER: Objection.
You may answer.
Q. And do you have literature in your office, Doctor, that you give to your patients or the parents or guardians of your patients which set forth the entitlement to which they may have access?
MR. BECKER: Same

objection.
A. I actually don't have literature. I mean, I have literature available to me, I don't -- outside of forms for the Bureau of Children with Medical Handicaps, I don't usually keep material to hand out, like the blue book or the new manual for -- I'm staring at it right now, there's a manual on my desk for the Special Education Requirements and Procedures for Children with Disabilities from the State of Ohio, and so I do keep those handy but, no, I don't -- except for the BCMH forms I don't keep materials for the families, no.
Q. And those entitlements are available to all Ohioans, regardless of need; isn't that correct, Doctor?
A. There are differences. I mention -- we mentioned two different things, the State of Ohio is mandated on the Federal law, PL94-142 to provide a -- the least restrictive environment for children to achieve education, and so they are required to give certain support measures as long as those are not considered medical needs outside of the realm of education. And so that's in the Free and Appropriate Education Act.
But the Bureau of Children with Medical Handicaps' eligibility is based on your income and your

diagnosis, so there are different requirements and eligibility, they are not all automatic. I'm not so sure about the Medicaid, slash, Healthy Start and those items, I'm not an expert in those areas. And I hope that I've answered the question that --

Q. Well, would you agree that nursing home expenses are paid for by the State and Federal government regardless of the parents' income, pursuant to Social Security medical assistance and supplemental security income for the blind and disabled?

MR. BECKER: Tom, can I have a continuing objection --

MR. MAGUIRE: Sure.

MR. BECKER: -- so that I don't have to --

MR. MAGUIRE: Sure.

A. Yeah, I just, I'm not certain, Mr. Maguire. Actually, that's an excellent issue. I do have children who are on Social Security, but not everybody that I have in my practice is actually eligible, and I'm really not familiar with what the actual standard for eligibility is. I probably should, but I don't.

Q. That manual you're referring to, Doctor, I can't see what it is, but --

A. Yes.

Q. -- did you say this is a blue manual?

A. Well, it's the manual -- I teach at the University of Findlay in the department of special education with my wife, the other Dr. Cameron, and because of recent changes in the law and so on they always make certain that you distribute details as to the eligibility for certain programs in special education if you have a handicap, so that's the manual that I'm referring to, it would be available, really, for professionals.

I imagine that a parent could request it, but that's not exactly the blue book, the blue book is a smaller version, I believe, for parents. Do you know what I'm referring to as the blue book? The blue book is a companion of the services that are available to children with special education, with special education requirements and disabilities, but addressed to parents, and that is --

Q. Do you have a copy of that blue book in your office?

A. Let me see: Golly gosh, I don't see one right now. I think I may have given the last one that I had out, but, as I said, I have that other policies and

procedures manual, so --

Q. All right, is the policies and procedures manual which I think you were first talking about, is that, really, an enlarged form of the blue book?

A. I believe so, yes.

Q. How big is that manual that we're talking about that you have in front of you?

A. It's a binder -- hold on one second: It weighs about five pounds, six pounds, and it's -- has, oh, roughly, oh, golly gosh, I would say -- it looks like 500 plus pages, I would say.

Q. Where can I get a copy of that, do you know?

A. This one is -- it comes to us from the Ohio Department of Education in Columbus, Ohio and its the year 2000 version. You can also get, I believe, a copy on disk from the special education resource centers. In the case of Ohio -- in the case of Toledo, actually, would be the Northwest Ohio Special Education Resource Center, or SERC.

Q. Okay, I'm going to ask Don to get the specifics of that; either that, or zerox the title page and the copy page, whatever.

A. Actually, it has the address also so we can --

MR. MAGUIRE: Can you do that, Don?

MR. SWITZER: Yeah, maybe we can get a copy of that.

