IN THE CIRCUIT COURT OF THE FOURTX JUDICIAL CIRCUIT, IN AND FOR DUVAL COUNTY, FLORIDA.

CASE NO.: 85-410-CA

DIVISION: G

"J"

LATOYA GREEN, by and through her mother and natural guardian, DIANE GREEN, and DIANE GREEN, individually,

Plaintiffs,

vs.

UNIVERSITY MEDICAL CENTER, INC., a corporation; R. PHENIUIE, SR., M.D.,; RICHARD HARTERT, M.D.; ERNEST FERRELL, M.D.; J. A. BATH, M.D.; RODOLFO PENA-ARIET, M.D.; THOMAS M. CHIU, M.D.; OLGA PRAT, M.D.,

Defendants,

Deposition of ELIAS GEORGE CHALHUB, M.D., taken on behalf of plaintiffs herein, pursuant to Notice of Taking Deposition, at Dining Room A, University Hospital, 655 West 8th Street, Jacksonville, Duval County, Florida, on Friday, May 29, 1987, at 1:10 p.m., before Sandra Crowley, CSR, Registered Professional Reporter-CM, and Notary Public in and for the State of Florida at Large.

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I N D E X

WITNESS: ELIAS GEORGE **CHALHUB, M.D.**

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MR. KEENAN: This will be the deposition of Dr. Chalhub taken on the 29th of May pursuant to agreement and notice to counsel, beginning the deposition at 1:10.

ELIAS GEORGE CHALHUB, M.D.,

having been produced and first duly sworn as a witness on behalf of the plaintiffs, testified as follows:

DIRECT EXAMINATION

BY MR. KEENAN:

Q Doctor, please state your full name.

A Elias George Chalhub.

Q Doctor, when were you first contacted regarding this case and your review?

A To the best of my knowledge, sometime in the fall.

Q 1986?

A Yes.

Q Who contacted you at that time?

A I really don't remember who exactly. Mr. Williams was the one that I was referred to

Q Was it a representative of St. Paul that initially made the contact?

A I believe it was.

Q Do you recall the site of the St. Paul office?

A I assume it was the Jacksonville office, but I really don't know.

Q Bad you ever worked with the St. Paul Jacksonville office before?

A I don't think so.

Q You then made contact with Mr. Williams?

A He made contact with me.

Q What materials did he furnish you a% that tine?

A He furnished me with the hospital records of the mother, of the child, some subsequent evaluations, which I can't name all by name at the present time, and a series of depositions.

Q Prior to your testimony today, have you had an occasion to review the nonstress test strips taken during the last two weeks of the prenatal course?

A No.

Q Have you hac! an occasion to review any of the slides taken by pathology of the placenta or the umbilical cord?

A NO.

Q Have you reviewed Dr. Joyner's records? And by that I mean, I believe he was the initial. obstetrician who diagnosed the pregnancy in question,

A I believe so. I believe those -- if those were included in those recards, then I can't remember that name specifically.

Q Have you reviewed the report or' April of this year

of Dr. Hodson?

A No.

Q Have you reviewed any CAT scans?

A Yes, I did.

Q Tell me generally what CAT scans you reviewed.

A Well, I was only given one CAT scan. If there are others, I would certainly like to review those. I reviewed the March 31st, 1983 CAT scan.

Q Would that have been the St. Vincent CAT scan?

A I believe so. It's the one that was done at this hospital.

Q Are you aware of the existence of any additional CAT scans?

A Bo, I'm not aware of any, but if there are, I would certainly like to review those.

Q All right, we'll do that today,

Is it your understanding, Doctor, that you've reviewed all of the depositions taken in the case?

A No, it's not my understanding that I've reviewed all the depositions.

Q What depositions do you know that have been taken that have not been furnished to you?

A Apparently there are some obstetrical experts, and again I don't know those names, that have been taken and I've not had the opportunity to review those.

Q By "experts," that distinguishes from an actual participant, care and treatment of this child?

A Yes, You know, I've reviewed Dr. Hartert's deposition and Dr. Ferrell's dewsition, Dr. Thompson's deposition. I don't remember all the others, but I've not reviewed any of the recent depositions that I think you-all have taken.

Q Dr. Kern from University of South Florida, Tampa?

A Yes, I have reviewed that one, but he's not an obstetrician, I don't believe.

Q You've had the occasion to review Dr. Montez' deposition?

A Yes.

Q Dr. Chiu?

A Yes,

Q Dr. Pena-Ariet?

A Yes.

Q Dr. Marzini?

A Yes.

Q Dr. Prat?

A Yes.

Q Do you know Dr. Ferrell?

A No.

Q Dr. Hartert?

A No.

Q Dr. Chiu?

A No.

Q Dr. Garis?

A No.

Q Dr. Thompson?

A No.

Q Do you know whether or not you have ever appeared as an expert witness in a case where they, likewise, appeared as an expert witness for one side or the other?

A Not to my knowledge. You know, I mean, that certainly could have happened, but I'm not aware of that.

Q Doctor, I understand that we're distinguishing testimony -- I understand you've given testimony in child abuse cases; you've given testimony as a treating physician. But my question concerns standard of care in a medical negligence case. With that definition, I understand that you've given testimony in Arkansas?

A Excuse me?

Q In Arkansas? Have you given testimony in Arkansas?

A Yes, I have.

Q How many cases have you reviewed and/or given testimony in Arkansas dealing with the standard of care?

A I don't think any.

Q Causation?

A One, to my knowledge -- and you mean in terms of medical malpractice or products liability?

Q Yes, medical malpractice.

A One case. Again, that's to the best of my recollection, but I believe that's all.

Q That was last September, wasn't it?

A I don't know when it was. It was sometime within the past two years.

Q It was an actual trial?

A Yes.

Q You have reviewed cases on the standard of care or causation which arose out of the State of Kansas?

A Yes.

Q Mississippi?

A Yes.

Q Of course, Alabama?

A Yes.

Q Georgia, of course?

A Yes.

Q California?

A No, I've not reviewed any malpractice cases out of California.

Q Do you recall a case involving Kizer Perminenta?

A Yes, but this was a child that was in Mobile, Alabama.

Q Recently in Kentucky?

A Yes.

Q Louisiana?

A I've not testified in Louisiana,

Q Not given a deposition dealing with either causation or standard of care in a case which you understood had a panel decision in favor of the plaintiff which arose out of Louisiana?

A Oh, I've given a depsition. I thought you meant testified in court. Excuse me.

Q No, no, deposition.

A Yes.

Q Have I missed any states? And, of course, we're now talking about Florida. Have I missed any states where you've actually appeared as a witness in a trial?

A I don't know. Which ones are you referring to?

Q Well, Arkansas, Kansas, Mississippi, Alabama, Georgia, Kentucky, Louisiana, and Florida.

A I don't believe I've testified in trial in Louisiana nor in Mississippi.

Q How about Tennessee?

A Not to my knowledge.

Q South Carolina?

A Nope.

Q Maryland?

A Nope.

Q Any states above the Mason-Dixon line?

A No, I don't believe so.

Q In terms of your review of cases, whether or not they actually give rise to a dewsition or trial testimony, what states have you, in fact, made such a review other than the ones that we've just gone over?

A There's really no way for me to tell you that. I don't keep those kind of records.

Q Do you, in fact, keep a copy of any depositions that you have taken or been given?

A Sometimes.

Q What is the criteria that you use to decide whether: or not you will request and maintain a copy of the dewsition that you give in a case?

A Well, I really don't have to:, much criteria. I mean, it it's there and I have a place to put it, I do; if not, it usually gets discarded.

Q Give me an approximation of the number of depositions that you think you have possession of.

A I don't really know, Mr. Reenan. I don't go back and look or count.

Q Do you think we're talking about more than 20?

A Oh, no, I don't think so.

Q More than ten?

A I don't know. I told you I didn't know the number.

Q Of course, you and I, I think, are celebrating a one-year anniversary. Didn't we meet for the first time on the 23rd of May of last year?

A You know, I don't know the date. It was approximately a year ago, yes,

Q I'll be hurt if you didn't save that deposition. Do you have that deposition?

A Yes, I do have that deposition.

Q What cases do you now have that you are -- you consider an active file, that is, no one has notified you to close it because of settlement or some termination of the case? Dealing again with either the standard of care or causation.

A Again, there's no way fox me to tell you that. I don't keep those kind of records. And basically, you know? I don't -- if I ever reviewed a case, I'll return the records. And if somebody wishes me to pursue it, they'll contact me at a later date.

Q You gave testimony in the South Florida case of -- I believe I'm pronouncing this right -- Ajuoko vs. Signa. Do you recall that ease?

A Who is that now?

Q A-j-o-u-k-o vs. Signa.

A Ajouko?

Q Yes.

A Yes,

Q You understood that that was set for trial for next week?

A No, that's apparently been settled.

Q When were you notified that case was settled?

A About a week to ten days ago.

Q You were retained by St. Paul or at least a St. Paul insured?

A No, I was retained by Mr. Sierra.

Q You understood that St. Paul was one of the carriers in the case?

A I don't really know who the carrier was in that case, to be honest with you.

Q Would I be correct, Doctor, in saying that in the Ft. Lauderdale area, that you Rave given opinions either by way of review, deposition or trial testimony in approximately six to eight cases?

A That's approximately right, yes.

Q You, as well, gave opinions in a Tampa case, did you not?

A Yes.

Q Orlando?

A I don't believe so.

Q Miami?

A *Yes.*

Q How many cases in Miami?

A I don't -- again, I don't know. There haven't been many cases in Miami, maybe two, maybe three at the most.

Q St. Petersburg?

A Two cases that I know of. That's the same area as St. Petersburg - Tampa.

Q When you told me about the Tampa cast?, does that include the two cases that you've given me under the St. Pete category?

A I believe so.

Q Ft. Pierce?

A I believe that's one case.

Q Would that include -- be included in any of the other numbers that you've given me?

A I don't know which other numbers you're referring to.

Q We've got six to eight in the Ft. Lauderdale area, two to three in the Miami area, approximately two in the St. Pete area, and I've asked you abut Ft. Pierce. Is Ft. Pierce --

A I would think so. I can't remember who the attorney was in that case. It wasn't a Ft. Pierce attorney,

so I don't know.

Q Jacksonville, either by way of review, deposition?

A No, I believe this is the first time I've ever been.

Q Have you ever reviewed a case that you understood arose in the Jacksonville area?

A Again, I don't know, I just can't tell you, because I don't know where all these cases come from.

Q I understand prior to being -- when you were initially contacted by Mr. Williams and his firm that you had not dealt with him on a case before?

A That is correct.

Q Is that also true of his law firm?

A To the best of my knowledge, yes.

Q Since being retained by their law firm last fall, have you had the occasion to discuss with them any other cases?

A No.

Q What about the Bullock firm here in Jacksonville?

A No.

Q The Mathews firm?

A I don't know who they are.

Q Doctor, one of your correspondences specified or requested certain donations be given to charitable organizations in and around the Mobile area?

A Yes.

Q When did you so implement that designation?

A When E decidad to come down here to give this deposition.

Q Had you ever made such a request in any other case?

A Yes.

Q How many other cases?

A I can't really tell you the number. I do that periodically.

Q What is the criteria you use to decide what case gets donated to a foundation and what does not?

A Well, when I feel like it's time to donate money to certain foundations, I am a charitable person. I contribute to the community, and when I think there's a need, I donate the money.

Q Over the last two years from your testimonial and review endeavors, what percentage or' that total fund would indeed find its way to a charitable foundation?

A I don't -- there's no way I can give you a percentage.

Q Well, could you tell ne, is it over a third, over a half, less than ten percent? Just give me an approximation.

A I don't keep that kind of record, okay?

Q Can you tell me as of 1986, during the calendar year of '86, what percent of your income would be derived from review of testimonial endeavors?

A Approximately five to ten percent.

Q Do you have any depositions scheduled for this coming month?

A I don't believe so.

Q How about July?

A I don't know. I don't keep the calendar, I do my calendars on a weekly to biweekly basis, so I'll, you know, change things around when the tine comes.

Q Other than this trial, what other cases are you aware of that have been set on a trial calendar for a specific date?

MR. WILLIAMS: This date, meaning June 29?

MR. KEENAN: No, any date.

A Let ne just think a moment. I believe there's a trial in July, but I really can't tell you what the name of it is.

Q Can you tell me where it is?

A No, I really can't.

Q You got one in October, don't you?

A Not that I'm aware of right now.

Q A Kentucky case?

A I don't -- I haven't been notified about any date.

Q Doctor, have you ever appeared as an expert for either side in a case where Dr. John Kern was also an expert?

A If I have, I'm not aware of it.

Q J. K. Williams?

A I don't know who he is, so I don't know.

Q E. M. Ostria?

A I don't know who that person is either,

Q J. Kellison?

A I don't know who that person is either.

Q Can you tell me the best you can recall what the St. Petersburg-Tampa cases were all about.

A Those were a good while ago, Mr. Keenan, and I really, you know, once they're over, it's hard to, you know -- I practice medicine on a daily basis; so I really don't keep those facts in mind,

If you have one in particular in mind that you're concerned about, I'll be glad to try to answer the questions the best I can, but I didn't come prepared to discuss any case except this one.

Q It would have been two months ago, March of '87, attorney by the name of, I believe, Larry Stuart, Gary Fox. Ring any bells?

A Yes, but I didn't testify in that case.

Q You gave a deposition?

A Yes.

Q You know the nature of the case?

A I believe it was a premature infant, but I can't really remember the specifics,

Q Over the past two years, Doctor, how many deliveries have you attended in whatever capacity?

A I don't attend deliveries.

Q When is the last time you actually were in the labor and delivery room and attended, even as a spectator, a delivery?

A Two weeks ago.

Q What was that occasion?

A It was a physician's child that had polyhydramnios -- or the mother had polyhydramnios, and they were expecting a child with a neuromuscular problem.

Q Over the last two years, how many times have you found yourself in that circumstance, that is as a pediat'rician, neonatologist being requested, based upon your background, to attend a labor and delivery?

MR. WILLIAMS: Object to the form.

A In the first place, I'm not a neonatologist, okay. 1 am a pediatrician and boarded, but I'm a neurologist and a child neurologist. And I'm not requested to go to C-sections, to the delivery room, because I don't practice that kind of medicine. So, you know, I don't go.

Q Well, within the last two weeks you went. I'm just asking you over the last two years, how many times, for whatever reason, were you called into a labor and delivery area?

A Well, I go frequently to a labor and delivery area, because I see sick babies in sick nurseries, but I don't go to the deliveries because I'm not requested. They usually have plenty of help,

Q Now, this occasion two weeks ago, were you actually in attendance at the delivery?

A *Yes.* That was a special circumstance.

Q My question is, how often do special circumstances occur where you are present at the actual delivery?

A That's rarely, because I don't do this. This was a special friend.

Q So over the last two years, you think that was the only time?

A Yes. I mean, I've tried to tell you I don't practice neonatology or obstetrics.

Q When is the last time, and even as far back as your residency or internship, that you actually engaged in resuscitative efforts following a labor and delivery?

A I really can't tell you that. I just don't remember.

Q Would it be years ago?

A Again, that's hard to be certain, you know. In my capacity as a practitioner and teacher and being in a hospital frequently in intensive care situations, you know, the occasion may arise. So I just don't know.

Q My question, though, I hope to confine to the immediate labor and delivery period where resuscitation efforts were done right there in the labor and delivery room. When is the last time that you actually performed any form of resuscitation?

A As I told you, I don't go to C-sections, and I don't go to routine deliveries, because that's not the kind of medicine I practice.

Q I understand that, but at some time in your career, you indeed have engaged in resuscitation of a delivered infant, have you not?

A Yes.

Q Through your internship, residency?

A Yes.

Q After your internship and residency, did you ever resuscitate an infant following -- immediately following delivery?

A Yes.

Q When is the last time you did that?

A I told you, I can't remember.

Q Is it beyond five years ago?

A Yes.

Q What is your present resident supervision responsibilities, if any?

A We don't -- I don't have any residents that I supervise at the present time. I'm predominantly in private practice, and am on the staff of the University of South Alabama Medical Center. And I function as a consultant and as a teacher when asked.

Q How often are you asked to supervise residents?

A Well, whenever I see patients there, I will talk with the residents and talk with the interns and talk with the house staff concerning the management problem.

Q Do you receive any compensation for your work with residents?

A No.

Q Have you ever been in charge of a residency program, that is your primary responsibility to oversee the proper functioning of a residency program?

A Yes.

Q When was that?

A From 1976 until, I believe, '83 or '84, and I just can't renember the last date.

Q This would have been in Arkansas?

A No, it would have been in Arkansas and in South Alabama.

Q As I understand it, Doctor, you do not express opinions regarding the standard of care as practiced by obstetricians?

A That's true. I'm not an obstetrician.

Q Have you ever, in your experience in rendering opinions, made opinions concerning the standard of care of obstetricians?

A No.

Q You are not a neonatologist?

A No, I'm not.

Q Do you, in fact, render opinions regarding the standard of care as practiced by neonatologists?

A No. I, you know, certainly have the opportunity to see patients with neonatologists and can express opinions from the standpint of a pediatric neurologist as well as I do for any other specialty, but I would do it from my position -- my training, my background, and my experience as a pediatric neurologist, but not as a practicing neonatologist or obstetrician.

Q Doctor, you, of course, are familiar with electronic fetal heart monitering strips?

A Yes.

Q But you don't consider yourself an expert to interpret the findings of such strip?, do you?

A No, I don't.

Q Be they external or internal?

A Or anywhere else.

Q Our imaginations might run wild with that one, Doctor. But tell me, do you consider yourself possessed with the expertise to review a nonstress test and interpret that test with regards to fetal well-being?

A I'm possessed with a number of things, but as I told you, I don't interpret fetal monitor strips.

Q And that goes with the nonstress test?

A Well, that is a fetal monitor strip.

Q Are you a pediatric radiologist?

A No, I'm not a pediatric radiologist.

Q When you are called upon in your care and treatment of a neonate -- you treat neonates, don't you?

A Yes, I do.

Q Neonates, would you be comfortable with a definition from birth till 28 days?

A No.

Q Tell me what your definition of a neonate would be.

A Birth to 30 days.

Q Your care and treatment of neonates, wnen the care and treatment requires that radiological studies be made, do you pssess the competency and expertise to interpret the films themselves?

A Which films are you referring to?

Q The radiology films.

A Which radiology films?

Q Let's talk about chest films.

A No, I do not -- I read chest films, but again, I do not consider myself of the necessary expertise to, one, testify as to the interpretation of that.

Q You rely upon the radiology department for that?

A Or the neonatologist.

Q You are aware, Doctor, that under certain circumstances, the placenta and umbilical cord will be sent to the pathology department?

A I don't understand your question. You mean just hypothetically unrelated to this situation?

Q Yes, That occurs, does it not?

A State your question again.

Q For a vast variety of reasons from tine to tine, placentas, together with umbilical cords, are delivered to the pathology department at given hospitals?

MR. DAVIE: Object to the form.

A You're just talking about in general in the world?

Q Yes.

A Yes, certainly.

Q Are you competent and experienced and possess the expertise to review the pathology slides and. interpret the

findings of those slides?

A No.

Q What health professional, if you had a question about the appearance of pathology slides, what professional would you rely OR?

MR. WILLIAMS: Object to the form.

A I don't understand that question.

Q Well, if in your care and treatment of a neonate you had a question, for whatever reason, as to the appearance and findings of the placenta and the umbilical cord that were preserved, to your knowledge, by sections, what medical personnel would you rely upon to interpret those actual slides and placental and umbilical findings?

MR. DAVIE: Object to the form,

MR. WAXMAN: Join in the objection.

MR. WILLIAMS: Me, too.

A Again, you know, unless you give me a specific situation, you know, that's hard to respond to that.

Q When is the last time that you have looked at pathology slides of a placenta and umbilical cord?

A I told you, I don't read those, so I don't look at them.

Q When is the last tine you looked at them?

A I really can't remember. I mean, it's been a long time.

Q Have you in the last five years requested, at your own initiative, that pathology reports be made concerning placental and umbilical status?

A Have I requested then?

Q Yes.

A For what reason?

Q For any reason.

A You know, I don't know. I may have and I may not have. I just don't know what you're referring to.

Q I understand, Doctor, that you have contributed to the literature in the area of cytomegaloviruses as well as meningitis, bacterial and viral syndromes?

A Yes.

Q You have done that, haven't you?

A Yes, I have.

Q And in contributing to the literature, are you called upon to actually look at placental and umbilical sections?

A You'll have to ask me what you're specifically referring to, and then I'll be glad to answer that.

Q Are there any forms of viral infection which can be defected upon microscopic examination of a placenta?

A Which particular virus did you have in mind?

Q Any.

A Again, you'll have to be more specific.

Q How many hospitals do you practice at?

A I practice at the Mobile Infirmary, Providence Hospital, Spring Hill Hospital, Knollwood Park Hospital, University of South Alabama Hospital.

Q Are there any persons in any of those pathology departments who hold themselves out to be a placental pathologist or hold a particular expertise in that area?

A I don't know.

Q When is the last time that you reviewed, to the best of your knowledge, any literature regarding pathology and diseases of the placenta?

A I review literature concerning neonates and maternal problems, child neurology problems every day. So, you know, it could happen on a daily basis.

Q Can you tell me on a daily basis or weekly basis or monthly basis, when was the last time that you recall specifically reviewing an article, journal, chapter or text dealing with the pathology of a placenta.

A That would happen on a weekly basis, Mr. Keenan, you know, and I can't separate out from every single article, you know, a pathology report on a placenta, you know; but obviously if it has to deal with a neonate, if it has to deal with problems related to that neonate, then it may be in the article. So, I mean, that happens frequently.

Q Do you know what is considered norm as to the

A No.

Q The diameter of the placenta?

A No.

Q Doctor, I understand that you do possess the expertise to interpret, without assistance from any other medica1 person, CAT scans of neonates and infants?

A Yes.

Q Doctor, in the cases that we have just outlined from the states that we've talked about, are you aware of whether or not the initiation of that contact was as the result of your contributions to the literature?

A No, I really don't.

Q And by that I mean, has anyone ever told you or have you asked, "How did you get my name?" And the response was, "Doctor, I read your article on such and so"?

A I think that's happened on a number of occasions.

Q With your CV, Doctor, and I apologize that I've got last year's CV. And I believe you told me last year that you received no income from the writing of journals; is that correct?

A That's correct.

Q And have you received any income from any of your contributions to literature?

A No.

Q Can you, Doctor, take a look at this CV, and we'll mark it as Plaintiff's Exhibit 1. Tell me whether or not -- and I've seen a recent depsition where that same CV has been used. I just want to ask you whether or not there's any substantial changes, and if so, what they would be.

A There are changes, but I'll have to go back and look at the recent CV.

MR. WILLIANS: For purposes of clarification, I'll be happy to have the doctor mail me one, and I'll mail everybody one, And we can, by stipulation, attach it later if that will help.

MR. KEENAN: Fine.

Q Just by way of clarification, Doctor, there does not appear to be any publications authored by you since last year, May of '86 when I took you: deposition. Are you aware of any?

A No, that's correct.

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

Q Doctor, as to article No. 27, could you read that into the record. I believe that's Cerebral Palsy diseases, OB/GYN?

A Yes.

Q Did I quote that correctly?

A It says, "Cerebral Palsy: An Obstetrical

Disease.'

Q And what is the publication earmarked?

A Well, it was intended to be submitted to the American Journal of Obstetrics & Gynecology, and I am still working on that article, because I want to update it. So it's not been published, and that would be on the new CV.

Q Are you waiting for any advancements, any particular findings that will then precipitate a conclusion of that article?

A No. I just wasn't pleased with all of the -- with the presentation. I just want to work on it some more.

Q What is the basic thrust of the article itself?

A Well, it concerns etiologies of cerebral palsy. It concerns aspects related to cerebral palsy, the definition of cerebral palsy, and trying to clarify what is the entity.

Q Does it deal, as well, with mecnanical forceps, vacuum extractor injuries that could give rise to cerebral palsy, or is it disease-oriented?

A I don't understand that question.

Q Okay. You talk about forceps injuries as the cause of cerebral palsy in that article?

A I'll have to go back and look. There is a section on obstetrical trauma, yes.

Q Eo you, as well, talk about labor and delivery

asphyxia?

A Well, again, what do you mean by "labor and delivery asphyxia"?

Q Well, do you understand what "labor and delivery" means?

A Yes.

Q And asphyxia, by your definition, is decreased flow of oxygen, isn't it?

A No.

Q What is your definition of asphyxia?

A Asphyxia is an alteration in blood gases in the delivery of oxygen and carbon dioxide. And it's characterized by hypercapnia and acidosis.

Q Didn't you tell me last year, Doctor, that hypoxia is a decrease in oxygen supply, and asphyxia is a decrease in the oxygen supply coupled with an increase in the pCO2 and, as well, the appearance of acidosis?

A That's what I've just told you now. Same thing.

Q My question, though is, does your article at all touch on labor and delivery asphyxia as we've just defined it?

A Again, I'm just not understanding what you mean by labor -- I don't use the term "labor and delivery asphyxia." What do you mean by that?

Q Do you talk in your article about asphyxia, using

your definition, which occurs from a time parameter standpoint between the point when labor begins right up to the time that delivery occurs? Does your article in any way touch upon that?

A Yes.

Q Is it in rough draft form?

A Well, it's better than rough draft.

Q Has it, in fact, been submitted?

A Not yet, no.

MR. WILLIAMS: Then I would move to strike any reference to it. If it hasn't been published -- we've been discussing it as a published article, I thought. And if it is in draft form not submitted and not published, I don't see the relevance to any reference to it. Move to strike any reference to it or comments about it.

Q Again, Doctor, what are you waiting for?

A Well, I like to do things very well, and I'm not satisfied with the article; so I want to continue to work on it.

Q Are you satisfied with that section which deals with labor and delivery asphyxia as you've defined it?

A I just -- I'll have to go back and look at the section right now, Mr. Kecnan. I can't do that from memory.

Q How many pages is it?

A I don't know.

Q Is it handwritten or typed?

A It's typed.

Q Does it contain any statistical information that you have originated?

A I don't recall, to be honest with you, right now. It's been awhile since I've looked at it.

Q Does it cite any of the NIH studies on the perinatal disorders?

A I'm sure it does, because that's certainly a part of anybody's review of the problem.

Q You've seen this one, haven't you, Doctor, "Prenatal and Perinatal Factors Associated with Brain Disorders"?

A Yes.

Q You saw that when it was first published, did you not?

A Yes, I did.

Q Let me read a section, and I'll flip it back over to you.

MR. WILLIAMS: Would you, again, identify it by year and author so we'll hnve it for the record.

MR. KEENAN: Sure. It's the NIH, April '85, John Freeman, collaborative effort -- would that be a proper tern, Doctor?

THE WITNESS: Yes, that's as good as any. Why don't you give the publication number.

MR. KEENEN: 85-1149.

THE WITNESS: No, let me show you what I'm talking about. Most NIH publications are identified by -- okay, you had it right, excuse me. 85-1149.

Q Let me, Doctor, direct your attention to page 207. If I may just kind of stand over you for a minute. I don't intimidate you doing this, do I?

A No, Mr. Reenan. I'll let you know if you intimidate me.

Q Under the section titled "Post-term Pregnancy," have you reviewed that before?

A Well, let me see which cnapter it's taken from, first. I'm reading from the "Prenatal and Perinatal Factors Associated with Brain Disorders,' chapter seven, by Calvin Hobel, H-o-b-e-l, from Maternal Fetal Medicine, Cedars-Sinai Medical Center, Los Angeles, California. And the chapter is entitled, "Factors during Pregnancy that Influence Brain Development."

I have read this, but it's been a good while.

Q Let's just -- and I want to use this just as a basis to get some definitions down if we could. It begins under "Post-Tern Pregnancy," "The pregnancy lasting longer than 42 weeks is defined as post-tern." Did I read that

correctly?

A You do very well, yes.

Q And do you agree with that definition?

A Yes.

Q And, as well, and I quote: "Thus, an increased risk of neurologic morbidity probably occurs only in post-term pregnancies complicated by poor fetal growth and placental insufficiency."

Did I read that right?

A Yes, you did.

Q In your experience, do you find that to be a correct statement?

A Again, it's so general, Mr. Keenan. You're going to have to give ne some specifics. You know, I just can't answer that, plus, I really haven't read this in a good while. So I'd rather not comment on this unless I had the opportunity to read the article and digest it. And if you want to take that time, I'll be glad to do it for you.

Q How long will it take you, Doctor?

A An hour.

Q An hour?

A Yes.

Q Doctor, we understand that there's no absolutes in medicine, and that you cannot predict each and every time what's ping to happen; but you're familiar with generai

statements, aren't you? General principles?

A Oh, I'm familiar with a lot of general principles,

Q Well, would that be a general statement that you could agree to?

A Well, again, this is a sentence taken out of context of an article, Mr. Keenan. I just can't do that without sitting down and reading the article, okay? And it's just not fair to do that.

If you have a specific question, then ask it, and I'll be glad to do my best to answer it.

Q Let's begin it this way, and you can keep that in front of you if you want to.

With the definition of a pst-term pregnancy being one that fasts 42 weeks, from your expertise and your professional standpint, generally what risks are associated, if any, with prolonged pregnancy?

A Now, we're talking hypthetically?

Q Hypothetically and general.

A In post-term pregnancies? Well, one can have growth retardation. One can have congenital malformations. One can have viral infections. One can have bacterial infections. One can have respiratory difficulty. One can have neuromuscular disease. One can have hypoplasia of certain organs. One can have excessive changes in certain body tissue. One can have persistent fetal circulation.

One can have meconium staining. One can have, let's see, certain tumors or neoplastic processes, and one can have the influence or' certain drugs on the infant or environmental toxins.

Q In your experience, Ikctor, does the incident rate of meconium staining in utero increase to any degree when the pregnancy becomes prolonged?

A What do you mean by "prolonged"?

Q Well, the definition that we just gave, plus 42 weeks.

A But there's a difference between pst-term and prolonged, so which are you using?

Q Prolonged, plus 42 weeks.

A Well, that's not the same thing. So which are you referring to?

Q Answer my question, Ikctor. Dealing witn --

A I don't understand your question; that's what I'm trying to ask you.

Q When dealing with a pregnancy that has gone beyond 42 weeks, does the incident rate of meconium staining increase to any degree, in your experience?

A Yes.

Q Why?

A Well, I don't know why. The incidence of meconium staining in all pregnancies is 10 to 20 percent, be it

post-tern or not. You know, in the inajority of the cases, it has little significance.

Q Using that figure of 10 to 20 percent meconium staining in all pregnancies, what figure are you comfortable with, Doctor, representing the percentage when dealing with post-term pregnancies?

A I don't know the figure, so I don't have a figure.

Q Is it higher than the 10 to 20 percent that you've just given me?

A No.

Q But you told me, though, initially, I believe -- and I want to be clear on this, Doctor -- that when talking about the higher incident rate of meconium staining in pregnancy plus 42 weeks, you simply don't know why that is?

A You mean what the mechanism is? No, I don't know the mechanism.

Q When meconium is passed in utero, that doesn't necessarily indicate that the fetus has aspirated the meconium, does it?

A Now you're talking hypothetical?

Q *Yes.*

A And in general?

Q *Yes.*

A No, that's correct.

Q What are the mechanisms that would cause the

fetus, assuming that meconium was present in the amniotic fluid in utero, what are the mechanisms whereby the fetus would actually aspirate the meconium, the reasons for the aspiration?

MR. WILLIAMS: Object to the form of the question. You're asking him if -- if you're asking him in general --

MR. KEENAN: Yes.

MR. WILLIAMS: As a medical doctor, okay, but are you asking him as an OBG-obstetrical opinion which he has told you he cannot do?

MR. KEENAN: Well, I will take it as a stipulation for the purpose of this deposition that he is not attempting to opine at any time obstetrical opinions, either standard of care or otherwise.

MR. WILLIAMS: We're just talking general medicine, hypothetical situation?

MR. KEENAN: Absolutely.

THE WITNESS: And unrelated to this case?

MR. KEENAN: Yes.

THE WITNESS: Okay. Now restate your question.

BY MR. KEENAN:

Q Assuming that there is meconium in utero, and assuming, as well, that the fetus has aspirated that meconium, my question is simply, tell me what the possible

mechanisms are why meconium was aspirated,

A I don't know all the mechanisms.

Q Just give me some of them.

A Well, you know, again, that's not an area of my expertise in terms of why infants aspirate meconium in utero. I know it occurs, and it probably occurs in a higher frequency than we know; but, you know, again, that's not an area of my expertise,

Q You're not willing, then, to describe from an expert's standpoint the mechanisms of meconium aspiration in utero?

A It's not that I'm not willing. It's just that I -- that's not an area of my expertise, so I can't opine upon that with a reasonable degree of medical probability.

Q Are you familiar with the term "meconium aspiration syndrome"?

A Yes.

Q Can you give me a number of neonates, where you considered yourself primary pediatrician, where one of the diagnoses, working or confirmed, was indeed an MAS?

A Well, I'm a consultant, Mr. Keenan, a neurological consultant. Neonatologists are the primary doctors that take cart? of neonates with multiple problems, and many of the infants that I see every day have various respiratory problems, some of then which may be meconium aspiration. So

the answer to your question is, as a consultant, I'm not the primary-care physician' €or newborns.

Q That would be a neonatologist?

A Yes.

Q Do you consider yourself, Doctor, capable of undertaking the primary care of a neonate with a diagnosis of meconium aspiration syndrome?

A Well, what do you mean by "capable"?

Q Well, does your experience and training and expertise and understanding of your own skills enable you, without benefit of a neonatologist, to assume the primary care of a neonate that indeed has what you believe to be meconium aspiration syndrome?

A No, because I don't do that on a daily basis.

Q Doctor, from your expertise and training, can you tell me whether or not meconium aspiration occurs in the majority of cases, either in utero or after birth, or do you know?

A Well, it has to occur in one or the other situaticns, so obviously it occurs in the majority.

Q Absolutely. Which one is in the majority, and which one was in the minority?

A That wasn't your question as I understood it.

Q All right.

A So what is your -- you asked me if they occurred

either/or, yes, they do, And that would obviously be the majority.

Q I believe I've struck on both choices, haven't I?

A Restate your question. Obviously I didn't understand it.

Q In order to aspirate meconium, there are only two possible times when that can occur: one, in utero; and two, after delivery. Have I hit on both?

A I believe those would exhaust the possibilities.

Q And if we are to look at the total number of neonates with the diagnosis of the meconium aspiration syndrome, percentage-wise, either majority or minority or if you can attach a particular percentage significance, tell me the difference between the two times. Which predominates?

A I don't think the -- that can accurately be answered, and the reason it can't accurately be answered is because there's no way to really measure the amount of meconium down in the alveoli, because oftentimes it may not show up on x-ray.

There's also an increasing awareness that just aspiration of amniotic fluid causes significant respiratory difficulty. And that's become appreciated over the past several years. It's been commonly thought that the aspiration of meconium occurs more frequently during the delivery and afterwards, but I think many people now nave

questioned, in fact, whether that indeed existed; because the only criteria that you had is whether there was meconium below the cords when one is suctioninq out the meconium.

And, again, there's no way to know. So I think the figures as far as I'm concerned, if one quotes those, are not valid, because there's no way to really measure that.

Q So given the state of the literature and the experiments, you simply have no opinion one way or another?

A No, I gave you my opinion, okay. I think that the accurate estimates are unknown,

Q Well, can you at least -- whether we're talking about 9 percent as opposed to 91 percent, can you at least tell me which of those two times would be in the majority in terns of appearance, if you know?

A Again, the literature, and most of tne older literature states that it occurs greater during the delivery and afterwards. However, we simply don't know the accurate figure, because it's very difficult to measure that.

Q But you understand I'm not asking you the accurate, precise figure. I'm just asking you the general figure, whether it's the majority --

A Well, I don't know the general figure, but we're here to be as accurate and precise as we can; and so I have to give you, you know, to the best of my knowledge an

accurate statement.

Q Being as accurate and as precise as you know how, tell me, by dates, what this pregnancy in this case was on the 20th of January, 1983.

A By dates, it was 43 to 44 weeks. By examination, it was 41 to 42 weeks.

Q And by examination, are we talking about anything other than DuBois?

A We're talking about the assessment by the neonatologist, which is the DuBois, yes. And also by the birth weight.

Q Birth weight being nine-nine?

A Yes.

Q Did you note in the record that this child had peeling skin, long fingernails and was meconium-stained?

A Sure.

Q With that in mind, would you agree that this child would have fallen in the postmature category?

A Well, it has certain features, okay, that may be seen in a child who is postmature. However, you see -- you you can see peeling skin and long fingernails on a 40-week-old infant as well as a 42- or 44-week-old, but it's rare to see a nine-Fund, nine-ounce baby 43 to 44 weeks without any decreased subcutaneous tissue, and otherwise not showing any other significant signs.

So, you know, the best I can tell you is by examination, I think the more accurate figure is 41 to 42 weeks. Certainly, you know, the dates that are calculated are 43 to 44 weeks.

Q Doctor, do you have an opinion whether this child was postmature or not?

A You know, I've given you the descriptions, okay, so, I mean, it depends on which figures and which assessment one wants to place the greater weight on.

Q Well, I'm asking you. You're the expert. Which weight did you place on what, and do you believe in your opinion, this child was postmature?

MR. DAVIE: Object to the form.

MR. WAXMAN: Join.

MR. WILLIAMS: Me, too. Answer it if you can,

A I've answered it the only way that I can, you know, by dates and by examination.

Q Well, let me see if I can do it this way, Doctor. Can you answer the following question yes or no and, of course, you can explain all you want. Was this child, in your opinion, postmature?

A Again, as I've already -- first of all, I can't answer the question yes or no, okay?

Q All right.

A So I have to explain it. I've told you the baby

has certain features that are seen in postmature infants, depending on your definition of greater than 42 weeks. By Dubowitz examination by the neonatologist, it's 41 to 42 weeks. By birth weight, it's certainly a large baby to be a postmature baby of 43 to 44 weeks without any decreased subcutaneous tissue, So I think the best estimate is that the child is 41 to 42 weeks,

Q Are you telling us that in all cases where the neonate would be categorized as postmature that you're always going to have decreased subcutaneous tissues?

A No. You were talking in generalities, Mr. Keenan, and in probabilities. And that's the probability. Anything is possible.

Q In reaching the opinions that you did in this case, was it important to you to determine the length of the actual labor and delivery time?

A I'm sorry, run that by me one more tiae.

Q Did you, in fact, determine how long in tine this labor and delivery was?

A In terns of the time that the mother pressnted to the hospital and delivered the infant? You mean the Friednan labor curve?

Q Yes.

A No, in terms of -- I did not calculate a labor curve, *okay*. I do know what tine she presented to the

hospital. And I'll have to look at the chart to refresh my memory, but I believe it was at 9:40 and delivered at 11:56.

Q And you know that she was six centimeters dilated at that time?

A Yes.

Q Well, did you have an opinion as to how long her labor had progressed in terms of time upon her appearance at the hospital, being six centimeters dilated?

A No. Could we just take a short break for just one second?

MR. KEENAN: Sure.

(Discussion off record and recess)

MR. WILLIAMS: I do object to the taping by Mr. Turbow since we have a court reporter here who is preparing an official record of this deposition,

As to the purpose of it, it's a disco-rery deposition, and we're not here to have a taped interview with the doctor. This is the purpose we are here for the dewsition is to have that prepared for all of us, and we're not going to permit the taping of this deposition by Mr. Turbow.

MR. TURBOW: My understanding or' the law is the court reporter that's here is the official transcript, that whatever she has is the official transcript. Re can read an6 sign and make changes and corrections on

the official transcript, that my tape is solely for our purposes.

It can't be used for any other purposes, and it would in no way affect your right to do anything, because there's no use of this tape, And my understanding of the law is that there's absolutely nothing wrong with it,

MR. WILLIAMS: Well, we're not here for an interview by you of the doctor. We are here for Mr. Keenan to take his deposition.

MR. TURBOW: Which we're doing,

MR. WILLIAMS: That's true. You can take all the notes you want to, but there's no provision for you to be able to come in and have a recorded interview with the doctor.

Now, you know, we've gone to a lot of time and expense for everybody to come over here, and I don't see any reason for you insisting to do that. The court reporter will have this for us when we're over with. And if you do that, then, you know, we will, I'm afraid, have to get a ruling on it. And we will have to regroup this whole thing again. And we're set for trial a month from today.

MR. TURBOW: Well, I can't make Cr. Chalhub proceed if you won't let him; and if you want him not

to proceed, you say it right on the record and say so.