Q. Are you telling me, Doctor, that you do or do not know whether these children are allowed, have entitlements, regardless of income, to specialized training and therapy and --

A. Yeah.

Q. -- transportation, medical and development and supportive costs by way of pathology and audiology, psychological therapy and counseling --

A. No. I do know --

Q. -- occupational therapy and recreation and physical supportive devices? Are you aware of whether or not these children whom you treat, regardless of the income -- or their income or their parents' income, are entitled to these support facilities?

A. I believe that that is subject to recognition by Social Security eligibility. I'm not -- there are -- and, again, I'm not talking as an expert in the area --

Q. Okay.

A. -- but I do know that, based on medical

expenses, for instance, based on the diagnostic criteria, there is help available to certain categories of children. I could not specify to you exactly who would be eligible. We, routinely, will refer patients to social services at the hospital, to the Bureau of Children with Medical Handicaps, to various agencies that deal with that, including Social Security Administration, but I don't know what the eligibility criteria is. I'm not evading the question, Mr. Maguire, I just don't --

Q. Oh, I understand. What's the course you teach in Findlay?

A. I teach the neurobiology of learning to graduate students in education.

Q. What was that, again, I'm sorry?

A. We teach the neurobiology of learning.

Q. The neurobiology?

A. Of learning to --

Q. What is that?

A. Essentially, it's a course that teaches the underlying brain functions and brain dysfunctions to educators who specialize in learning disorders and children with special handicaps or needs.

Q. Okay, basically, you're teaching these

people how to teach children with learning disorders, right?

A. In essence, or, at least, providing them the background so they can do that.

Q. But they'll have insight into how to teach these children, is that correct?

A. That's correct.

Q. What does your wife do, you mentioned her?

A. She's the director of special education at the University of Findlay.

Q. And how does her job differ from yours?

A. She is an educator by training, she has a doctorate in special education and curriculum development, and her job is to teach educators, she doesn't work in the field anymore at this time.

Q. Neither you nor your wife teach the handicapped children, you teach the people who educate the handicapped children; would that be a fair assessment?

A. That is a fair assessment.

Q. Do you have any feeling as to whether this child will ever be able to live independently, or can you say one way or the other?

A. My general feeling at this time -- if I have

to be pinpointed to this period of time where I am projecting what I know about his development, I would say that the likelihood is that he is going to be a dependent individual with regards to his activities of daily living and his financial status, meaning income and so on. I -- it's not clear to me today, anyway, that he could be an independent liver, but I will add -- I have to hasten to add, I do not know that with absolute certainty today.

Q. Nor with any medical probability, correct?

MR. BECKER: Objection, he's just given you probability.

MR. MAGUIRE: Just a minute, Mr. Becker, let me examine the doctor.

Q. You can't say what the future, with respect to independent living, is with any medical probability, correct, Doctor?

MR. BECKER: Objection. You may answer, Doctor, or you may indicate that you've already answered.

A. I'm a little uncomfortable about what it is

that you're distinguishing for me between what I said and what you're asking.

Q. You don't know what the future holds for the child with respect to whether or not he is going to be able to live independently; is that a fair statement?

A. Well, I don't think that's a fair statement. What I said was that if I project where he is at today, I would say that he would not be independent, but I --

Q. Okay.

A. But there are many items, as I've discussed with you before, that would make me re-question this over time --

Q. All right.

A. -- if there was any change.

Q. Is the child ever going to be able to marry if he chooses?

A. I wish you hadn't brought up that question, Mr. Maguire, I've had some very odd occurrences in my practice recently of quite severely retarded individuals tying the knot, so I don't know that -- I'll beg to pass that.