MR. WILLIAMS: Well, I do. That's what I'm saying. That's what I'm making this motion for.

MR. TURBOW: Well, let's call Judge Shepard.

MR. WILLIAMS: All right.

(Mr. Turbo speaking on phone to Judge Shepard)

MR. TURBOW: Judge Shepard, we're in the discovery deposition of Dr, Chalhub, and we've been here approximately an hour. We took a break, and aftet the break, we had a tape recorder and wanted to tape the balance of the dewsition, recognizing that it is not the official transcript, that the court reprter has the official transcript.

And Mr. Williams, the attorney for Dr. Chalhub, has objected to our being able to make a tape of the dewsition and has instructed his witness not to proceed any further in answering questions.

Yes, the reporter is taking it down, too.

Basically to have it for our own benefit a lot quicker than the reporter will have it.

Well, thers is the official reporter here.

Okay. Okay, Judge. Thank you.

(End of phone conversation)

MR. TURBOW: He sustained Mr. Williams' objection.

MR. WILLIAMS: Okay.

(Discussion off record)

MR. WILLIAMS: During the interruption, which you took down, we called Judge Shepard, the judge who is assigned to this case. Mr. Turbow talked to him on the phone and explained to him his reasoning for wanting to tape the deposition; and I did not speak to the judge, but apparently the judge ruled and sustained my objection and told you not to record it. I presume that was his decision; is that correct?

MR. TURBOW: Right. What the judge said was that he did not see any reason that he should have to testify before anybody but the official reporter.

MR. WILLIAMS: So with that, then we'll dispense with the tape and are ready to proceed.

BY MR. KEENAN:

Q Doctor, in looking over your CV, can you pint to me, as you did last year, any particular articles which you believe apply to this case and your opinions regarding causation?

A I will do the best I can, you know, within the limits of my recollection of what's in every single erticfe.

Q Surely.

A So if you'll leave ne that latitude.

Q Sure.

A No. 5, No. 6, No. 9, No. 10, 12, 13, 25, 28. In

the abstracts: 5, 2, 9, 15. I think that's -- now, there may, again, be some omissions or comissions, but, you know...

Q You understand, Doctor, that there was an approximate 50-pound weight gain by the mother?

A Yes.

Q To what do you attribute that?

A I guess to eating.

Q Does the weight gain in *any* way impact on ths brain damage in this case?

A Not to my knowledge. 3ut again, you know, I'm not an obstetrician in terms of what you possibly have in mind, but, you know, as a pediatric neurologist in this particular situation, the weight gain is not a factor in my conclusions.

Q Did you review the nonstress test traces?

A You already asked me that, and I said no.

MR. WILLIAMS: Object.

Q You did not?

A No.

Q Bid you review the external fetal heart monitoring strip?

A No.

Q Did you know that one was available?

A I know there was one that is not available.

Q External fetal heart monitoring strip.

A No, I didn't know that was available.

Q But you have been told that the internal, although it existed at one time, was not available at this pint?

A That is correct.

Q Did you note in the labor and delivery records prolonged decelerations to 80 noted at 9:40?

A Can you just point that out to me, on which page, and let's look at that.

Q Sure. It would be on the first line of whet would be the physicians' notes.

A Physicians' notes or labor and delivery record?

Q Right here, Doctor.

A Okay. It's also in another place, too.

Q Well, Doctor, that's the point of my question. There are notations at 9:40 about prolonged decalerations, and then there are, as well, notations at 10:45 of prolonged decelerations. Did you see both notations?

A Yes.

MR. WILLIAMS: What's the second time?

MR. KEENAN: 10:45 and 9:40.

Q Did you assume for the purposes of your opinions, Doctor, that, in fact, prolonged decelerations occurred at both instances, 9:40 and 10:45?

A Yes.

Q In reaching your opinions in the case, Doctor, do you have an opinion as to what caused those two prolonged decelerations, one occurring at 9:40 and the other one occurring at 10:45?

A Well, you know, a prolonged deceleration with recovery is fairly common, you know, in many pregnancies. And, you know, in isolation, you know, usually mean nothing. As in this case, I don't think one can attribute anything significant to two prolonged decelerations in which the fetus obviously recovers and goes on and develops a normal heart rate and has no sign of any significant intrauterine asphyxia.

Q Well, Doctor, my question was, do you know, whether it's significant or not, do you know what the cause of those two separate prolonged decelerations is in this case?

A No, I don't think, anybody knows. I mean, they can be the head pressing against the umbilical cord for a short period of time. They can be the head pressing against the cervix. You know, it could be, you know, a number of things, but again, to have two isolated decelerations with recovery means absolutely nothing unless it's correlated with other factors.

Q It's then a possibility, Doctor, that those two incidences of prolonged decelerations were the product of

cord compromise?

A Oh, I think anything is pssible, but the facts, you know, in -- hypothetically, you know, anything is possible. The facts in this case don't support that.

Q Well, what do the facts in this case support as being the reason for those two prolonged decelerations, one at 9:40 and 10:45, according to your review of the records?

A Well, as I said, you know, I don't know what the cause is. It could be any number of causes. Their significance is what becomes important,

Q You noted thick meconium present upon rupture of the membranes at 11:05?

A Yes, that is correct,

Q Doctor, did you reach an opinion as to how much meconium was present?

A I don't understand what you mean.

Q Well, are we talking 2 cc's, 10 cc's? What voiune are we talking about?

A It doesn't say, and I don't know how to estinate that.

Q Well, in looking back in retrospect and looking at all the other aspects of the case, do you have an opinion in the totality of all the facts and circumstances as to how much meconium was present?

A Well, it depends on how much amniotic fluid was

present, and I don't know how to measure that.

Q For the purposes of your opinions, did you assume any particular color of the meconium?

A I didn't assume anything. I'll be glad to read for you what the record and the description is.

Q Well, you did not assume whether it was green or yellow?

A No. I mean, I just have to go with what's in the record.

Q Would you agree generally, Doctor, that thickness of meconium implies recent production?

MR. WILLIAMS: Object to the form.

MR. WAXMAN: Join.

A What do you mean by "recent"?

Q Within four hours.

A Okay, I'm sorry, I don't understand your question. Please just restate it for me.

Q Sure. Generally, Doctor, would you agree that the thickness of meconium, that is, meconium that is noted to be thick, implies recent production of meconium?

MR. DAVIE: Object to the form.

MR. WILLIAMS: Object to the form.

MR. WAXMAN: Object.

Q And by that I mean within four hours.

A No, usually it doesn't mean that.

Q What significance, if any, do you attach to the notation of "thick meconium"?

A Well, the significance is that it was thick, I mean, as opposed to thin.

Q I understand that, but what does that, from your diagnostic expertise, tell you?

A Well, again, as an isolated factor, it may mean nothing. As I've already stated to you, 10 to 20 percent of all babies are born with meconium. It has to be taken in consideration with other factors of the labor, the delivery and pregnancy. And when it's taken in consideration with that as it is in this baby, you know, who obviously did have meconium aspiration, then it becomes a factor.

Q What significance is the notation "thick" in this case, then?

A Well, again, it can be significant; it cannot be significant. I mean, there are many babies that have thick meconium that have no problems. There are babies that have thick meconium that have problems,

When you take it in constellation with other findings, such as Apgars, such as the appearance at birth, such as subsequent problems, then it becomes more important.

Q You do hold the appearance -- or the opinion, Doctor, that the child aspirated meconium, don't you?,

A Yes, I do.

Q When?

A It's my opinion that the child aspirated meconium in utero.

Q Is that to say, then, that no meconium was aspirated after delivery?

A Oh, no, that's not to say that. I mean, obviously at any time that a baby has meconiun in the amniotic fluid and one makes an attempt to suction it, and suction it out of the mouth and the nares and below the cords, that you can't get it all out. We know that.

Q But you'll agree that your opinion is that the majority of meconium that was aspirated was aspirated in utero as opposed to after delivery?

A Now you've changed your question a little bit. That's a different question than you asked me before, so I won't agree with you. Is that a different question then?

Q Well, Doctor, we've established that in your opinion the child aspirated meconium in utero?

A I've stated that, yes.

Q All right, Of the total amount of the meconium that was aspirated at any tine by this infant, or fetus, how much of that, in terms of percentage, was actually aspirated in utero?

MR. WILLIAMS: I object to the form of the question. We're talking about a doctor who is

explaining about aspirated meconium that was then suctioned down to and including below the cords. And now you're asking his percentage opinion, I guess.

I would like for you to clarify it, if you could. Are you talking about percentage remaining after the suctioning, whether that was done in utero or after birth or the total amount?

MR. KEENAN: I want the total amount after resuscitation and intubation.

A There's no way to answer that.

Q When, in your opinion, Doctor, within a reasonable degree of medical certainty in point in tine did this fetus aspirate meconium for the first time?

A You know, again, there's no way for me to tell you that, because I don't know any other way that anybody can document how that can occur at the tine it occurs, because obviously babie that aspirate meconiun in utero, you know, may demonstrate absolutely no difficulty. So I can't. tell you when it occurred.

Q So you cannot tell me whether all the meconium that was aspirated in utero occurred before or after labor and delivery started?

A No, I can tell you by the appearance of this child and by the subsequent course and the x-rays that this child aspirated meconium in utero, but I can't tell you when; and

I can't tell you how much, because there's no way to estimate that.

Q Well, can you tell me how much was aspirated before labor began?

A Maybe we're — we're obviously not communicating. When you say "how much,' what are you referring to?

Q The total amount of meconium that was aspirated before the child was delivered represents a hundred percent for the purpose of my question. I'm simply asking you, of that hundred percent picture, how much, in terms of percentage, occurred before labor began and then how much occurred after labor began?

A I don't know whether there is anybody that can tell you that. If they can, then they know more than I do.

Q Do you hold the opinion that this fetus at no time during labor aspirated meconium?

A I don't know the answer to that.

Q Can you tell me, Doctor, whether or not the prolonged deceleration at 9:40 and as well the prolonged decelerations noted at 10:45 produced meconium?

A There's only one prolonged deceleration, *not* -- not decelerations at 10:45, okay.

Q I'll clarify that question then.

A All right. So ther restate your question again,

Q Can you tell me whether or not the prolonged

deceleration at 9:40 and as well the prolonged deceleration at 10:45, as noted in the records, produced meconium?

A Can I tell you whether that did?

Q Yes.

A No, there's no way for me to tell you that,

Q And you can't say that it didn't, either?

A NO.

Q Doctor, do you hold opinions concerning the standard of care as practiced by Dr. Montez, the pediatric resident?

A No.

Q Do you hold opinions regarding the standard of care as practiced by Dr. Chiu?

A No.

Q You then hold no opinions regarding the standard of care of any physicians in this case?

A That is correct.

Q Your testiinony then is directed to only the causation aspect or' the case as well as the future needs of the child?

A That is correct.

RR. KEENAN: Roland, just so we understand, that expert compliance would now stand to be incorrect.

MR. WILLIAMS: What is that?

MR. KEENAN: No. 2.

MR. WILLIAMS: This is correct. He is not expected to testify as to the standard of care of Dr. Chiu but is expected to testify concerning the proximate cause aspect of it, And that, as written, is incorrect and needs to be amended.

MR. KEENAN: So I don't need to go through my standard of care inquiry, because you're simply not going to ask him that?

MR. WILLIAMS: Dr, Chalhub will offer no opinions concerning standard of care of Dr. Chiu.

MR. KEENAN: Nor Dr. Montez or any other --

MR. WILLIAMS: Nor Dr, Montez or any of the other physicians involved. Is that correct?

THE WITNESS: That's correct. Excuse me for one minute.

MR. WILLIAMS: Let's make sure we got this clarified.

(Discussion off record and recess)

MR. WILLIAMS: That statement as previously made, he offers no standard of care opinion of any of the people involved in this litigation. Now, if you need any amplification on that, we can go through the name of all of then, but we don't have any standard of care answers.

MR. KEENAN: Sure.

MR. WILLIAMS: That's an error by attorney.

Q Doctor, you assumed, did you not, Dr. Hartert, when Re did the bulb suction and used the DeLee trap, obtained meconium?

A *Yes.*

Q How much?

A I don't know. If it's stated in here, if you'll show it to me I'll be glad to read it, but I don't recall how much.

Q When the baby then was passed from Dr. Habtert to Dr. Montez, you understand that Dr. Montez intubated the child?

A That is correct.

Q Do you know how many tines he intubated the child?

A Twice.

Q Rnd do you know whether or not he obtained meconium when he intubated twice?

A Yes.

Q How much?

A I don't know.

Q Doctor, do you hold the opinion that all the meconium that was aspirated was removed before positive pressure was applied?

MR. DAVIS: Object to the form.

MR. WILLIAMS: Join.

MR. WAXMAN: Join.

A I don't, you know -- I don't know the answer to that. I think the vast majority was attempted to be removed by DeLee and by suction prior to handing it to Dr. Montez, but as you may or nay not know, one has to watch out for the well-being of the infant. And you attempt to suction and maintain an airway the best way you can, so sometimes you have to give positive pressure while you're suctioning, and in between then while you're intubating and removing the meconium. And many times too much suction can cause a bradycardia, which you don't want to do anyway.

Q In reaching your opinions, Doctor, did you concede the possibility that the application of positive pressure could have had the effect of forcing the meconium further down?

A Well, I think the meconium was already there. As I've stated, the child aspirated meconiun in utero, and certainly positive pressure could force more meconium. You can't remove it all just by suctioning below the cords, I mean, that's well-known.

But obviously, whatever they did, they did extremely well, because the baby had really excellent Apgars at five minutes and really a fairly good Apgars at one minute.

Q Let's chat about that for a minute. When is the

last time that you had the responsibility for assigning Apgars?

A I guess the last time that I was acting in the capacity of a pediatrician, attending a cesarean section or a delivery at someone's request.

Q Was that *two* weeks ago?

A No, I was not there for that purpose.

Q When was that?

A Oh, sometime between 1972 and '76.

Q That was the last time?

A Yes.

Q Okay. You know how to figure up an Apgar?

A Yes.

Q You know the five categories?

A *Yes.*

Q Tell me what those are.

A Heart rate, respiratory rate, color, reflex, irritability of muscle tone,

Q Is there any way, based on the record and review in this case, that you can ascertain what the particular components are in the Apgars assigned?

A No, they were not subdivided.

Q In your understanding of Apgars, that one in five are what?

A Six and eight or nine, depending on which note

you re reading.

Q Of that six as evidenced at one minute, what were the respirations?

A I don't know whether that's recorded. I'll just have to look. I don't know what the respirations were, but if you have it --

Q I don't have it, Doctor.

A If you want to pint it out to me, then I'll be glad to look at it.

Q In reaching your opinions concerning the causation in this case, Doctor, do you have question about the validity of the Apgars sums?

A E don't understand what you mean by that.

Q Do you question their correctness?

A No, I don't: have any reason to question the correctness. I mean, I think obviously the assignment of the Apgsr score is a fairly routine procedure, and one does the best they can when making that observation.

9 There are no facts or circumstances before the assignment of the Apgar score or after that tend to contradict or to hold their validity in question as far as you' re concerned?

MR. DAVIE: Object to the form.

MR. WILLIAMS: Join.

A Well, again, which ones did you have in mind?

Q Any of them.

A I can't answer that question without knowing what you're asking.

Q In reaching your opinions, did you consider that the Apgar scoring could be incorrect?

MR. DAVIE: Object to the form.

MR. WILLIAMS: Join.

A I had no reason to consider that they were incorrect. What -- do you have a reason to consider they would be incorrect?

Q Let me ask it this way. Based on your full review of the records, you have no reason to believe that the Apgars are incorrect?

A No.

Q Do you know, Doctor, whether or not the five-minute Apgar was assigned before or after positive pressure was applied?

A I don't recall, but I'll be glad to check and let you know.

Q What assumption did you make?

A Well, I really didn't make any assumption. I, you know, would like to be accurate, I just can't recall at the present tine.

Q Well, let me just put the records in proper perspective and state that the recards are absent.

Dr, Montez says he doesn't know. That's all the evidence we have. Based on that, what assumption do you make as to the five-minute Apgar based on your knowledge of the case?

MR. WILLIAMS: As to its correctness, in other words?

MR. KEENAN: Yes,

A What is it -- again state your question. I'm not sure I understand it.

Q We have a five-minute Apgar of either eight or nine. And we know that positive pressure was applied at some pint, The records are absent as to when. The testimony is absent as to when.

And I'm asking you whether or not you reached an opinion as to whether or not a five-minute Apgar was assigned before or after positive pressure was applied?

A Well, if it's not recorded, and Dr. Montez doesn't remember, then obviously it's not available. But I don't see what difference it makes. I mean, the baby has responded with a normal Apgar by five minutes.

Q Doctor, page two of the admission note of the transitional nursery indicates an entry time 12:10. Reading: 'Black female infant admitted to recovery nursery from delivery room in arms of Dr. Montez. Color, cyanotic. Grunting. Nasal flaring. Thick, greenish-colored mucus obtained from throat. Seen by Dr. Montez. ABG's done."

Did you see that notation in the record?

A You'll have to show me which one that is.

MR. WILLIAMS: What record?

Q Child's record, Here you go, you can have this.

Page two of the child's records, do you see that notation, Doctor?

A Right. I'm reading from the admission notes of the child's record. And you want me to read this into the record?

Q I already did, Doctor. I just simply want to know in reaching your opinions of the case, is the tine as noted correct as far as you're concerned?

A Well, I mean, I have no reason to question that it's incorrect. I mean, it's stated; it's there.

Q You understand that ABG's were ordered as indicated in that 12:10 note?

A That is correct.

Q And you understand that the ABG results were obtained at approximately 12:26?

A 12:20, to my understanding.

Q And you understand that the pH value at that point was 6.99?

A Yes, I do.

Q You would categorize that as severe acidosis?

A I would categorize that as moderate acidosis.

Q What was the status of the pH at 11:56, Doctor -- approximately 11:56, the time of delivery?

A It was probably normal.

Q At 12:10?

A I don't know. Probably decreasing,

Q Acidotic?

A Well, you know, again, that's only speculation, you know. I don't know. I mean, if the gases were drawn absolutely at 12:10, then it was 6.99. If the gases were done at 12:11, then it's, you know, I don't know what it was at 12:10.

Q Was the pCO2 elevated at 12:20?

A Let me just get those gases out.

(Discussion off record)

A We want the first set of blood gases?

Q Yes,

A Well, I can only find the second one here unless someone has it in their record.

Q If I told you at 12:20 the pCO2 was 70, would that indicate to you an elevation?

A Yes, it would.

Q Significant?

A Yes. Significant in relationship to this infant, yes.

Q And a p02 of 31 indicates?

A That the p02 is low,

Q At what pint, Doctor, does the pH reach where you consider the child to be acidotic?

A Are you talking hypothetically and unrelated to this case?

Q Yes.

A Well, I would think that acidosis below -- that 1 would consider significant would be, again, below 7.2.

Q Can you tell me when the pH in this child went below 7.2 for the first time?

A The first set of blood gases that were done.

Q We understand that, but in looking back and understanding all the facts and circumstances of this case, do you have an opinion of when this child first became acidotic?

A Well, you know, there's no way to know, as you well know, Mr. Keenan, because we don't have any blood gases, okay. But with an Apgar of six at one minute and an Apgar of eight or nine at five minutes, it would be difficult for me to believe that a child would be Significantly acidotic with that Apgar at that point. So I don't know. Soinetiine between 12:01 and 12:12, the child. became significantly acidotic.

Q What, in your opinion, Doctor, could cause the acidosis in this case within a reasonable degree of medical

certainty?

A Lack of oxygen going to the lungs.

Q And what caused that condition? Again, within a reasonable degree of medical certainty.

A Persistent fetal circulation and meconium aspiration.

Q Did the meconium aspiration cause the persistent fetal circulation in your opinion?

A No.

Q Bid they occur simultaneously?

A No.

Q Did the persistent fetal circulation cause the meconium aspiration?

A I don't know whether I can answer that. I don't know how to answer thet.

Q When did this child, in your opinion, have the persistent fetal circulation problem?

A The child had the persistent fetal circulation problem in utero.

Q When?

A Again, there's no way to give you a totally specific tine. By the seriousness of it, I would have expected the child to have pulaonary hyperplasia of the smooth muscles for a number of days prior to birth.

Q And was the pulmonary hypoplasia the direct

by-product of the persistent fetal circulation?

A NO.

Q What caused the pulmonary hypoplasia?

A It's -- first of all, pulmonary hyperplasia of the endothelial muscles. In this particular situation, I'm not certain what caused it. About a third of the causes of persistent fetal circulation are unknown, and others are associated with various factors. So I don't know whether I can tell you what caused it in this situation.

Q What are the possibilities?

A Bacterial infection, viral infection, uteral placental insufficiency, toxemia, tumors of the placenta, metabolic disease secondary to acidosis, intrauterine asphyxia, hypertension, drug abuse, vaginal infections, and there are other causes.

Q What evidence in this case indicates the possibility of a bacterial infection?

A I didn't say that that was the case,

Q I understand. So there's no evidence?

A I don't have any evidence that there was a bacterial infection, no.

Q Viral infection?

A No.

Q Toxemia pregnancy?

A No.

Q Drug abuse?

A Well...no.

Q Vaginal infection?

A Well, the mother certainly had a history of Trichomonas and other vaginal infections in the past. You know, whether she had it at that time, I don't think it was cultured.

Q You indicated placental insufficiency?

A Yes.

Q Was that present, in your opinion, in this case?

A No.

Q Intrauterine asphyxia was listed, as well?

A Yes.

Q Did that occur in this case?

A Not by the labor, delivery and Apgar scores.

Q You rule out the possibility of intrauterine asphyxia occurring during labor and delivery?

A What do you mean "rule it out"?

Q It's considered no possible contributing factor to this child's brain damage?

MR. WILLIAMS: Object to the form.

MR. DAVIE: Object to the form.

MR. WAXMAN: Join.

A Well, again, you have to take -- you know, you practice medicine based on the whole, all of the facts or,

at least, to the best of your ability the facts, And in this particular situation, the recorded fetal heart tones are well within normal limits. The baby did not appear to be suffering from any intrauterine distress as measured by that: parameter.

The baby is also born with meconium aspiration, has an Apgar of six, which would be explained on that basis. Responds quite nicely, and has an Apgar of eight, which would be totally inconsistent with any significant intrauterine asphyxia.

Q Did the passage of this pregnancy beyond 42 weeks contribute in any degree to the development of persistent fetal circulation?

A Well, in the first place, it's not certain whether the pregnancy was past 42 weeks. At least by examination, the baby was 41 to 42 weeks, okay. If you want to use dates, then it did go past 42 weeks. And anything is possible. It certainly is possible that it contributed; I just don't know.

Q If we could list the causes of this child's brain damage, that is the causes which would encompass within the reasonable degree of medical certainty definition, please tell me what those would be. And I apologize if we've already gone over those to a limited degree.

A No, there's no -- you don't have to apologize.

The cause of this baby's neurological deficit is postnatal asphyxia, hypoxia and ischemia.

Q By postnatal, we're referring to what period?

(Discussion of€ record and recess)

6 Doctor, back on the record. I believe we broke as you were going to give me your definition of postnatal, in the cont xt of postnatal asphyxia.

A Meaning after birth.

Q In your opinion, did this child suffer any asphyxia in utero?

A In my opinion, no,

Q And although there are few absolutes in medicine, is it your testimony that there was absolutely no asphyxia in utero?

MR. WILLIAMS: Object to the form.

MR. DAVIE: Object to the form,

MR. WAXMAN: Join in the objection.

A That's not what you said. You know, granted there are no absolutes, but we're talking within a reasonable degree of medical probability. And within a reasonable degree of medical probability, it's my opinion there was no intrauterine asphyxia based on the facts, based on the laboratory recards, based on the Apgar *scores*, and based on the chart.

Q Did this infant in utero suffer any growth

retardation, Doctor?

A Well, if it did, it must have been a monster baby. Not that I can tell.

Q You do not have the opinion that there was any intrauterine growth retardation in this case?

A Well, I don't know how one would, you know, measure intrauterine growth retardation. The child was nine pounds nine ounces and did not appear to have any significant decreased subcutaneous tissue and did not appear to be a growth-retarded infant.

Q And it, as well, had a head circumference of 34?

A Yes.

Q Which is in the normal range?

A Yes.

Q Goes the Apgar, the head circumference, as well as all the facts and circumstances that you know about the case in any way give rise to evidence that this child suffered brain damage in utero?

A I've already answered that several times.

Q And the answer is no?

A No.

Q So all of the brain damage suffered by this child was after delivery?

A Well, again, with the way as I stated it --

Q Within a reasonable degree of medical certainty?

A Within a reasonable degree of medical probability, it's my opinion, you know, based on the facts and based on taking the pregnancy, the labor, the presentation, the Apgar scores, and the subsequent developments, that the brain damage that this infant suffered was in the postnatal period.

Q The postnatal asphyxia that you have indicated occurred as the result of one insult or multiple insults?

A Again, there is -- what do you mean by "multiple insults" first, excuse me.

Q Well, the understanding of your definition of asphyxia being a decrease in the oxygen supply and increase of pCO2 and the production of acidosis. Did that occur as the result of one particular pint in time or was it over a period of days? Can you describe for me the mechanism of how that happened, that is, postnatal asphyxia?

A The postnasal asphyxia occurred both over a number of days and then again on the 25th, at which time the infant had a pneumothorax, pneumonediastinum and marked bradycardia with cardiac resuscitation.

Q Did the child suffer any pstnatal asphyxia from the time it left the labor and delivery room until it arrived at the transitional nursery?

A Now, again, the child appeared to be doing extremely well with an Apgar of eight, which is why I would

have taken, you know, the baby to a transitional nursery as was done in this case, but because of the baby's obvious problems, worsened quickly and was transferred to the neonatal intensive care nursery.

Now, what time frame the pH became at a certain level, and at what time frame the pCO2 increased, and at what time frame the pO2 decreased, again is unknown. But we do know that the body has many mechanisms. So on a 50- to 20-minute basis, the body is able to compensate for those rapid changes.

And I would doubt seriously whether any permanent damage would have occurred during that tine, because lactic acidosis, which accounts €or the acid and also the respiratory acidosis, is initially a protective mechanism of the brain.

So in that short period of time, I would doubt whether there was any significant brain danage.

Q So that I understand what you mean by "at that tine,' you understand that the child arrived in tne neonatal intensive care at approximately 12:25?

A Yes.

Q Had the child, upon arrival at the neonatal intensive care unit, suffered any irreversible asphyxia damage at that time?

A You know, again, there's no way to know that for

certain, but based on my experience, my knowledge and my understanding of neonatal metabolism, glycolysis, lactic acidosis, neuronal injury, I would have to say in that short period of tine, permanent brain damage would still be in question and probably not, just based on generalities.

Q You cannot, then, during that period give us an opinion within a reasonable degree of medical certainty as to whether or not the asphyxia which occurred from the time of the transitional nursery until arrival into the neonatal intensive care nursery in fact caused any irreversible brain damage?

MR. WILLIAMS: Object to the forn.

MR. DAVIE: Object to the form,

A That's not what I said. I said it is my opinion that in all probability that irreversible brain damage did not occur in that *short* period of time for the various reasons that I gave you.

Q And that is within a reasonable degree of medical certainty?

A That's what I just said -- probability.

Q At what point did the child suffer irreversibie brain damage, if that had not occurred prior to the arrival at 12:25 in the neonatal intensive care unit?

MR. WILLIAMS: Object to the forn.

A You know, again, I don't know how anybody can tell

you specifically at what point irreversible -- the only way one can tell is by following a child. Even up until the 25th, you know, children can have cardiac arrest and make a full recovery. Obviously this child did not.

There's no way to know at that time how much lack of oxygen and how much blood flow occurred to brain based on the pathophysiologic mechanisms that are occurring. This child obviously had a number of them ongoing, and their individual contribution and the individual times and the amount is a not a quantitative measurement.

Q Let's identify them first. That is, your description of "a number of them going on." When is the first event that occurs that contributes to the irreversible brain damage?

A At the tiae the child goes into respiratory distress, between 12:10 and 12:25. At the time the blood gases were drawn, the child began to have increasing difficulty, was transferred to the neonatal intensive care unit, and begins having difficulty then.

After that period of time, up until a number of days after the 25th, the child has the pssibility of receiving permanent brain danage.

Q Let's see if we can identify the possible complications in terms of particular events. You've indicated to me the pneumothorax, which I believe occurred

at 1900 hours on the 24th.

A The first one.

Q Yes. From 12:10-12:25 period that you have just described until the pneunothorax, which was noted at 1900 hours on the 24th, are there any other events between the 20th and the 24th that you can point to as indicating possible contributing factors to the irreversible brain damage?

A The child was on a ventilator, was having increasing oxygen demands due to the persistent fetal circulation, and was requiring higher oxygen concentrations, had to be -- receive excessive ventilation, had to receive bicarbonate, had to receive a number of supportive measures.

So during that period of time, there was little question that the child was exposed to high risk for permanent neurological deficit.

Q What effect did the aspiration of meconium have on the development of this postnatal asphyxia that you've described?

A Well, it contributed to it.

Q How?

A Well, by making oxygenation more difficult.

Q Can you tell me, Doctor, if the meconium was not aspirated, would the child still have developed postnatal asphyxia?

MR. WILLIAMS: Object to the form.

A Without a doubt.

Q To what degree, if you can tell me, did the meconium that was aspirated contribute to the severity of the brain damage?

A There's no way that I can tell you that, There's no quantitative way to estimate that.

Q There's no way you can tell me if it was less than half or more than half?

A No.

Q In what way does the passage of a pregnancy beyond 42 weeks -- assuming that that is a correct date -- have on the development of this pstnatal asphyxia?

A Well, first of all, you're assuming a fact which may not be accurate, As I've already said, the description of a 41- to 42-week baby, if we assume hypothetically that it's past 42 weeks, it may contribute nothing. I mean, you know, there are many babies born at 43 weeks, 44 weeks that have no problems whatsoever. This baby happened to have persistent fetal circulation, develop meconium aspiration, and develop the complications as a result of that, and suffered permanent neurological injury,

Q If this child, Doctor, had been C-sectioned on the 7th of January, in your opinion, would any brain damage occur?

MR. DAVIE: Object to the form.

A I can't answer that qusstion. I don't know ths answer.

Q If the child would have been C-sectioned at the point of hospital admission on the 20th, can you tell me within a reasonable degree of medical certainty whether the child would have suffered brain damage?

A In my opinion, the sans sequence of events would have occurred.

Q Well, I need to understand. If you can't tell me on the 7th of January but you can tell me on the 20th, at what point in time between the 7th of January and the 20th of January does the C-section and the doing of the C-section in no way affect the outcome of the brain damage of this child?

MR. WILLIAMS: Object to the form.

MR. MVIE: Object to the form.

A Now, wait a minute. I don't think I understand your question.

Q As I understand your categorization, Doctor, when I asked you within a reasonable degree of medical certainty if the child would have been C-sectioned on the 7th of January, would it have received brain damage, you said you didn't know.

I asked you that sans question applied to the 20th

of January, and you said, yes, I can tell you that the brain damage would have been the same; it had no effect.

I'm simply asking you when, between the 7th and the 20th, does the doing of the C-section within a reasonable degree of medical certainty not affect the outcome in this case?

MR. WILLIAMS: Object to the form.

MR. DAVIE: Same objection.

A Again, it's an unanswerable question. In the first place, there's no indication to do a section on the 7th as far as I can tell from my standpint, And the second point is that on the 20th, the child has already developed the persistent fetal circulation, because that occurs in utero. The child, in all probability, has meconium. In any event, if it didn't, the same sequence of events occur: severe fetal circulation, high oxygen requirements, high pCO2, changes in cerebrometabolic rate, pneumothorax, pneumomediastinum, resuscitation, exposure *to* permanent neurological deficit.

Q In your experience, Doctor, does the development of the persistent fetal circulation have a higher incident rate with prolonged pregnancies than with normal pregnancies?

A I don't know those figures. I'll have to check.

Q When did the PFC first develop in utero?

A Well, you know, I can't look in utero, okay. You can tell by the seriousness and the severity of it that it obviously had been there for a period of time.

Q Well, are we talking a month, two days, five days, three weeks? Just give me an approxination, Doctor.

A At least several days.

Q We're talking about a high of four and a low of two?

A I don't know that, Mr. Keenan, Again, this is only speculation.

Q Did the vaginal delivery in this case as opposed to a C-section increase the stress on the fetal well-being?

MR. DAVIE: Object to the form.

MR. WILLIAEIS: Join.

A Now, you know, you used some general terns there, and i don't understand what you mean by that. Maybe if you could just clarify that for me a little bit,

Q Are you familiar with the term "fetal reserve"?

A You'll have to tell me what you mean by it.

Q Have you heard the tern?

A Yes.

Q What is your definition of that term?

A Well, I don't usually use it, so you have to tell me what you're asking.

Q The ability of the fetus to withstand the

contractions of labor. The temporary, intermittent, interruption of oxygen'supply produced as the result of contractions, particularly, I believe, the squeezing of the intervillous space.

A As you define it, it appears that this child tolerated that quite well.

Q As evidenced by the fetal heart monitors?

A And the Apgar scores.

Q Xave you assumed that this fetus from the time of rupture of the membranes at 11:05 to 11:56 showed no signs of distress to the obstetricians attending the pregnancy, labor and delivery?

MR. DAVIE: Object to the form.

A Not only do I assume it, there's nothing in the record to suggest that it occurred. I mean, you know, it's just not there.

Q Was the pstnatal asphyxia that occurred somewhere between 12:10 and 12:25 in and of itself sufficient to cause the damage that you see today in this child?

A No.

Q Can you give me an approximation as to the total damage picture as to what type of damage you would have expected to be produced as the result of the postnatal asphyxia that occurred between 12:10 and 12:25? That is, how disabled, how danaged would you expect a child under

these circumstances to be if that is the only postnatal asphyxial event that the infant encountered?

MR. WILLIAMS: Object to the form,

MR. DAVIE: Object to the form.

A The question is too general without any specific factors, so I really can't answer it unless you're going to give me a whole lot of specifics.

Q Surely. The specifics are the knowledge of the prenatal. care, the knowledge of maternal history, the knowledge of this Labor and delivery, and the knowledge that postnatal asphyxia occurred somewhere between 12:13 and 12:25 with the Apgars as you know them, the records as you know then, If that child would have suffered no additional asphyxial insult or deprivation, what would you expect to be the neurological deficit of that child today?

A I would expect --

MR. DAVIE: Object to the form.

MR. WILLIAMS: Join.

A Any more objections? Based on that information and based on the fact that you're not -- that I assume the pH comes right back to normal, then I would expect, probably, no deficit.

Q Did the child receive irreversible aspnyxial damage prior to the pneumothorax on the 24th?

A You know, again, within a reasonable medical

probability, yes, but it's hard to quantify that, okay. The only way that anybody can quantify irreversible brain damage is to follow an individual over a period of time.

However, you don't have the opportunity, because you have a number of events that occur. In the -- in toto, we have a child that has severe multiple problems, who had severe multiple insults which all contributed to this child's severe neurological damage.

Q Did the meconium aspiration ever resolve?

A Sure.

Q When?

A I'll have to look back at the chest x-rays and, you know, when the subsequent -- it's cleared but, you know, again obviously it does get better.

Q To what do you attribute the clearing?

A Now, again I don't know the pathology of the clearing events in the meconium aspiration. That's best answered by a neonatologist, but the lung is obviously healing, the macrophalia is clearing, the debris in the alveoli are repairing themselves.

Q Did the persistent fetal circulation resolve itself?

A Yes, it did.

Q When?

A When the requirements for oxygen decreased and the

pulmonary blood flow increased.

Q Which occurred when?

A Again, you'd have to look, you know, through the series of gases and determine, you know, when those events -- sometime after the 25th.

Q To what do you attribute the cardiac arrest which we understand occurred on the morning of the 25th?

A I attribute it to the pneumothoraces, the pneumomediastinums, and the hypoxia to the myocardium.

Q And what caused the hypoxia to the myocardium?

A The inability to ventilate the child because of the complications which developed in a critically ill child such as this.

Q And I believe, Doctor, you told me that placental insufficiency, in your opinion, did not contribute to the brain danage?

A I don't believe I said that.

MR. WILLIAMS: Object to the forn.

Q Did it?

A No, you've just taken it totally out of context. What are you talking about? Put it in context for ne.

Q Did placental insufficiency in any way contribute to the brain damage in this child?

A What kind of placental insufficiency? At what time and in what situation?

Q Well, in utero at any tine.

A What kind of placental insufficiency? What are you talking abut?

Q An inability of the placenta to transfer needed oxygen to the fetus.

A Well, by the only measurements that we have of electronic fetal monitoring, auscultation, Apgar scores, presentation at birth, obviously, no. And also by ths appearance of the baby.

Q So you do not list placental insufficiency by that definition and those explanations of the facts to be a contributing cause of the brain damage in this child?

a Not, in that sequence, no.

THE WITNESS: Let's pause for just one minute.

MR. WILLIAMS: Let's take a break.

(Discussion off record and recess)

Q I just want to sum up this area. The child's irreversible brain damage within a reasonable degree of medical certainty was caused by postnatal asphyxia?

MR. WILLIAMS: Object to the forn. Asked and answered.

A Yes, as a result of persistent fetal circulation, meconium aspiration, pneumothorax, pneumomediastinum, lack of *oxygen,* lack of blood flow.

Q And we've identified that the persistent fetal

circulation developed in utero in a time frame of between two and four days prior to delivery?

A No, that's what you developed, I said I don't know, okay?

Q You used several days, I believe.

A Yes.

Q Several days meaning more than a week?

A No.

Q Less than a week?

A I would think so.

Q And the meconium aspiration occurred in utero?

A Yes, as well as after birth, too.

Q More than a week preceding?

A I wouldn't think so, but I don't -- you know, again, there's no way to quantitate that.

Q And the pneumothorax that we're talking about is the ont on the 24th?

A Yes.

Q Any others?

A Well, there was a right and a left pneumothorax.

Q And you indicate, as well, as a contributing factor, "lack of oxygen." When dici that --

A And blood flow,

Q I'm going to ask a two-part question. When did the lack of oxygen begin which was the contributing factor

to the pstnatal asphyxia? Did that occur in utero?

A No.

Q And, as well, lack of blood flow, did that occur in utero?

A We have no evidence that that occurred in utero,

Q And the lack of oxygen which contributed to the postnatal asphyxia occurring after delivery began when?

A Well, began when the baby started requiring high levels of oxygen.

Q When was that, in your opinion and understanding of this record?

A After 12:25.

Q And what about the lack of blood flow? When did that develop?

A Well, again, you know, it's difficult to be absolutely certain. When you have ongoing asphyxia and hypoxia, one deveiops a certain amount of cerebral edema which will swell the endothelial cells of the cerebral blood vessels and impair cerebral blood flow.

Furthermore, asphyxia interrupts all blood Cerebralauto regulation which also affects cerebral profusion.

Certainly on the 25th when the child had cardiac arrest, there was lack of blood flow. So there are multiple contributing factors on multiple days. Again, to quantify, it is extremely difficult.

Q Doctor, the articles which you've indicated as being 5, 6, 9, 10, 12, 33, 26, 28, and the abstracts as being 2, 5, 9 and 15, do any of them deal with the development of postnatal asphyxia with persistent fetal circulation, meconium aspiration, the development of pneumothorax, lack of oxygen, and lack of blood flow?

A I don't know that, Mr. Keenan, Probably not as you've stated.

Q Doctor, if this child between 12:10 and 12:25 had instituted mechanical ventilation, blood gases, Tham's sodium bicarbonate, in your opinion, would irreversible brain damage to the extent that we see in this child have occurred?

MR. WILLIAMS: Object to the form.

MR. WAXMAN: Join in the objection.

MR. DAVIE: Same objection.

A I'm sorry, what was the tine period again? I missed that.

Q Between 12:10 and 12:25.

A No, it wouldn't have changed the outcome one bit,

Q Now, I would take it, Doctor, there is nothing known to medical science in 1983 that could have been brought to bear in a timely fashion on this child to minimize the development of the brain damage in this case?

MR. DAVIE: Object to the form.

MR. WAXMAN: Object to the form,

MR. WILLIAMS: Join.

A On the contrary, Mr. Keenan, I think the care, you know, as I see it, was excellent. They attempted to treat the persistent fetal circulation with Tolazolene, alkalosis, increasing oxygen concentrations, intubation, assisted ventilation, treating the acidosis and, in fact, the infant was improving.

However, as one knows, the complication rate from ventilation, mechanical ventilation, this particular disease entity, being persistent fetal circulation, meconium aspiration, is pneumothorax and pneumomediastinum that occurs. It's an unfortunate event. It's difficult to treat, and the fact that this baby is alive is a credit to these physicians.