Q. You can't say one way or the other?

A. No, I can't say that, that would be unfair.

Q. What about, if the child were to marry, would the child be able to have children?
A. Would he physiologically be able to? I don't know that there is any reason why he wouldn't physiologically be able to procreate. In other words, I don't know at this point in time that there is anything that tells me he will not produce semen, or have an inability to produce an erection to have intercourse. Whether or not he would desire to do that, have the inclination or goal orientation, I have no idea.
Q. And, of course, you are unable to say at this point whether that desire would ever formulate one way or the other in his mind because of his mental disability, correct?
A. That's correct.
Q. Do you have any affiliations with the Sunshine Childrens Home?
A. Yes, sir.
Q. Are you aware of the costs of maintaining children out there?
A. No, I'm afraid I have completely lost track of that over the years.
Q. Okay. Do you have any association with Lott Industries?

A. No, not directly. Many of my patients, of course, are working there, but I don't have any direct association with them.
Q. Would Austin be a candidate for Lott Industries in the future, or can you say?
A. I cannot say at this point.
Q. I think that's all at this time.
MR. MAGUIRE: Can we take a three-second break?
MR. BECKER: Go ahead, Tom.
(Whereupon, a short recess was taken.)
MR. SWITZER: Doctor, I just have a few questions for you.
- - -
CROSS EXAMINATION
BY MR. SWITZER:
Q. From a neurological standpoint, would you tell me what you would expect to see in an infant that would affect the life expectancy of the child.
A. When we are asked questions about life expectancy, neurologically, the items that we consider, specifically, are the presence of disorders or diseases that, in themselves, lead to death or demise of the patient. I'll hasten to add that, because of the

dramatic changes in medical care that have taken place over the 18, 20 years that I've been in neurology and pediatrics, we do not include in that items that are what we consider actuarial issues.
For instance, in considering your life expectancy, I wouldn't consider the fact that you could die from an automobile crash in getting out of here, so we only -- and that could happen tomorrow and then your life expectancy would be curtailed. So when you ask me, is there anything neurologically that we look at in an infant that would curtail life? The answer is, yes, those would be conditions that carry an intrinsic and inexorable progression towards death at an early age, such as Tay-Sachs disease, such as tri-basil leukodystrophy, such as the medical -- the leukodystrophy, if you could diagnose it at that age, Canavan's disease, which can present early on.
So those kinds of things would be predictive of a shortened life expectancy. And I recognize that that's a different view that you might have, from a legal perspective, but the -- I stand -- the basis for that statement, actually, is very strongly confirmed by experience. We have -- to give you a good example, the Sunshine Childrens Home is no longer known as Sunshine

Childrens Home, it changed its name. And the reason behind that is that their clients are no longer children, they have outgrown their childhood, they are now young men and women, some of them in their 30s. I've had patients in their 40s, I've had patients in their 50s and even 60s. So it's diagnosis driven, the life expectancy, as opposed to being driven by circumstances.
For instance, if you have a tracheostomy -- or to address Dr. Grossman's articles and concerns, the fact that you're recumbent so you're going to have more aspirations and so on, but if that was the case, then Mr. Hawkins would be long dead, would he not? Being the physicist who has ALS. And we don't consider those in, quote, life expectancy, but from his disease point of view he should have been long dead. I hope I've answered the question in a fair manner.
Q. Yes, I hear what you're saying. As far as you know, then, the last MRI that Austin has had, or CAT scan for that matter, was in December 1999?
A. I believe so, I'm not looking at my notes but -- do you wish me to check?
Q. If you want to, I think that's the last report.

A. Yeah.
Q. At least, that I saw in your chart.
A. And one should add, that is the last one that I appear to have ordered. Let me just check. Yes, I see that my last order, actually, for an MRI was in the fall of 1999, so that would correspond to his last MRI ordered by me.
Q. I need to ask you a question about the opinions that you anticipate giving at trial. I think you've discussed some of them, but I'm not so sure it's been, at least, as I understand, every opinion you're going to be asked: Are you going to be rendering any opinions in this case as to the most likely cause of Austin's neurological injuries?
A. No, sir.
Q. Are you going to be rendering any opinions in this case as to the most likely time when the event that caused his neurological injuries occurred?
A. No, sir.
MR. MAGUIRE: I'm sorry, I didn't hear the answer.
MR. SWITZER: The answer was no.
MR. MAGUIRE: Okay.