Q You, of course, reviewed the pathology report in this case?

A Which pathology report?

Q The only pathology report of the placenta.

A Yes.

Q Is there any evidence as noted in the pathology report that supports your opinion of the postnatal asphyxia and the contributing factors as you've outlined?

A I don't think that's even relavant.

Q In ycur opinion, the pathology report indicates a

functioning, nondiseased placenta?

A No. If you want to ask me my opinion, then ask me.

Q Sure. Fine.

A But don't tell me my opinion and then ask me if I agree.

Q Well, I've tried to do that, Doctor, and you have problems answering my question.

A No, I'm trying to do my best; Mr. Keenan; I really am.

Q I understand.

A I've been trying hard all afternoon.

Q I understand you are,

A So what is your question?

Q What is your opinion about the pathology report?

MR. WILLIAMS: Object to form. As it relates to what?

MR. KENNAN: To the condition of the placenta.

A It describes a mature placenta.

Q Any abnormalities noted?

A Not, you know, that I can see in that, but again, I'm not a fetal pathologist.

Q How many children, Doctor, have you been consulted on that, in your opinion, their brain damage was a result of postnatal asphyxia with contributing factors of the PFC, the

MA, the pneumothorax, the blood loss the lack of oxygen?

A There's really no way to give you an estimate, I've been seeing children in neonatal intensive care units since 1970, and the conditions have existed since that time. Persistent fetal circulation has been described since 1965, but obviously existed before that but was unrecognized, So, I mean -- you know, it happens, okay. It's an unfortunate, unpreventablc entity,

Q Well, I don't mean to cut you off. I understand it happens, and I understand that this is not the first time in the annual anals of medical. science that it has, This is not the first case, is it?

A Not to my knowledge.

Q I'm just asking you in your frequency, in your practice, how often do you see it?

A I've tried to tell you that there's no way for me to tell you that. I mean, I see a lot of sick babies, okay? I just can't -- I don't keep track, you know. I don't put a pint in a column for PFC and one for meconium aspiration and one for postnatal asphyxia. But obviously if I'm consulted, it usually is a problem with the nervous system, and it's always in the postnatal period. And in the majority of the cases, it is a requirement in defining what the insult is to the baby and what contributed to it. So actually it comes into play a large proportion of the tine.

Q Is it under your expertise and experience to, in fact, diagnosis a PFC?

A No, that's done by the neonatologist and the cardiologist.

Q And, as well, the meconium aspiration?

A Yes.

Q Are you brought in to the diagnosis and the care and treatment of an infant who develops a pneumothorax as a result of mechanical ventilation?

A If it has neurological impairment, yes.

Q Explain, if you will, Doctor, the significance of the CAT scans that we have presented here on the x-ray box. And please, so that we can get through this, if you can generalize your statements, I would appreciate it.

MR. DAVIE: Object to the form.

MR. WILLIAMS: Join.

A I'll make it really short for you. You know, this is the first time I've seen these, so I'd like to Rave the opportunity to study then. I'll be glad to send my findings in writing to Mr. Williams who can forward them to you.

Q As I understand it, the only CAT scans that were made available to you were the March '83 CAT scans?

A Then that was this morning. I really have not had tine to sit down and analyze them.

Q What part, if any, did the March '83 CAT scans

have in the formation of your opinions as to causation of the case?

A Well, the report wasn't very helpful, but after seeing it, I've got to sit down and put it in perspective, And again, I will send you what I think I see on that CAT scan -- not send you, excuse me, Mr. Williams, who will forward it to you.

Q All right.

MR. KEENAN: Roland, let me do this, I don't want to be stuck with a report without an ability to find out further on that report. If we can agree that we can get that in writing in a timely fashion, and as well, if I have any questions, be able to put them in the form of either an interrogatory or a telephone conference to be solely on that issue.

MR. WILLIAMS: Have you got any problem with that?

THE WITNESS: I have no objection to that.

MR. WILLIAHS: I don't either. Let me ask you this while we're talking, ballpark of how long do you think it will take to get your analysis?

THE WITNESS: Well, I've got to get a copy of the other set, which is apparently not -- I don't know where those came from, because they are certainly not here. They were provided this morning, so...

MR. WILLIAMS: Assuming we can get you those today

or Monday or so then you can get us a response back by --

THE WITNESS: By next week.

MR. WILLIAMS: By next week.

MR. KEENAN: Fine.

Q I understand you've not had a chance to see Dr. Hodson's report, Do you know who he is?

A No.

(Plaintiff's Exhibit No. 2 was marked for identification.)

Q I have had marked as Exhibit 2 for purposes of this deposition the letter dated the first of April 1987 from Dr. Hodson. Do you understand that Dr. Hodson occupies the same category of health specialty as you do?

A It says child neurologist; however, I have no knowledge of his training, current status and certification, so I have no reason to believe that he's not, but people will call themselves what they want.

Q You examined the child today?

A Yes, I did.

Q Approximately 30 minutes?

A A little bit longer, yes.

Q What was your purpose?

A Well, whenever I am asked to give an opinion in terns of causation, I would like the opportunity to examine

the child, which -- and I try to do that in every situation that I possibly can unless it is not allowed or it was not done so that I can make sure that what I'm testifying is, to the best of my ability, accurate, unbiased, and giving you as well as the court an appropriate opinion.

Q Have you had an occasion to review the pediatrician's ongoing records, that is Dr. Chu -- and by that I mean C-h-u?

A No.

Q You have reviewed the Nernours records?

A No, I haven't.

Q Have you reviewed any of the medical records concerning this child after its discharge from University Hospital?

A I do have some. I don't know all the dates and the nanea of those visits. I don't have those here,

Q Do you have the records concerning ths orthopedic procedures performed on this child?

A Well, I asked the mother this morning, and she said there weren't any orthopedic procedures.

Q But you just don't recall what records you reviewed?

A No. They went up to approximately, I think, two and a half years of age, but after that I don't have much.

Q Take a look, Doctor, at the basic records of

Nemours, which are contained in our volume six. See whether or not indeed you have had an occasion to review those.

A No, I have not seen these records.

Q All right. Doctor, you recorded the head circumference on this child; did you not?

A Yes, I did.

Q And what was your recording today?

A Well, to the best of my tape measure, 44 centimeters.

Q Would you categorize the child with a condition known as microcephaly?

A Yes, I would.

Q And you didn't have the occasion to chart the head circumference on the child, did you? Plot it?

A No, but it's clearly two standard deviations below the mean for that age.

Q Do you have an opinion as to whether or not this child has severe psychomotor retardation?

A Yes, I do.

Q And is that irreversible?

A Yes, it is.

Q And she, as well, has a seizure disorder?

A Yes, she does.

Q When was the last time the mother reported to you that the child had a seizure?

A She feels that approximately two months ago, but again, I'm not sure from my brief conversation with her what she thinks a seizure is and what isn't a seizure, because she reports certain movements that may be just spasticity or jitteryness. But I have no reason to believe the child would not have seizures,

Q And as well -- and I'll direct your attention to the last paragraph of Dr. Hodson's report where he indicates, and I quote: "I believe that as long as she is provided with adequate standards of medical care, she will have a normal life expectancy,"

Is that the first time that you understood that the local pediatrician made that assessment?

A Apparently this is not a pediatrician. He's a neurologist.

Q Neurologist.

A He may be a pediatrician also, but he's classified as a child neurologist.

Q Is that the first tine that you understand that that opinion has been rendered by a Jacksonville physician?

A *Yes.*

Q Is it your opinion that this child, if given the appropriate medical care in keeping with the standards required will have a normal life expectancy?

A No, that's absolutely absurd.

Q Tell me, then, within a reasonable degree of medical certainty when this child will be placed in her grave.

MR. WILLIAMS: Object to the form.

MR. DAVIE: Sane objection,

MR. WAXMAN: Join,

A Well, I, you know, think that's, you know, a rather crude way of placing it, Mr. Kecnan. The question -- and I don't use that type of terminology. We would hope that this child would, you know, achieve every benefit and be able to achieve the maximum of her potential, but by the nature of the severity of her neurological deficit, the microcephaly, the spastic quadriparesis, the seizure disorder, the mother's statement that the child has constant infections -- probably from aspiration -- and a child that's nonambulatory, will be nonambulatory, has limited movement, by all of the studies and by my experience as being director of chronic care facilities for children for a number of years, that the life expectancy is between 10 and 20 years maximum.

Q To what studies do you rely?

A National Institute of Health studies which are going to be published shortly.

Q They're not out yet?

A No, but thers are clearly other studies in the

literature which document that.

Q Namely?

A I can't give you all of the names. Some of the articles are Herb Grossnan --

Q Grossman from Michigan?

A Yes.

Q Okay.

A Ballsirini, Ferrindelli. There's a number of authors.

Q Do you believe that the Grossman life expectancy studies are reliable and authoritative?

A Well, I have no reason to believe they're not.

Q Do you know any other life expectancy studies other than Grossman's that are reliable and authoritative that are in print that we can look at?

A Well, what do you mean by "reliable and authoritative"? I don't know what you mean.

Q Contains facts which you accept as true and generalities?

A Yes, accept facts that I would agree with, yes.

Q Is it your opinion, Doctor, that one of these infections will ultimately kill this child?

A In my experience, that's usually the case, Mr. Keenan. A child that has chronic respiratory infections, as this child does, has extreme difficulty with

handling oral secretions and probably aspirates on a chronic basis usually does develop an infection which becomes overwhelming, and especially with a seizure disorder. The incidence of sudden unexpected death and epilepsy is extremely high.

Q Isn't SIDs basically a reservoir diagnosis to gut a label on the unexplainable?

A I don't believe I mentioned SIDs.

Q I thought you said sudden infant death?

A No, no, I didn't say that.

Q What did you say?

A I said sudden unexpected death.

Q Is it your opinion, then, within a reasonable degree of medical certainty that it will be an infection which will cause this child to die?

A No, it can be an infection. It can be a seizure. It could be a ventricular arrhythmia as a result of a seizure disorder. The child clearly is at risk for many things which could take its life. That's, you know, unfortunately the problem with childrsn with severe neurological impairment.

Q Do you have an opinion as to whether or not the mother has rendered adequate care for her little girl?

A I don't know any way to estimate that. I net the mother the first tine this morning. She appears *to* be a

nice, caring individual who loves her child.

Q What is it about the 10- to 20-year time period, Doctor, that, in your opinion, is the expected demise of the child? Is it the wearing down of the immune system? Is it the increased susceptibility of the child? Just what is it?

MR. DAVIE: Object to the form.

MR. WILLIAMS: Join.

A I don't know the answer to that, Mr. Keenan.

Q Do you hold the opinion that she will never develop language skills?

A I think within a reasonable medical probability, she will not develope language skills.

Q And she will not develop independent ambulation?

A I would agree with that.

Q And would you, as well, agree that she will never achieve any form of employment status?

A I would totally agree with that,

Q Do you have an opinion, Doctor, whether at any tine, either present or future, this child will require institutionalization?

A Well, that's a difficult question to answer. My -- I can give you my personal opinions and -- which is the way I practice medicine is, I an a physician who does not like to institutionalize children. I think that they are best suited with their families who love them and care for

them, if that is able to be done, and they are able to deliver that type of care and depending on the nature of the child's disability.

Obviously if there are 15 children in a family with limited resources, a child is not going to get the attention that one needs and would require additional assistance. However, if there is a limited number of children, and the resources are available, then I think a child that will require basically custodial care is best suited in a home in which the individuals love and care for the child.

Q How come?

A What do you mean "how come"?

Q Why is that true?

A Why is what true?

Q Why is it true that the family setting and the love that can be garnered in the family setting is much better than the institutional setting?

A I think that's self-explanatory, Mr. Keenan. If you don't understand that, I can't explain it to you.

Q So it's commonsensical then?

A I don't understand that response.

Q Let me ask this question. From a purely economic standpoint, Docto , in terms or' dollars, isn't it cheaper to institutionalize a child with this condition?

A No, I think to the contrary.

Q So if we are posed with two modalities, one, continue the child in the home under the care and supervision of the mother as opposed to institutionalization, it's your opinion that institutionalization would give rise to a higher economic figure than home care?

MR. DAVIE: Object to the form.

MR. WILLIAMS: Join.

A Are you talking about this child or just a hypothetical situation?

Q This child.

A You know, again, the needs, as I see this child going to have with the severity of tho deficit, can be met by a loving, caring parent given appropriate instruction on a periodic basis. I see no need to institutionalize a child for basically custodial. care.

Q Did you have an occasion, Doctor, to review the life care plan as formulated by Paul Deutsch?

A No.

MR. KEENAN: We will mark this as Plaintiff's 3.

(Plaintiff's Exhibit No. 3 was marked for identification.)

Q Doctor, again not in generalities, but having reviewed this child, is it reasonable for the child to

require physical therapy, occupational therapy and speech therapy evaluations once a year?

MR. WILLIAMS: You said "reviewed." Did you mean examined, having examined the child?

MR. KEENAN: Yes.

A I'm sorry, I don't understand your question,

Q On the first page -- I'm going to be going through and asking you a series of questions about the reasonableness. I'm just going to ask you whether or not these recommendations are, indeed with your knowledge of the child, reasonable; whether you're critical of any of these, If you want to take a look at them.

A I'm going to have to, Do you want to pause while I go through all of this, then we'll do this; otherwise, you know, I just can't sit here and read a 15-page document and tell you what I think about it,

Q I'm going to help you, Doctor. The first page is entitled Projected Zvaluations. Do you see that?

A Yes.

Q And on the left-hand side you see Rehab, Physical, Occupational and Speech Therapy?

A Yes.

Q All right. And then you see the second colunn which is, when this will be instituted; the third column is, how often, or for how many years; and then the fourth column

is, how often per year. I'm only going to ask my questions through those four columns.

I'm just asking you whether or not those estimates, with your knowledge of this child, are reasonable,

MR. DAVIE: Well, let me interpose an objection to what I anticipate to be a whole line of questioning in terms of this doctor kind of critiquing the occupational therapist or in, any way event, Dr. Deutsch. I think -- and if you'll grant me a continuing objection, I'll just be able to do this and then shut up.

MR. KEENAN: Fine.

MR. DAVIE: But I think it's inproper, A, to spring this life care plan on him and just ask him to critique it off the top of his head. And secondly, I'm not sure that a pediatric neurologist is the appropriate fellow to be asking the questions about, you know, Dr. Deutsch's work.

MR. KEENAN: Well, let me just --

MR. WILLIAMS: Join in that objection, and also object to the form of the question and continuing ones if you'll give me the same.

MR. WAXMAN: And I join in all those objections and add that it may be speculative ana outside this

witness' expertise.

MR. KEENAN: Fine. I'm sure the court reporter joins in the objections, too, in that it's 4:10, but let me ask you this, Roland. If you tell me that this doctor will *not* take the witness stand at trial and opine as to the specific evaluative needs, hone improvement needs, therapy needs, then I won't ask him any questions about the reasonability of this life care plan.

If, on the other hand, he is going to testify further in addition to his estimate of life expectancy, as to the reasonability of timing of evaluations, rendering of medical services, home improvements, respite care, then I'm entitled to ask him the questions.

MR. WILLIAMS: Can we take a stretch, and let me talk to him a minute about that, and I'll come back and give you an answer.

MR. KEENAN: Sure. Your answer nay mean about 45 minutes.

(Discussion off record and recess)

Q Doctor, we've had a brief discussion off the record which I hope -- and your counsel hopes -- will expedite the questioning regarding ***your*** opinions about the life care needs of this child. And recognizing that that

exhibit sets forth time requirements beyond 10 and 20 years, obviously you disagree with the continuation of those services that may be legitimate between now and age ten, but in your opinion will not continue beyond the 20-year period; is that correct?

A That's correct.

Q And in looking over the life care plan, you have specifically pointed out to ne two areas where you disagree that any effort and expense should be given. And that is speech therapy and occupational therapy.

A Up to a certain point, okay, and I'll clarify that for you.

Q Okay. Before you do that, are there any others that are set forth in that exhibit which you disagree with?

A Well, psychological evaluation. Gnce a certain level of psychological testing is established, then it is only redundant and unnecessary to put a child through repeated testing, you know, when an IQ has already been established.

Q And now I've got no speech therapy, no occupational therapy, no psychological testing beyond certain points.

A Yes, beyond certain points.

Q Are there any others that fall in the catagory of your disagreement that we need to talk about because,

otherwise, we're going to go back and talk about those three areas.

A No, I don't think so.

Q Do you agree with the home improvements needs?

A Which? What about the home improvement needs?

Q That's an indication -- and I want to make sure you're not agreeing to something that you don't want to agree to -- architectural renovations, which I believe would almost be the last page, Doctor, indicating ramping, floor coloring. Do you agree, disagree or don't have an opinion?

A I don't have an opinion on that.

Q What about the transportation as set forth in A-15, being a van?

A Well, again, I would think that the child will have to be transported. If the child increases significantly in size, will require a wheelchair and will require transportation, yes,

Q So you do have an opinion that those figures are reasonable, in your opinion?

A Well, I don't know about the -- you know, I don't know what vans cost, but I'm just telling you --

Q Aside from the cost?

A Yes.

Q Surgical intervention, which is A-14, the heel cord lengthening and the back fusion?

A In the first place, I think back fusion is going to be unnecessary. Heel cord lengthening, the child will need, but again, that would only be as a last resort, because this child will never be ambulatory. And there's no sense putting a child through, you know, a painful procedure when it is not going to make any difference in the child's function.

Now, if it makes a difference in whether the child can sit into the wheelchair and making the degree -- the feet at 90 degrees without posterior splints, then I would agree with it. But again, that's something that has to be assessed.

But I see no reason for a back fusion when there's scoliosis. And there's no evidence of scoliosis at the present tine, The child will never be ambulatory.

Q And what was your comment about the heel cord lengthening?

A Again, the way we approach this situation is that we do it only as a benefit to the child in a seating position. If the feet are painful and not able to be put in an appropriate position with posterior splinting, then I don't think it's unreasonable to do a heel cord lengthening. It's not going to change the overall function of the child; it's for comfort.

Q If you will turn to page A-4, Doctor. Those are a

series of recommendations regarding wheelchairs and travel chairs,

A I don't have any problem with those.

Q Now, as I understand the therapy and evaluations, aside from your objection that some will last beyond 20 years, and you obviously object to that because of the life expectancy, you specifically object to certain of the recommendations regarding speech, occupation and psychological testing?

A Yes.

Q And that encompasses your objections which we'll talk about. That's a complete list?

A That's correct.

Q If you care, Doctor, narrate then your concerns and objections regarding those three areas,

A Okay, once a child has established a psychological profile and it's repeated on a several-year basis, it doesn't change. And if a child's IQ is 20 and it rennins 20 for three years, there's absolutely no benefit to continue to test a child by psychometric testing.

In terns of occupational therapy, as I understand occupational therapy, they deal with the upper extremities, and in future planning, job training, et cetera. Well, this child is not going to be employable. This child is not going to be educable.

And this child is going to have extremely limited use, if any, of the hands. As the mother says, the child can't use the hands now and is not going to be able to. So I find it useless to waste the mother's time, the child's time when it can be used for other things that would be more gratifying and more stimulating for the child than occupational therapy.

In terms of speech therapy, once a child reaches seven to eight years of age and has not achieved speech, then speech therapy on a continuing basis also makes no sense.

Q Is that it?

A That's it.

Q Assuming, Doctor, that the mother is unable to care for the child by sickness or death, describe for me, if you will, if you have an opinion, of what type of institution should care for this child, assuming that there are other family members not able to assume the care of the child.

A It would have to be a facility that would meet the child's needs at that time. And I can't tell what they are. If they are similar to what it is now, it's going to be a chronic care facility that can deal with a child that has microcephaly, spastic quadriparesis, and a seizure disorder.

Q Would your opinion about the life expectancy of

this child change assuming immediate institutionalization?

A No.

Q The family setting as opposed to institutionalization would have no difference in terms of life expectancy?

A It depends on who you read. Some people feel that when a child is institutionalized, their life expectancy is shorter because they tend not to get as close an observation, as close a care as they would with individuals who are with them constantly and have a greater interest in their well-being.

Q Doctor, what is the level of this child's cognition regarding its own situation? And maybe that's an inartfuf question, but does it realize its circumstances?

A You know, again, I did not do any psychological assessment. In my opinion bassd on seeing children like Latoya, that she is not cognizant of her disability.

Q Do you hold that as an opinion within a reasonable degree of medical certainty or do you need to study that further?

A No, I think that's within a reasonable degree of medical probability.

Q When were her first seizures recorded?

A I'd have to go back and look at that. I just don't know.

Q Were they within the first several days, within the first day?

A NO.

Q Before the 24th?

A Again, I'm -- you know, I'm just -- I'll have to go back and look. I'm not trying to be evasive. I just don't remember right now.

Q Prior to your testimony today, how many hours do you believe you had in the case?

A Oh, approximately 10 to 12 hours.

Q What is your fee -- deposition fee is 250 an hour?

A Yes.

Q What is your fee for reviewing?

A $125.

Q What is your fee now for courtroom testinony?

A It is $208 an hour during the tine if testifying and the tine of traveling. I don't charge for sleeping and eating and other needs.

Q What is that --

A It encompasses an eight-hour day.

Q What I'm asking you, assume that you come over to Jacksonville on an afternoon flight, you spend the evening, and you testify later on in that afternoon. What's the charge for all of that?

A Probably $1,500.

Q Other than the CAT scans that you'll review, are you planning on doing any other additional reviewing?

A There's no way to tell. You know, if there's more information -- obviously there's other depositions, I'll read them. And obviously, there's certain records which I've not reviewed, and I'm going to review those.

Q Doctor, I believe you told me last year that you had never been a defendant in a medical negligence suit, is that correct?

A That's correct.

Q Hopefully that is true today?

A So far. I haven't checked the mail today.

MR. KEENAN: As strange as it might seem, I'm done.

MR. WAXMAN: No questions.

MR. WILLIAMS: One thing I'd like to do is, out of this book that we were referring to, just make a copy of this page that we were reading from, which is 207 and 208, I think.

MR. KEENAN: We'll just make that Plaintiff's 4.

(Plaintiff's Exhibit No. 4 was marked for identification.)

(Witness excused)

(The deposition was concluded at 4:35 p.m.)

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C E R T I F I C A T E

STATE QF FLORIDA)
)
COUNTY OF DUVAL)

I, Sandra Crowley, CSR, Registered Professional Reporter-CM, and Notary Public in and for the State of Florida at Large, hereby certify that I reported in shorthand the foregoing deposition at the time and place indicated herein, and that the preceding pages are a true and correct transcription of my stenotype notes of said deposition.

I further certify that I am neither of counsel nor attorney to either of the parties in said cause, nor interested in the event of said cause.

I further certify that after the said depsition has been submitted to the witness for signature, the original thereof will be delivered to Don Keenan, Esquire, attorney for piaintiffs, for filing with the court or his safekeeping.

WITNESS my hand and official seal in the City of Jacksonville, Duval County, Florida, this 13th day of June 1987.

Sandra Crowley, CSR, RPR-CM
Notary Public, State of Florida
at Large. My commission expires
September 2, 1988.

ACCURATE REPORTING SERVICE
OF JACKSONVILLE
501 West Bay Street, Suite 25C
Jacksonville, FL 32202 (904-355-8416)

ERRATA SHEET

This is to certify that I, Elias George Chalhub, M.D., have read the foregoing transcription of my testimony, pages 1 through 120, inclusive, given on 120, and find the same to be a true and correct transcription of said testimony with the following exceptions (if any):

Page	Line	Where it reads	Should read

Sworn to and subscribed before me this ____ day of _____, 19a7.

_____ Notary Public, State of Florida at Large. My commission expires _____.

_____ Elias G. Chalhub, M.D.

CURRICULUM VITAE
ELIAS G. CHALHUB, M.D.

DATE AND PLACE OF BIRTH: July 12, 1943 Boston, Massachusetts

CITIZENSHIP: United States

MARITAL STATUS: Harried, Wanda Dianne (July 16, 1945)

CHILDREN: Elias George Chalhub, III (February 19, 1971)
Erin Elizabeth Chalhub (February 10, 1976)

EDUCATXON: 1965 - B.A. - Emory University, Atlanta Georgia

1969 - M.D. - Emory University, Atlanta Georgia

TRAINING: 1969–79 Intern, North Carolina Memorial Hospital, University of North Carolina

1970–72 Staff Association, United States Public Health Service, National Institute of Allergy and Infectious Disease, Section of Virology and Immunology

1972–73 NINDS Special Fellow in Pediatrics, Washington University School of Medicine, St. Louis Children's Hospital

1973–74 NINPS Specie,,: Fellow in Fediatrics, NINDS Special Fellow in Clinical Neurology, Washington University School of Medicine, Barnes Hospital, St. Louis Children's Hospital

1974–76 NINDS Special Fellow in Fediatrics, NINDS Special Fellow In Child Neurology, Washington University School of Medicine, St. Louis Children's Hospital

MILITARY SERVICE: July, 1970–72 Surgeon, United States Public Health Service

July, 1970–72 National Institute of Allergy and Infectious Disease

July 1972 Inactive Reserves, United States Public Health Service

LICENSURE: Arkansas -#R-2389; Florida #15739; Missouri - #R4625; Georgia- Current; Alabama - #8386

PLAINTIFF'S EXHIBIT
1 5/29/87

CURRICULUM VITAE
ELIAS G. CHALHUB, M.D.

SOCIETY MEMBERSHIPS:

Member, American Medical Association
Member, American Academy of Pediatrics
Member, American Academy of Neurology
Member, Child Neurology Society
Member, Liaison to the American Academy of Pediatrics
Member, Southern Child Neurology Society
Member, Southern Society for Pediatric Research
Member, Southern EEG Society
Member, American Association on Mental Deficiency
Member, American Epilepsy Association
Member, Central Society for Neurologic Research
Member, Medical Society of Mobile County
Member, Muscular Dystrophy Association
Member, National Association for Retarded Citizens
Member, Professor of Child Neurology

BOARD CERTIFICATION:

National Board of Medical Examiners, *1972* #105238

Diplomate, American Board of Pediatrics May, 1976

Diplomate, American Board of Psychiatry and Neurology with Special Competence in Child Neurology, 1977

APPOINTMENTS:

1976–78 Associate Professor of Pediatrics, Neurology, University of Arkansas Little Rock, Arkansas

1976–78 Head, Division of Child Neurology Department, Fediatrics, University of Arkansas, Little Rock, Arkansas

1976–78 Medical Director, Arkansas Children's Colony

1976–78 Neurologic Consultant to the National Toxicological Research Center

1976–78 Medical Director, Handicapped Children's Center, State Health Department, Little Rock, Arkansas

1976–78 Director, Developmental Disabilities Center, Arkansas Children's Hospital

1977–78 Vice-Chairman, Medical Section

Arkansas Chapter of American Association on Mental Deficiency

1978- Chairman, Research Committee for Arkansas Association for Retarded Citizens

1978- Advisory Committee for University of Arkansas Multidisciplinary Rehabilitation

1978- Associate Professor of Neurology Head of Child Neurology, University of South Alabama, Mobile, Alabama

1978-Co-Director, Muscular Dystrophy Clinic, Mobile, Alabama

1979- Member, Board of: Advisors, Mobile Association far Retarded Citizens, Mobile, Alabama

1978- Consultant, Crippled Childrens Service, Mobile, Alabama

1979-80 Member, Utilization Review Committee, University of South Alabama, Mobile, Alabama

1978- Consultant - Albert P. Brewer Developmental Center, Mobile, Alabama

1979-82 Member, Admissions Committee University of South Alabama College of Medicine

1980-82 Member, Scientific Advisor, Mobile Junior League

1980-83 Director, Rotary Child Study Center

1980-83 Director, Multidiscipline Assessment Clinic, Crippled Children's Clinic, Mobile, Alabama

1981-62 Member of Executive Committee of Providence Hospital

1981-83 Member, Board of Advisors, Oakhill Baptist School

1981-83 Chairman, Intensive Care Committee, Providence Hospital

1981–83 Member, Pediatric Intensive Care Committee, University of South Alabama Medical Center, Nobile, Alabama

1981–83 Member, board of Advisors, Epilepsy Chapter of Mobile

1981–83 Member, Rotary Rehabilitation Committee, Mobile Infirmary, Mobile Alabama

1984– Continuing Medical Education Committee of the Alabama Medical Association

1984–85 Board of Directors of the Old Dauphin Way Learning Disabilities School

1984–85 Chairman, Neurodiagnostics Committee, Providence Hospital

1984–85 Chairman, Neurodiagnostics Committee, Springhill Memorial Hospital

1986–Chairman, Fediatric Intensive Care Unit, Mobile Infirmary Medical Center

COMMUNITY ACTIVITIES:

1983–84 Member of the Rotary Club

1984 Program Chairman of the Rotary Club

1984–85 Board of the Directors of the Julius T. Wright Girls School

1984–85 Touchdown Club of Mobile

AWARDS:

1976–77 Teacher of the Year, University of Arkansas, Little Rock, Arkansas

1977–78 Teacher of the Year, University of Arkansas, Little Rack, Arkansas

1977–78 Appointed to the Carter Commission on Mental Health–Liaison Committee on Mental Retardation

1977–76 Chairman, Children's Mental Health and Handicapped Committee, American Academy of Pediatrics, Arkansas

PEER EXAMINATION:

1977–78 Peer Review Committee for Review of Research Efforts for the National Center for Toxicological Research

1979-80 Examiner in Adult Neurology, American Board of Psychiatry and Neurology, New Orleans, Louisiana

1980-81 Examiner in Adult and Child Neurology, American board of Psychiatry and Neurology., Atlanta., Georgia

1981-85 Examiner in Adult Neurology, American Board of Psychiatry and Neurology, Houston, Texas

NATIONAL COMMITTEES:

1980-81 Member, Section on Training in Child Neurology, Child Neurology Society

1981-82 Member, Developmental Disabilities Committec, Child Neurology Society

1982-83 Member, Membership Committee Child Neurology Society

1984-86 Section Chairman of Council on Continuing Medical Education, State of Alabama

GRANTS AND CONTRACTS:

1. Institutional Grant (326-77-250) $7,500, 1977-78. Study of Methods for Rapid Detection of Congenital Cytomegaloviral Infection. Principal Investigator: Lee Chalhub, M.D.

2. Developmental Disabilities Grant (#77-284) "The Establishment of a Diagnostic Evaluation Clinic for Neurologically, Develcpmentally, and Emotionally Handicapped Children," 1977-79, $25,000 awarded annually for 3 years. Principal Investigator: Lee Chalhub, MD

3. Developmental Disabilities Grant (#77-282) "The Establishment of Genetic Screening and Chromosomal Analysis for the State of Arkansas," 1977, $25,000 awarded annually for 3 years. Principal Investigator: Florence Char, M.D. Co-Investigator: Lee Chalhub, M.D.

4. Department of Mental Retardation-Development Disabilities Purchase of Service Contract for "Disgnostic Evaluation of Retarded Children," 1977-78, $75,000, Program Director: Chalhub, M.D.

1979-80 Examiner in Adult Neurology, American **Board** of Fsychiatry and Neurology, New Orleans, Louisiana

1980-81 Examiner in Adult and Child Neurology, American **Board** of Psychiatry and Neurology, Atlanta, Georgia

1981-85 Examiner in Adult Neurology, American **Board** of Psychiatry and Neurology, Houston, Texas

NATIONAL COMMITTEES:

1980-81 Member, Section on Training. in Chi1d Neurology, Chi1d Neurology Society

1981-82 Member, Developmental Dis-abi1ities Committec, Child Neurology Society

1982-83 Member, Membership Committee Child Neurology Society

1984-86 Section Chairman of Council on Continuing Medical Education, State of Alabama

GRANTS AND CONTRACTS:

1. Institutional Grant 1326-717-250) $7,500, 1977-78. Study of Methods for Rapid Detection of Congenital Cytomega-loviral Infection. Principal Investi-gator: **Lee** Chalhub, M.D.

2. Developmental Disabilities Grant (#77-284) "The Establishment of a Diagnostic Evaluation Clinic for Neuro-logically, Developmentally, and Emotion-ally Handicapped Children," 1977-79, $25,000 awarded annually for 3 years. Principal Investigator: Lee Chalhub, MD

3. Developmental Disabilities Grant (#77-282) "The Establishment of Genetic Screening and Chromosomal Analysis for the State *of* Arkansas," 1977, $25,000 awarded annually for *3* yea-s. Principal Investigator: Florence Char, M.D. Co-Investigator: Lee Chalhub, M.D.

4. Department of Mental Retardation-Development Disabilities Furrhase of Service Contract for "Disgnostic Evaluation of Petardea Children," 1977-78, $75,000, Program Director: Chalhub, M. D.

CURRICULUM VITAE

ELIAS G. CHALHUB, M.D.

PUPLICATIRNS

1. Murphy, B.M., Chalhub; E.G., Chanock, R.M.:. Temperature Sensitive Mutants of Influenza **Virus;**, II. JOURNAL **OF** INFECTIOUS DISEASES, Vol. 126: 170, 1972.

2. Murphy, **B.M.**, Chalhub, E.G., Nusinoff, S.R., Kasel, J. & Chanock, RM: Temperature Sensitive Mutants of Influenza Virus. III. Further Characterization of the ts-1 (E) Influenza A Recombinant (H3N2) Virus in Man. JOURNAL OF INFECTIOUS DISEASES, **Val,** 128:479, 1973.

3. Murphy, B.M., Baron, S., Chalhub, E.G., Uhlendorf, C., Chanock, R.M.: Temperature Sensitive Mutants of Influenza Virus. IV. Induction of Interferon in the Nasopharynx of Wild-Type and a Temperature Sensitive Recombinant Virus. JOURNAL OF INFECTIOUS DISEASES, Val. 128:488, 1973.

4. Murphy, **E.M.**, Richmond, D.R., Chalhub, E.E., Uhlendorf, C.P., Baron, S.B., Chanock, R.M.: Failure of Attenuated Temperature Sensitive Influenza A (H3N2) Virus to Induce ~~Heterologous~~ Interference in Man to Parainfluenza Type I. INFECTION AND IMMUNITY, pp. 62-68, 1975.

5. Chalhub, E.G., Volpe, J., Gado, M.: Linear Nevus Sebaceous Syndrome Associated with Porencephaly and Nonfunctioning Major Cerebral Venous Sinuses. NEUROLOGY, Vol. 25:857-860, 1975.

6. Chalhub, E.G., DeVivo, D.C.: Diphenylhydantoin Induced Dystonia and Choreoathetosis in Two Retarded Epileptic Children. NEUROLOGY, Vol. 26:494, 1976.

7. Barton, L.B., and Chalhub, E.G.: Myositis Associated with Influenza A Infection. J PEDIATRICS, Vol. 87:1003, 1976.

8. Chalhub, E.G.: Neurocutaneous Syndromes in Children. PEDIATRIC CLINICS OF NORTH AMERICA, Vol. 23:499, 1976.

9. Chalhub, E.G., DeVivo, D.C.: Phenytoin Induced Choreoathetosis. J PEDIATRICS, Vol. 89:153, 1976.

10. Chalhub, E.G., and Nelson, J.S.: Cytomegalovirus Infection of the Newborn: Its Relationship to Congenital Malformation of Developing Brain. NEUROLOGY, Vol. 90, 1977.

11. Chalhub, E.G.: IN VITRO and IN VIVO Induced Hypoglycorrhachia in the Rabbit with Diplococcus Pneumonia. NEUROLOGY 1969.

12. Chalhub, E.G., DeVivo, D.C.: Porencephaly Associated with Coxsackie A9 Infection in the Neonate. NEUROLOGY, Vol. 27: 574, 1977.

6 Chalhub, **E.G.**, Boenzinger, **J.**, Feigin, R.D., Middlekamp, J.N., and Shackelford, G.D.: Congenital Herpes Simplex Type II Infection with Extensive Hepatic Calcification. DEVELOPMENTAL MEDICINE AND CHILD NEUROLOGY, **Vol.** 19:527, 1977.

14. Baker, S.J.; Chalhub, E.G., Shackelford, P.: Group B Streptococcal Ventriculitis. PEDIATRICS, 1979.

15. Chalhub, E.G.: Treatment of Bacterial Meningitis with Intravenous Amoxicillin. PEDIATRIC NEWS, **December** 1975.

16. Chalhub, **E.G.**, Rappin, I: Neurocutaneous Syndromes. PEDIATRICS, Rudollp. A.M., **Ed.**, Appleton, **Century**, Crofts, 1982.

17. Chalhub, **E.G.**: Centrofacial Lentigenosis. HANDBOOK OF CLINICAL NEUROLOGY, Vol. 3:26-27, 1981.

18. Chalhub, **E.** G. : Klippel-Trenaunay-Weber syndrome. HANDBOOK OF CLINICAL NEUROLOGY, Vol. 43:24-26, 1981.

19. Chalhub, E. G.: Maffucci-Kast Syndrome. HANDBOOK OF CLINICAL NEUROLOGY, Vol. 43:29-30, 1981.

20. Chalhub, E.G.: Chediak-Higashi Syndrome. HANDBOOK OF CLINICAL NEUROLOGY, Vol. 43, 1981.

21. Chalhub, E.G.: Neurocutaneous Melanosis. HANDBOOK OF CLINICAL NEUROLOGY, Vol. 43:33-34, **1981.**

22. Chalhub, E.G.: Reye's Syndrome Complicated by a Generalized Herpes Simplex Type I Infection. J PEDIATRICS, Vol. 98, No. 1:73, 1981.

23. Chalhub, E. G. : Peutz-Jeghers Syndrome. HANDBOOK OF CLINICAL NEUROLOGY, Vol. 43:41-42, 1981.

24. Chalhub, E.G.: Treatment of Bacterial Meningitis. MANUAL OF NEUROLOGICAL PROBLEMS, Little Brown **and** Company In Press.

25. Chalhub, E.G. : Viral Meningitis. MANUAL OF NEUROLOGICAL PROBLEMS, Little brown **and** Company. In Press.

26. **Williams, J; Powell,** Blalock, C.P., Dunaway, C.L., Chalhub, E.G. : Schizencephaly. In **Fress.** CT, JOURNAL OF COMPUTER TOMOGRAPHY, 1983.

27. Chalhub, E.G.: Cerebral Fatsy: An Obstetrical Disease. Submitted to AMERICAN JCURNAL OF OBSTETRICS & GYNECOLOGY 1985. In **Press,**

28. Peavey, K., Chalhub, E.G.: Group B Streptococcal Infection An Important Cause of Intrauterine Asphyxia. Submitted to AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY, 1983.

29. Chalhub, E.G.: Choreoathetosis and Dystonia Related to Tegretol Overdose. Submitted to J PEDIATRICS, In Press.

30. Chalhub, E.G.: Coxsackie A21 Neonatal Infection. Submitted to PEDIATRICS. In Press,

BOOK REVIEWS

1. Chalhub, E.G.: VIRAL DISEASES OF THE CENTRAL NERVOUS SYSTEM. Edited by L.S. Illis, 1975, Baltimore, Williams and Wilkins, NEUROLOGY, Vol. 26:903, 1976.

ABSTRACTS

1. Chalhub, E.G.: In Vitro and In Vivo Induced Hypoglycorrhachia in the Rabbit with Diplococcus Pneumonia. Presented at the 20th Annual Meeting of the American Academy of Neurology, Washington, D.C., 1969.

2. Selker, R. & Chalhub, E.G.: Mental Development in Hydrocephalics: Effect of "Elapsed Time" Between Meningocele Repair and Shunt. American Association of Neurological Surgeons, April 1970.

3. Chalhub, E.G., & DeVivo, D.C.: Diphenylhydantoin Induced Choreoathetosis and Dystonia in Two Retarded Epileptic Children. Presented at the 26th Annual Meeting of the American Academy of Neurology, Miami, Florida, 1975.

4. Chalhub, E.G., & DeVivo, D.C.: Coxsackie A9 Infection Associated with the H-E- Syndrome and Porencephaly. Presented at the Child Neurology Society meeting, Monterey, California, October 1976.

5. Chalhub, E.G., & Arrington, R.W.: Neonatal Hypoxic Brain Injury Associated with Nuchal Cord Encirclement. Southern Society for Pediatric Research, New Orleans, Louisiana, February 1976.

6. Chalhub, E.G. & Nelson, J.S.: Congenital Malformation of the Human Central Nervous System Associated with Cytomegaloviral Infection. Child Neurology Society, October 1977.

7. Hill, D.E., Schedewie, H., Chalhub, E.G., Boughter, M., Sziszak, T.: Evidence for the Transthecal Transfer of Insulin in Subhuman Primates. Canadian Pediatric Society June 1977.