Q. If we could, why don't I just mark and we'll just attach to the transcript as Exhibit A the --
MR. SWITZER: I guess this is, what, the front cover and table of contents to that manual you wanted, Tom?
MR. MAGUIRE: Yes.
MR. SWITZER I'm just going to mark it as Exhibit A and we'll attach it to the transcript.
(Whereupon, Defendant's Exhibit A was marked.)
Q. Can I get a copy of your most recent Curriculum Vitae and you can just send that to Mr. Becker or whatever, and he can send it to us, you don't need to scrounge around your desk today.
A. The answer is yes, I'm sorry.
Q. Okay, I appreciate that.
MR. MAGUIRE: What was the question? I heard the yes.
MR. SWITZER: I wanted a copy of his most recent CV and he said he would send a copy to Mike and Mike would send it to us.

MR. MAGUIRE: All right.
Q. Next question, Doctor: I notice that, at least, you have some books in your office on pediatric neurology. If you were going to look up any questions or had some -- or wanted to do some up to date reading, so to speak, on pediatric neurology as it relates to hypoxic ischemic encephalopathy, are there any particular textbooks you would look at?
A. Well, I would tentatively use -- I think the real answer is, if I was looking for something specific I would probably go to the current literature or something, if I had a specific question, but the -- the standard text that we use for reference are Menke's Textbook of Child Neurology and Swaiman and Wright and now Swaiman and Ashwal Pediatric Neurology, and Volpus (phonetic) Textbook of Neonatal Neurology.
Q. I also notice on your floor you do have some journals --
A. Yes.
Q. -- that remain unopened but I'm sure they will be. What journals in pediatric neurology do you subscribe to?
A. The Journal of Pediatric Neurology and Developmental Medicine and Neurology. And in addition

to the adult literature which -- the Child Neurology Society's official order is the Annuls of Neurology.
Q. I think in response to Mr. Maguire's question you did give him your diagnosis of Austin's current -- at least, his physical difficulties, and you indicated he is mentally retarded?
A. Yes.
Q. Okay. And what label would you put on that?
A. Label as in degree of severity?
Q. Degree, I'm sorry.
A. Certainly, at this point, he is severe.
Q. Severe, okay. I've never met you before today --
A. I don't believe so.
Q. -- I don't believe? So in that case, let me just ask you a few questions about your experience in testifying: How often do you become involved in testifying in malpractice cases, generally? On an annual basis, every five years, every --
A. As infrequently as I can, is that a fair answer?
Q. That is a fair answer, yeah.
A. I've actually -- it happens periodically, maybe once every two or three years. It depends on the

patients that I treat because 99 percent of the cases are children that I treat as a child neurologist so I'm not on the circuit, so to speak. I've had maybe one or two cases outside of the state, but that's about it.

Q. You've been practicing child neurology for 18 years did you say?

A. Roughly. I finished my fellowships in training in 1983, so about -- yeah, I graduated in 1975 from medical school so --

Q. Throughout your career, I take it that Austin is not the first child that you've taken care of with as severe of injuries as he has, both motor and cognitive, am I correct?

A. Very definitely.

Q. Have you had other children with Austin's disabilities, both in motor and cognition, that have not survived into adulthood, for reasons related to the neurological injuries that they've suffered?

A. I'm going to be picky but I'll be happy to expand on that.

Q. Go ahead.

A. The response is that, no, there's nothing -- I have not had patients who have died from the neurological injuries that he has. And I'll expand on

that --

Q. Yes, please.

A. -- for the sake of voracity: What you're asking me is -- wouldn't be the question that I would ask, but I will answer, is, there is nothing neurologically in him today that would precipitate, directly, his death. And I will add, though, that -- remember what I said about your dieing in a car accident, that, for instance, should he develop epilepsy on a regular basis; well, we know that the statistical reality of patients with epilepsy, which is not related at all to his condition of cerebral palsy, that is, the death rate, is estimated at one in 656 deaths. In other words, sudden death in epilepsy, unpredictable, occurring at any time between ages zero and 75, is a known fact and it occurs at a rate of one in 656, so that that says, I have a condition that is actuarially associated with unpredictable mortality, an otherwise unexpected mortality, which is the most important. In other words, expected mortality in him, I don't have any reason for being concerned about it.

Q. If you have a child with as severe of neurological injuries as Austin has and that child dies as a direct result of a problem, for example, with his

gag reflex and he aspirates and dies, would you consider that death to be related to the neurological injury or some other cause?

A. That's death from aspiration, not the neurological injury.

Q. Okay.

A. Yeah.

Q. I know I took a quick look at your office chart, and you do have a lot of documents in there we don't have, so I would ask -- I don't know if you have a copy service here that can make a copy of these documents?

A. Yes, we do.

Q. Every page? And maybe you could --

A. They will contact you directly.

Q. Sure. Why don't we do that.

A. That's Smart Corporation.

Q. If you can make the arrangements, then, we can just get a complete copy, that way we'll have everything. Have you made any notes for your involvement in this case or on behalf of Austin that are not contained --

A. No.

Q. -- within your records?

A. Except for, as you saw me scribbling questions from Mr. Maguire so I wouldn't forgot what he asked me.

Q. Have you written any letters or reports setting forth your opinions in this case, other than is set forth in your office chart?

A. No.

Q. Thank you, very much, Doctor.

MR. SWITZER: Tom, I'm done.

MR. MAGUIRE: I just have a couple questions, Doctor.

- - -

RECROSS EXAMINATION

BY MR. MAGUIRE:

Q. I want to make sure I understand about the test scans: You did, at one time, read the CAT scan and those MRIs, correct?

A. At some point in time it is my practice to look at them.

Q. Those interpretations you made did aid you in your care and treatments of Austin, right?

A. That's correct.

Q. Where are those films, are they in your office or are they --

A. Shouldn't be in my office.
Q. -- in the hospital or what?
A. They shouldn't be in my office, they should be at the hospital.
Q. Okay, you don't store films in your office?
A. No, I do not, except when I fail to return them.
Q. But you do have access to those films, do you not?
A. Yes, I do.
Q. With respect to the life care plan, I take it from some of your answers that you're neither going to bless it nor condemn it; is that correct?
MR. BECKER: I'm going to object. You can answer, Doctor, based on your understanding.
A. Yeah, the -- if by blessing you mean that I -- I've looked at it and thought it was an appropriate outline of the kinds of things that a child with neurological or orthopedic handicaps might need, I think the answer is it's a blessing. What I referred to earlier was that there is some items in there that I cannot predict would be needed, such as two surgeries one surgery or any surgery at all. Does that -- is that

a fair answer, Mr. Maguire?
Q. Yes.
A. Thanks.
Q. I think that's all.
MR. SWITZER: Okay, thank you.
MR. BECKER: Thank you, Doctor. And I would recommend that you read the deposition, I'm sure it's going to be ordered. And, if so, please indicate that to the court reporter.
(Whereupon, a discussion was held off the record.)
(Whereupon, the deposition was concluded at 8:48 p.m.)

DONALD I. CAMERON, M.D.

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CERTIFICATE

STATE OF OHIO)
) SS.
COUNTY OF LUCAS)

I, Kendra L. Lake, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named Witness, DONALD I. CAMERON, M.D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotype in the presence of said Witness afterwards transcribed by computer-aided transcription; that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid.

I do further certify that the testimony was taken at the time and place in the foregoing caption specified. I do further certify that I am not a relative, counsel, or attorney of said party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio, on this 4th day of February, 2002.

KENDRA L. LAKE
My Commission expires Notary Public

** NOTES **