8. Morrissy, R.T., Chalhub, E.G.: Myotonic Dystrophy: Caution for the Orthopaedist. Presented to the American Academy of Orthopaedics, 1976.

9. Chalhub, E.G., Collie, W., Goka, T., Howell, R.: Progressive Neurologic Disease Associated with Hypercupremia: A New Copper Metabolic Defect? Presented to the Child Neurology Society, 1977-78.

10. Baker, J.S.; Chalhub, E.G., & Shackelford, F.: Group B Ventriculitis. Society for Pediatric Research, 48th Annual Meeting, New York, 1981.

11. Chalhub, E.G., & Tamauchi, T.: Reye's syndrome: A Reasonable Approach. Southern Society for Pediatric Research, 1978.

12. Chalhub, E.G., Bornhofen, J.H., Char-, F., & Morrissy, R.A. : Congenital Fiber Type Disproportion, Mitral Valve Prolapse and the Williams "Elfin Facies" syndrome in a Family. Southern Society for Pediatric Research, Clinical Research, Val, 26:821A, 1978.

13. Chalhub, E.G., Bornhofen, J.H.: Congenital Fiber Type Disproportion Associated with Mitral Valve Prolapse and Idiopathic Hypercalcemia of Infancy. Southern Society of Child Neurology, 1977.

14. Eisenach, K., Chalhub, E.G., Yamauchi, T.: Countercurrent Immunoelectrophoresis: Laboratory and Clinical Corretation of Bacterial Meningitis in a Pediatric Population. Clinical Research, Val. 26:821A, 19713.

15. Chalhub, E.G., & Nelson, J.S.: Watershed Cerebral Infarction in Sickle Cell Anemia: A Pathologic and Clinical Description LE 16 Children. Southern Child Neurology Society, 1979.

16. Worsham, C., Chalhub, E.G., Wiseman, H., Silverboard, G.: Coxsackie Virus A21 Disseminated Neonatal Infection. Clinical Research, Vol. 28, 1980.

17. Chalhub, E.G.: Spinal Ependymoma in Childhood: Unusual Features. Clinical Research, Vol. 28, 1980.

CERTIFICATE OF SERVICE

This is to certify that I have served all parties to the above-styled case with a copy of the within and foregoing Supplemental Answers of Defendant, Alexander F. Saker, M.D., to Plaintiff's Interrogatories by causing copies of same to be hand delivered to counsel of record, as follows:

Don C. Keenan, Esq.
William J. Berg, Esq.
Keenan Building
148 Nassau Street
Atlanta, Georgia 30303

Robert G. Tanner, Esq.
Long, Weinberg, Ansley & Wheeler
2500 The Equitable Building
Atlanta, Georgia 30303

This 9th day of May, 1986.

George W. Hart
George W. Hart

For Your Information

BRENT M. TURBOW

ANDREW K. HODSON, M.D.
Child and Adult Neurology

BAPTIST MEDICAL PAVILION
SUITE 1207
820 PRUDENTIAL DRIVE
JACKSONVILLE. FLORIDA 32207
(904) 398-9501, 9502

1 April 1987

Brent Turbow
1050 First Union Bldg.
Jacksonville, Florida 32202

RE: LATOYA GREEN

Dear Mr. Turbow:

Latoya Green was brought to my office this morning by her mother for neurologic evaluation. My last contact with Latoya was in April of 1985, when I saw her at Nernours Children's Clinic. Since that time, Latoya has been followed at the Nemours Children's Clinic, Dr. David Bailey has been the primary physican following Eatoya through the CP clinic, Recently, because of reported staring episodes Latoya underwent an EEG, and was started her on Depakene liquid 5cc twice a day. Mrs. Green has been unable to successfully administer the medication, and she claims that Latoya takes approproximately half a teaspoon full a day, most of which she spits. Latoya has been followed by orthopedics at Nemours, and has recently had splints removed. Following the splinting procedure, she has developed a superficial skin ulser on the left anterior shin. Latoya attends the Ray Watson Center where she receives therapy. In addition, she attends physical therapy at Nemours on a twice weekly basis.

There is no family history of inherited neurologic disease. The parents are unrelated. Latoya has an older 14 year old sibling, who is apparently healthy. There has been no fetal loss. The pregnancy was unplanned. According to the mother, the expected date of delivery was the 20th of December. Latoya was born one month late by dates on the 20th of January. Latoya was born after approximately a 4 hour labor. There was evidence of fetal distress with meconium aspiration. We have no record of Apgar scores. She was transferred to the neonatal intensive care unit where she subsequently went on to develop seizure activity. After 4 weeks, she was transferred from University Hospital to St. Vincent's.

Developmentally, Latoya has been retarded throughout. She has never learned to sit unsupported. She has no independent reach or transfer. She cannot stand unsupported. Cognitively, she has developed no language skills. She may recognize certain faces, to which she responds by non-specific grinning. She can carry out some simple single step commands such as "raise your head", or "look at me". She is not toilet trained. She is unable to feed herself, and requires total care.

PLAINTIFF'S EXHIBIT 5/29/87 2

She was admitted to Nemours Hospital in 1984 under my care for treatment of pneumonia.

On examination today, Latoya was ***14.5*** kgs in weight, she was 97 cms in height, and her head circumference was 47 cms. These measurements are all below the 5th percentile for her age. She has no specific dysmorphic or cutaneous abnormalities. She was in regular sinus rhythm. Her blood pressure was 90/60 in the right arm. Her heart sounds were normal. She had no cranial or carotid bruits. Her chest was clear *to* auscultation. There was no organomegaly.

Cognitively, she was performing in the severe range of retardation. There was some degree of meaningful contact, and **as** described above she would respond to certain limited single step commands such as raising her head and making eye contact with her mother. She made no use of expressive language. She was unable to close her eyes on command. Her visual fields appeared to be intact to confrontation. She had full range of ocular movements without nystagmus. Her fundiscopic examination was normal. Facial movements were symmetric. She startled bilaterally to sound stimulation. She had exaggerated glabellar snout and jaw reflexes. There is a marked vestibular influence on body tone which was generally diminished. Her head control was poor. She sat when supported with a marked kyphotic posture. Deep tendon reflexes were symmetrically exaggerated. She had extensor plantar responses and intermittent clonus. Sensation could not be tested, and there was no clear cut ataxia.

Latoya has a non-progressive encephalopathy manifest by microcephaly, severe psychomotor retardation, spastic quadriparesis, and seizure disorder. It is my opinion that she will require constant custodial care. I believe that as long as she is provided with adequate standards of medical care, she will have a normal life expectancy. In **view** of her microcephaly and relative lack of development, I doubt that she will show any or minimal improvement in her cognitive skills. I doubt that she will ever develop language skills. In my opinion she will never achieve independent ambulation. As regards to her seizures, she will need constant medical supervision with a least six monthly visits for neurological assessment. At the present time, she is being followed through the Nemours Children's Clinic where she receives physical therapy. I believe that she should continue in her current setting at the Ray Watson Training Center.

Signed:

Andrew K. Hodson, M.D.
Child.Neurologist
AKH: gp wp395.0
cc:Nemours

AUL M. DEUTSCH & ASSOCIATES, INC.
:08 Hillcrest Street
O. Box 6933
rlando, Florida 32853
15) 898-7710

LIFE CARE PLAN

Projected Evaluations

A1

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

Evaluation	Age/Year ai Which Initiated	Age/Year at Which Suspended	Per Year Frequency	Base Cost Per Yeer	Growth Trend	Recommended By:
EHABILITATION PSYCHOLOGICAL VALUATION	4 4/1987	1 X ONLY	1 X ONLY	ALREADY ACCOMPLISHED	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D.
PHYSICAL THERAPY	4 4/1987	LIFE EXPECTANCY	1 X / YEAR	$50.00-$65.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D., BASED ON A REVIEW OF AVAILABLE MEDICALS
OCCUPATIONAL THERAPY	4 4/1987	21 2004	1 X / YEAR	$50.00-$65.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D., BASED ON A REVIEW OF AVAILABLE MEDICALS
SPEECH THERAPY	4 4/1987	21 2004	1 X / YEAR	$50.00-$65.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D., BASED ON A REVIEW OF AVAILABLE MEDICALS

PLAINTIFF'S EXHIBIT

AUL M. DEUTSCH & ASSOCIATES, INC.
:08Hillcrest Street
3. Box 6933
:lando, Florida 32853
35) 898-7710

LIFE CARE PLAN

Projected Therapeutic Modalities

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

A2

Therapy	Age/Year at Which Initiated	AgelYear at Which Suspended	Frequency of Treatment	Base Cost Per Year	Growth Trend	Recommended By:
REHAB ILITATION PSYCHOLOGY/ HAB ILITATION TEAM LEADER	4 4/1987	LIFE EXPECTANCY	THROUGHOUT THE YEAR AS NECESSARY FOR1 YEAR; THEREAFTER AVAILADLEAS A RESOURCE PERSON	$2,500.00-$3,000.00 FOR 1 YEAR; THEN $400.00-$600.00/ YEAR	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH,, PH.D.
PHYSICAL THERAPY	4 4/1987	21	1 X / WEEK TO SUPPLEMENT SCHOOL PROGRAM	$2,640.00 TO SUPPLEMENT SCHOOL PROGRAM WITH ATTENDANT PROVIDING FOLLOW-UP PHYSICAI THERAPY @ HOME TO SUPPLEMENT PROGRAM	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D., BASED ON A REVIEW OF AVAILABLE MEDICALS
OCCUPATIONAL THERAPY	4 4/1987	21 2004	1 X / WEEK TO SUPPLEMENT SCHOOL PROGRAM	$2,640.00 TO SUPPLEMENT SCHOOL PROGRAM WITH ATTENDANT PROVIDING FOLLOW-UP PHYSICAL THERAPY @ HOME TO SUPPLEMENT PROGRAM	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCW, PH.D.,BASED ON A REVIEW OF AVAILABLE MEDICALS
SPEECH THERAPY	4 4/1987	21 2004	3 X / WEEK NOW TO SUPPLEMENT PRESCHOOL PROGRAM ;THEN 2 X / WEEK @ AGE 5 TO SUPPLEMENT PUBLIC SCHOOL PROGRAM	$8,784.00 FOR 1 YEAR; THEN $5,856.00 /YEAR ONCE PUBLIC SCHOOL PROGRAM IS UEGUM	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D.,BASED ON A REVIEW OF AVAILABLE MEDICALS
PARENT EDUCATION AND TRAINING IN STIMULATION AND DISABILITY MANAGEMENT	4 4/1987	19 2002	2 X / MONTH FOR 3 MONTHS @ AGES 4, 7, 10, 13, 16, AND 19	$420.00-$540.00 @ AGES 4, 7, 10, 13, 16 & 19	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D.

AUL M. DEUTSCH a ASSOCIATES, INC.
208 Hillcrest Street
.O. Box 6933
rlando, Florida 32853
05) 898-7710

LIFE CARE PLAN

Diagnostic Testing/ Educational Assessment

A3

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Date Prepared: 4/24/87

Diagnostic/ Development Recommendations	Age/Year at Which Program Initiated	Age/Year at Which Program Suspended	Frequency per Year of Intervention	Base Cost Per Year	Growth Trend	Recommended By:
EDUCATIONAL TESTING (FOR USE BY THE SUPPLEMENTAL THERAPISTS)	5 9/1988	21 2004	1 X / YEAR	$250.00-$350.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D.
SPECIAL EDUCATION PROGRAM	5 9/1988	21 2004	DAILY-- EDUCATIONAL PROGRAM	COSTS COVERED UNDER PL94-142; WITH APPROPRIATE SUPPLEMENTS AS OUTLINED IN THERAPIES	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D.

PAUL M. DEUTSCH & ASSOCIATES, INC.
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LIFE CARE PLAN

Wheelchair Needs

A4

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

Wheelchair Type	Age/Year at Which Purchased	Replacement Schedule	Purpose of Equipment	Base Cost	Growth Trend	Catalogue or Supplier Reference
ORTHO KINETICS TRAVEL CHAIR	4 4/1987	1 X ONLY	ADAPTIVE WHEELCHAIR, STROLLER AND CAR SEAT	$975.00-$1,275.00	TO BE DETERMINED BY ECONOMIST	ORTHO KINETICS
ORTHO KINETICS CARE CHAIR III	9 1992	2 X ONLY	ADAPTIVE WHEELCHAIR	$1,275.00-$1,575.00	TO BE DETERMINED BY ECONOMIST	ORTHO KINETICS
EVEREST AND JENNINGS SEATING AND POSTURING SYSTEM	18 2001	1 X / 7 YEARS TO LIFE EXPECTANCY	ADAPTIVE SEATING SYSTEM	$1,823.00-$2,300.00	TO BE DETERMINED BY ECONOMIST	EVEREST AND JENNINGS

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LIFE CARE PLAN

Wheelchair Accessories and Maintenance

Name; LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

A5

Wheelchair Accessory	Age/Year at Which Purchased	Replacement Schedule	Purpose of Equipment	Base Cost	Growlh Trend	Calalogue or Suppller Reference
MAINTENANCE:						
ORTHO KINETICS TRAVEL CHAIR	5 1988	1 X / YEAR	MAINTAIN EQUIPMENT	$90.00-$100.00/ YEAR	TO BE DETERMINED BY ECONOMIST	LOCAL SUPPLIER
ORTHO KINETICS CARE CHAIR III	10 1993	1 X / YEAR	MAINTAIN EQUIPMENT	$120.00-$150.00/ YEAR	TO BE DETERMINED BY ECONOMIST	LOCAL SUPPLIER
EVEREST AND JENNINGS SEATING AND POSTURING SYSTEM	19 2002	1 X / YEAR	MAINTAIN EQUIPMENT	$180.00-$230.00/ YEAR	TO BE DETERMINED BY ECONOMIST	LOCAL SUPPLIER
WHEELCHAIR CUSHION	4 4/1987	1 X / 2-3 YEARS	SEATING AND POSITIONING AID	$120.00-$150.00/ 2-3 YEARS	TO BE DETERMINED BY ECONOMIST	LOCAL SUPPLIER

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LIFE CARE PLAN

Orthopedic Equipment Needs

A6

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

Equipment	Age/Year of Purchase	Replacement Schedule	Purpose of Equipment	Base Cost	Growth Trend	Catalogue or Supplier Reference
TUMBLE FORMS JEDGE 5" X 24" X 28"	4 4/1987	1 X ONLY	AID IN GROSS MOTOR ACTIVITIES	$100.00	TO BE DETERMINED BY ECONOMIST	PRESTON, INC.
SIDE LYING POSITIONER	4 4/1987	1 X ONLY	POSITIONER AND THERAPY AID	$167.00	TO BE DETERMINED BY ECONOMIST	PRESTON, INC.
ADOLESCENT SIDE LYING POSITIONER	10 1993	1 X ONLY	POSITIONER AND THERAPY AID	$225.00	TO BE DETERMINED BY ECONOMIST	PRESTON, INC.
TUMBLE FORMS FEEDER SEAT WITH FLOOR SITTER WEDGE (MEDIUM)	4 4/1987	1 X ONLY	FEEDING SEAT AND POSITIONING AID	$177.00	TO BE DETERMINED BY ECONOMIST	PRESTON, INC.
TUMBLE FORMS FEEDER SEAT WITH FLOOR SITTER WEDGE (LARGE)	11 1994	1 X ONLY	FEEDING SEAT AND POSITIONING AID	$246.00	TO BE DETERMINED BY ECONOMIST	PRESTON, INC.

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LIFE CARE PLAN

Orthopedic Equipment Needs

A7

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/74/87

Equlpment	Age/Year of Purchase	Replacement Schedule	Purpose of Equlpment	Base Cost	Growth Trend	Catalogue or Suppller Reference
ADAPTIVE STANDER WITH TRAY AND ABDUCTOR PAD	4 4/1987	1 X ONLY	AIDS MUSCLE TONE AND SKELETAL DEVELOPMENT	$765.00	TO BE DETERMINED BY ECONOMIST	ORTHO KINETICS

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LIFE CARE PLAN

Orthotics/Prosthetics

A8

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Date Prepared: 4/24/87

Equipment Description	Age/Year of Purchase	Replacement Schedule	Base Cost	Growth Trend	Recommended By:	Other
AFO'S (BILATERAL)	4 4/1987	1 X / 12-18 MONTHS TO AGE 18	$250.00-$350.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D.,BASED ON A REVIEW OF AVAIL-ABLE MEDICALS AND PAHENT INTERVIEW	

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LIFE CARE PLAN
Drug/Supply Needs

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

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Supply Description	Drugs (Prescription)	Purpose	Per Unit cost	Per Year cost	Growth Trend	Recommended By:
	ROUTINE PHARMACEUTICALS AS PRESCRIBED BY PHYSICIAN INCLUDING: COLACE; DEPAKENE; AND ANTIBIOTICS	ROUTINE CARE	———	$350.00-$450.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D., BASED ON A REVIEW OF AVAILABLE MEDICALS & FAMILY INTERVIEW
DIAPERS (NOW THROUGH AGE 12)	———	BOWEL AND BLADDER CARE	$20.00/WEEK	$1,040.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D., BASED ON A REVIEW OF AVAILABLE MEDICALS & FAMILY INTERVIEW
DEPENDS (ADULT DIAPERS)	———	BOWEL AND BLADDER CARE	$65.00/CASE OF 64	$1,473.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D., BASED ON A REVIEW OF AVAILABLE MEDICALS & FAMILY INTERVIEW

*A RANGE OF COSTS FOR PHARMACEUTICALS IS GIVEN DUE TO FLUCTUATION OF ANTIBIOTIC TREATMENT DUE TO RESPIRATORY INFECTIONS

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LIFE CARE PLAN

Aids for Independent Function

A9

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Date Prepared: 4/24/87

Equipment	Age/Year of Purchase	Replacement Schedule	Purpose of Equlprnent	Base Cost	Growlh Trend	Calalogue or Suppller Reference
LATOYA IS FUNCTIONING AT TOO LOW A LEVEL TO BENEFIT FROM ANY AIDS TO INDEPENOENT FUNCTION						

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LIFE CARE PLAN

Future Medical Care–Routine

A13

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

Routine Medical Care Description	Frequency of Visits	Purpose	Cost Per Visit	cost Per Year	Growth Trend	Recommended By:
NEUROLOGICAL EVALUATION	2 X / YEAR AS LONG AS ANTI-SEIZURE MEDICATIONS ARE UTILIZED	ASSESS NEUROLOGICAL CONDITION	$35.00-$45.00	$70.00-$90.00	TO BE DETERMINED BY ECONOMIST	DR. ANDREW HODSOB
ORTHOPEDIC EVALUATION	2 X / YEAR	ASSESS ORTHOPEDIC CONDITION	$30.00-$40.00	$60.00-$80.00	TO BE DETERMINED BY ECONOMIST	DR. ROBERT POHL
GENERAL MEDICAL	1 X / YEAR	ROUTINE CARE	$25.00-$30.00	$25.00-$30.00	TO BE DETERMINED BY ECONOMIST	PAUL M. DEUTSCH, PH.D.,BASED ON A REVIEW OF AVAILABLE MEDICALS

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LIFE CARE PLAN

Home Furnishings and Accessories

A10

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

Equlprnent	AgelYear of Purchase	Replacement Schedule	Purpose of Equipment	Base Cost	Growth Trend	Catalogue or Supplier Reference
TLC BATH SEAT (48"); (52"); AND (72")	4 (48") 411987 8 (52") 1991 12 (72") 1995	1 X ONLY 1 X ONLY 1 X ONLY	AID TO BATHING	48" $249.00 52" $279.00 72" $295.00	TO BE DETERMINED BY ECONOMIST	ORTHO KINETICS
ELECTRIC HOSPITAL BED WITH SIDE RAILS	7 1990	1 X / 10 YEARS	POSITIONING AND AN AID TO CARE	$1,950.00-$2,150.00	TO BE DETERMINED BY ECONOMIST	DETTMER MEDICAL
'SPACE SAVER MAT AND PLATFORM	4 4/1987	1 X / 10 YEARS	EXERCISE/ THERAPY AREA	$894.00	TO BE ~ETERMINED BY ECONOMIST	PRESTON, INC.

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LIFE CARE PLAN

Future Medical Care Surgical Intervention or Aggressive Treatment Plan

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

A14

Recommendallon (Deacription)	Age/Year Initiated	Frequency of Procedure	Per Procedure cost	Per Yeer *Cost*	Growth Trend	Recommended By:
HEEL CORD LENGTHENING PROCEDURE	4 1987 AND 9 1992 (ESTIMATION)	1 X NOW AND 1 X @ APPROXIMATELY AGE 9	$2,500.00- $3,500.00 (ESTIMATE)	$2,500.00- $3,500.00	TO BE DETERMINED BY ECONOMIST	DR. ROBERT POHL
BACK FUSION	AT APPROXIMATELY AGE 10-15 1993 - 1998	1 X ONLY	$3,500.00- $4,500.00 (ESTIMATE)	$3,500.00- $4,500.00	TO BE DETERMINED BY ECONOMIST	DR. ROBERT POHL

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LIFE CARE PLAN

Transportation

A15

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Date Prepared: 4/34/87

Equlpment Description	Age/Year of Purchase	Replacement Schedule	Purpose of Equlpment	Base Cost	Growth Trend	Catalogue or Suppller Reference
VAN WITH WHEEL-,CHAIR TIE DOWNS AND LIFT	4 4/1987	1 X / 5-7 YEARS*	TRANSPORTATION	$22,000.00-$24,000.00	TO BE DETERMINED BY ECONOMIST	DETTMER MEDICAL

"TRADE-IN VALUE TO BE DETERMINED BY ECONOMIST

FOR INFORMATION ONLY--NO PREDICTION OF FREQUENCY OF OCCURRENCE AVAIALBLE

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LIFE CARE PLAN

Potential Complications

A16

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

COMPLICATION	COST/COMPLICATION	GROWTH TREND
CONTRACTURE DEFORMITIES	$3,300.00-$6,600.00	TO BE DETERMINED BY ECONOMIST
RESPIRATORY COMPLICATIONS	$4,500.00-$6,600.00	TO BE DETERMINED BY ECONOMIST
RENAL COMPLICATIONS	$5,500.00-$8,800.00	TO BE DETERMINED BY ECONOMIST

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LIFE CARE PLAN

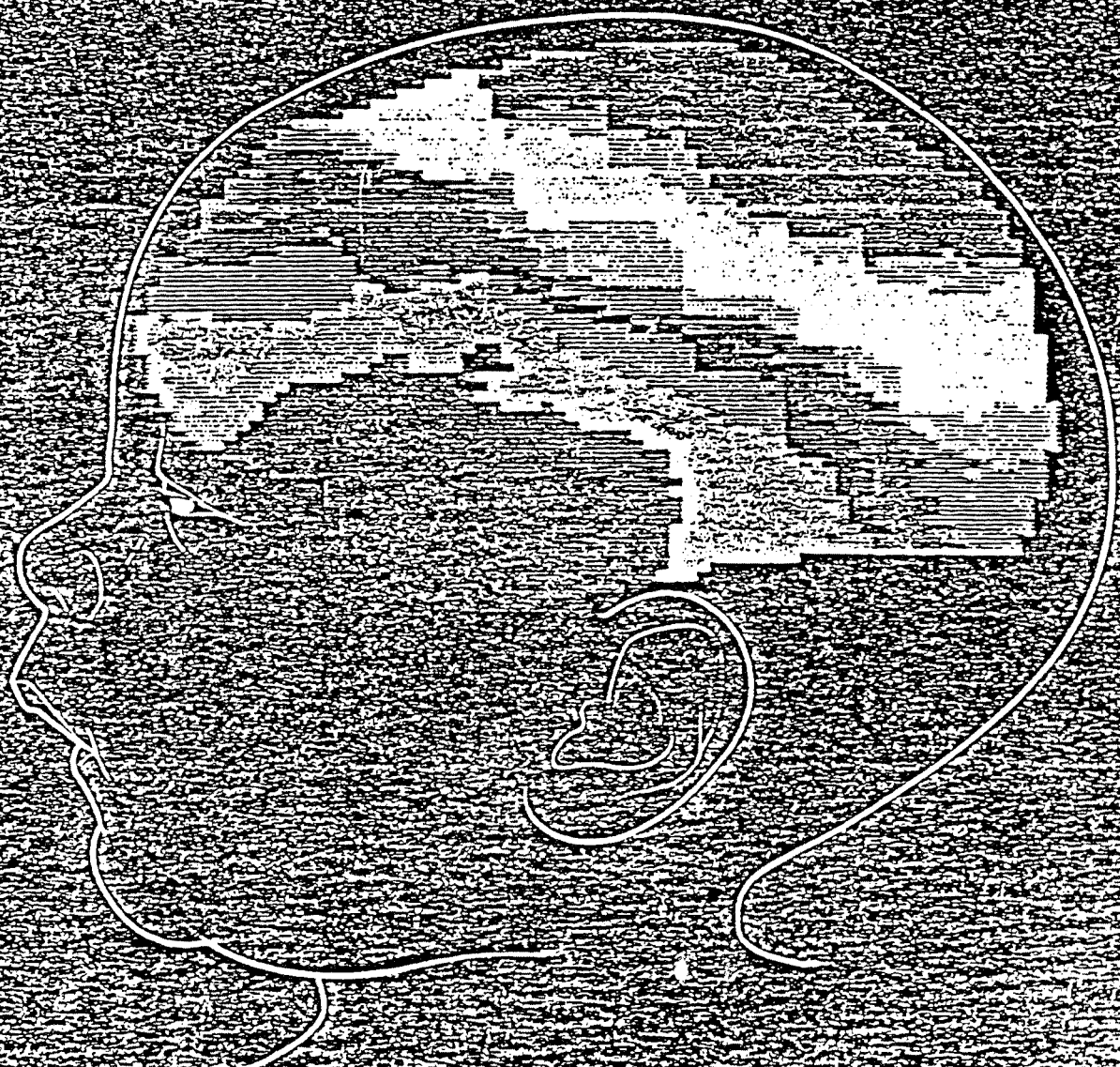
Architectural Renovations

A17

Name: LATOYA GREEN
DOB: 1/20/83
D/A: 1/20/83
Dale Prepared: 4/24/87

ACCESSIBILITY NEEDS		ACCESSIBILITY NEEDS		COSTS
RAMPING	X	BATHROOM:		IT IS ANTICIPATED THAT APPROXIMATELY $12,000.00-$18,000.00 IN RENOVATIONS WOULD NEED TO BE MADE.
LIGHT CONTROLS		SINK		
FLOOR COVERINGS	X	CABINETS		THIS IS A 1 X ONLY EXPENSE
HALLWAYS	X	ROLL-IN-SHOWER	X	
DOORWAYS	X	TEMPERATURE CONTROL GUARDS		GROWTH TREND TO BE DETERMINED BY ECONOMIST.
COVERED PARKING	X	HEATER		
		FIXTURES		IF AN ATTENDANT BEDROOM NEEDS TO BE ADDED, AN ADDITIONAL $7,000.00-$9,000.00 IN COSTS WILL BE REQUIRED.
KITCHEN:		DOOR HANDLES		
SINKS/FIXTURES		ADDITIONAL ELECTRICAL OUTLETS		
CABINETS		CENTRAL HEAT/AIR		
APPLIANCES		THERAPY/EQUIPMENT STORAGE ROOM	X	
WINDOWS		ATTENDANT BEDROOM		
ELECTRIC SAFETY DOORS		OTHER:		
FIRE ALARMS				
SMOKE DETECTORS	X			
INTERCOM SYSTEM	X			

Prenatal and Perinatal Factors Associated with Brain Disorders



PLAINTIFF'S EXHIBIT
4 5/29/87

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
National Institutes of Health

Heart Disease

Maternal heart disease, when symptomatic, jeopardizes fetal survival (51). In addition, there is an increased incidence of prematurity snd lower birth weight babies born at term to mother's with minimal heart disease (52). When the severity of maternal heart disease is improved by drugs or surgery, the fetal prognosis is greatly improved. Reduced fetal growth is especially pronounced in women with cyanotic heart disease (53). Reduced cardiac output resulting from heart disease during pregnancy reduces uterine blood flow and fetal oxygen supply.

Post-Term Pregnancy

The pregnancy lasting longer than 42 weeks is defined as post term. Attenpting to clarify the risk status of the post-term pregnancy, Browne (54) noted that the incidence of toxemia, poor fetal growth, fetal distress and perinatal mortality increased after 42 weeks, and that elective delivery reduced perinatal mortality. Subsequently, in a series of papers published by Beischer et al., low maternal urinary estriol vas significantly correlated with fetal distress during Labor, Oligohydramnios was correlated with degrees of severe placental insufficiency (55,56). Thus, an increased risk of neurologic morbidity probably occurs only in post-term pregnancies complicated by poor fetal growth and placental insufficiency. In the absente of intrauterine growth retardation, oligohydramnios and placental dysfunction, the post-term pregnancy could be considered at low risk for poor outcome. In recent years, perinatal mortality in carefully monitored post-term pregnancies approached zero (57,58).

Nicholas J. Eastman, in 1947, was the first to suggest that "only when the factors causing prematurity are clearly understood can any intelligent attempt at prevention be made (59)." Analyzing pre-term births at the Johns Hopkins Hospital between 1926 and 1945, he found low economic status, race, and poor prenatal care and nutrition associated vith pre-term deliveries.

Papiernik, in 1969, first reported a method of identifying risks for pre-term labor (60). Subsequently, Papiernik and Kaminski (37,61) showed that a multifunctional scheme provides a precise prediction tool for pre-term labor. They introduced the concept of risk assessment as new factors appear at subsequent stages of pregnancy to improve predictive power,

Using the British Perinatal Survey data base, Fedrick and Anderson identified several historic predictors of risk for pre-term labor (62). These included low maternal age, weight, and social class, smoking, single parenting, threatened abortion, and a history of prenatal hemorrhage, perinatal loss or low-birth-weight live borns. They devised a scoring system to assess the risk of spontaneous pre-term birth (63). Because the majority of the components of this score related to past pregnancy performance, the system was not effective in identifying the primigravida likely to deliver prematurely. The risk factors for pre-term delivery identified in the above studies are listed in Table 7-2.

Only recently have models been devised to identify high-risk mothers and to intervene to reduce the risk of prematurity. The first was developed at the Beclere Maternity Hospital in Clamart, France, by Papiernik (64). This hospital, with 2,000 deliveries per year, experienced a step-wise reduction in pre-term birth from 10.1 to 3.4 percent between 1973 and 1979. Because

DEPOSITION OF **ELIAS** GEORGE CHALHUB, **M.D.** TAKEN **29 MAY 1987**

ABSTRACT

PAGE/LINE

4/12 It was to his best knowledge, sometime in the fall, was first contacted regarding this case and review - in 1986.

4/17 Believes Mr. Williams was the one that **he** was referred to.

4/20 Believes it was a representative of St. Paul that initially made the contact - assumed site of St. Paul office was the Jacksonville office.

5/1 I don't think **so** (worked with this St. Paul Jacksonville office before?)

5/7 Was furnished with hospital records of DG, some evaluations, and a series of depositions.

5/11 No, prior to today,' has not had an occasion to review the non-stress test given during the last two weeks of the prenatal course,

5/15 No, has not had occasion to review any of the slides taken by the pathology dept. of the placenta or umbilical cord.

5/19 If those were included in the records. Can't remember that name specifically, (review of Dr. Joyner's records?)

5/24 No. (have not reviewed the report of April of this year of Dr. Hodson.)

6/3 Did review one CAT scan. Believed **it** was March 31, 1983 CAT scan.

6/9 I believe **so.** (C-scan had been taken at St. Vincents)

6/12 No. **Is** not aware of any existence of any additional CAT scans but would certainly like to review them.

6/21 There are some obstetrical experts, don't know these names, that depositions have been taken, Not had an opportunity to review.

7/1 Has reviewed Dr. Hartert's Dr. Ferrell's

	deposition and Dr. Thompson's deposition, Dr. Montez, Dr. Chiu, Dr. Pena-Ariet, Dr. Marranzini, Dr. Prat depositions.
7/22	Does not know Dr. Ferrell or Dr. Hartert. Does not know Dr. Chiu, Dr. Garis, Dr. Thompson.
8/7	Not to my knowledge. It certainly could have happened, but am not aware (that they appeared as an expert witness in the case, likewise appeared as an expert witness for one side or the other)
8/12	Yes. (Has given testimony in Arkansas).
8/22	Does not think has reviewed and/or given testimony in Arkansas dealing with the standard of care.
8/24	Bas given causation testimony in one case - believes sometime within the past two years - was a trial.
9/11	Has reviewed the standard of care on causation which arose out of the State of Kansas and Mississippi, Alabama, Georgia.
9/23	This child was in Mobile, AL.
10/1	Recently in Kentucky, yes, in Kentucky.
10/5	Had given a deposition, Thought you meant testified in Court.
10/17	Doesn't believe testified in trial in Louisiana or Mississippi.
10/21	Has not testified in Tennessee, South Carolina or Maryland.
11/4	No way for him to tell. Doesn't keep those kinds of records. (Review of cases he has done whether or not they actually gave rise to a deposition or trial testimony.)
11/10	Sometimes does keep copy of depositions taken or given - has no criteria about which ones he keeps or discards.
11/23	Does not think it was more than 20. (in his possession).
12/3	He doesn't remember the date. Approximately one year ago that he and DCK first met.

12/21 Did give testimony in the Ajuoko v. Signa case - has been settled.

13/16 That's approximately right. (has given opinions, either by way of review, deposition or trial testimony in approximately 6-8 cases in the Ft. Lauderdale area,)

13/21 Did give opinions in a Tampa case.

14/1 Yes, in Miami,

14/3 Doesn't know how many cases in Miami, maybe three at the most,

14/7 Two cases that he knows of in St. Petersburg.

14/14 I believe that's one case (Ft. Pierce).

15/23 Yes-has given donations to charitable organizations in and around the Mobile area.

16/2 I decided to do this when I came down here to give this deposition.

16/5 Yes. (made such a request in other cases - can't really tell the number of cases.)

17/1 Approximately five to ten percent (income would be derived from review of testimony endeavors.)

18/21 Did not testify in that case, gave a deposition, (March 87 - attorney by name of Larry Stewart, Gary Fox).

20/1 Frequently, go to Labor & Delivery area. To see sick babies and sick nurseries. Don't go to deliveries. I'm not requested.

20/12 Is rare, because I don't do this. (special circumstances that occur when you are present at the actual delivery)

20/16 Yes. I don't practice neonatology or obstetrics (over last two years, think that was the only time.)

21/5 Does not go to C-sections and doesn't go to routine deliveries, not the kind of medicine he practices. (Labor and delivery period where resuscitation efforts was done right there in the labor & delivery room.)

21/22 Yes, it was beyond five years ago that he ever

resuscitated any infant following a delivery.

22/16 Yes, from 1976 until believes 1983 or 1984, in Arkansas and South Alabama, had been in charge of residency program.

23/1 Does not express opinions regarding the standard of care as practiced by obstetricians or neonatologists.

23/20 Yes, is familiar with the electronic fetal heart monitoring strips. Does not consider himself an expert to interpret the findings of such strips.

24/11 No, I am not a pediatric radiologist.

24/19 Definition of a neonate would be birth to 30 days.

24/22 Reads chest films, but does not consider himself of the necessary expertise to testify to the interpretation of them.

25/17 Yes. (Vast variety of reasons from time to time placentas togethe with umbilical cords are delivered to the pathology dept.)

25/24 Is not competent and experienced to review pathology slides and interpret the findings.

27/1 I may have and I may have not (in the last five-years, requested that pathology reports be made concerning placental and umbilical status).

28/8 Practices at Mobile Infirmary, Providence Hospital, Spring Hill Hospital, Knollwood Park Hospital, University of South Alabama Hospital.

28/9 Reviews literature concerning neonates and maternal problems, child neurology problems everyday - could happen on a daily basis.

28/15 Would read materials frequently if it dealt with the pathology of the placenta in relation to the neonate.

28/25 No. (what is considered the norm to be the length of the umbilical cord?
No. (Diameter of the placenta)

29/14 Thinks it has happened on a number of occasions that people have responded. ("Doctor, I read your article on such and so.")

29/23 No. Has not received any income from any contributions to literature,

30/13 No. There are no publications authored by him since last year, May of 1986. (Plaintiff's Exhibit 1)

30/20 Yes. (Article #27, read into the record - believed that cerebral palsy disease, OB-Gyn.)

30/24 It says "cerebral palsy: an obstetrical disease',

31/2 Intended to be submitted to the AGO&G, but still working on it. Not been published, that would be on my new CV.

31/7 Wasn't pleased with it. Needed some more work.

31/12 Basic thoughts of the article itself concerns etiologies of cerebral palsy. Concerns aspects related to CP, the definition of CP and trying to clarify what is in the entirety.

32/10 Asphxyia is an alteration of blood gases in the delivery of oxygen and carbon dioxide characterized by a hypercapnia and acidosis.

32/25 Yes. (Article about asphyxia, which occurs from a time parameter standpoint between the point of labor begins right up to the time labor occurs)

33/6 Its better than a rough draft - has not been submitted yet.

34/12 Yes. Has seen the article "Prenatal and perinatal. factors associated with brain disorders" - saw it when it was first published'.

34/23 Reading from NIH, April 1985, John Freeman. Yes. (Agrees. 'The pregnancy lasting longer than 42 weeks is defined as post-term.")

37/13 Post-term pregnancy:- one could have growth retardation, congenital malformations, viral infections, bacterial infections, respiratory infections, neuromuscular disease, hyperplasia of certain organs, changes in body tissue, persistent fetal circulation, meconium staining, etc.

38/19 Yes. Pregnancy that has gone beyond 42 weeks - the incident rate of meconium staining increases to a degree.

38/23 Incident of meconium staining in all pregnancies is 10 to 20%, be it post term or not.

39/17 No, that's correct. (Meconium is passed in utero, that doesn't necessarily indicate that the fetus has aspirated the meconium.)

40/23 Do not know, that's not an area of my expertise in terms of why infants aspirate meconium in utero.

41/21 Am a consultant, not a primary care physician for newborns.

42/15 States it occured in the majority (whether or not meconium aspiration occurs in the majority of cases, whether in utero or after birth).

43/10 Can not accurately be answered. Reason it can't be answered is there is no way to really measure the amount of meconium down in the alveoli.

45/14 Sure. Did note in the record that this child had peeling skin, long fingernails and was meconium-stained.

45/17 The child has certain features that may be seen in a child who is post-mature. Its rare to see a nine pound nine ounce baby 43 or 44 weeks without any decreased subcutaneous tissue.

46/18 I can't answer the question yes or no. (Was the child post-mature?)

52/9 As a Pediatric neurologist in this particular situation, the weight gain is not a factor in my! conclusion.

52/21 No. Did not review the external fetal heart monitoring strips.

52/24 I knew there was one that is not available.

53/1 No. I did not know that the external fetal heart monitoring strip was available.

53/22 Yes. (For purposes of your opinion, prolonged deceleration occurred at both instances, 9:40 and 10:45.)

54/1 Prolonged deceleration with recovery is fairly common in many pregnancies. Can not attribute anything significant to #2 decelerations.

54/24 Anything is possible. The facts in this case don't support that. (Cord compression)

55/14 It doesn't say how much meconium was present and I don't know how to estimate that.

57/1 "Thick meconium is an isolated factor. It may mean nothing. When it is taken in consideration with that as it is in this baby, who obviously did have meconium aspiration, then it becomes a factor.'

57/23 Yes. I do. (Hold the opinion that the child aspirated meconium.)

58/1 It's my opinion that the child aspirated meconium in utero.

58/20 Can tell you by the appearance of this child and the subsequent course that this child aspirated meconium in utero. Can not tell you when or how much.

60/25 Can not tell the prolonged deceleration at 9:40 and at 10:45 produced the meconium.

61/15 It is correct that he does not hold any opinion regarding the standard of care of any physicians in this case.

61/18 It is correct that his testimony is directed to only the causation aspect of the case as well as the future needs of the child.

64/12 The meconium was already there, The child aspirated meconium in utero. Postive pressure could force more meconium. Can't remove it all just by suctioning below the cords.

66/10 I do not have any reason to question the correctness about the validity of the APGA sums.

71/2 Would think that pH below 7.2 would be considered acidosis.

71/24 Lack of oxygen going to the lungs. (Could cause the acidosis in this case within a reasonable degree of medical certainty.)

72/3 Persistent fetal circulation and meconium aspiration, (Caused that condition,)

72/16 The child had a persistent fetal circulation

problem in utero,

72/20 There's no way to get a total specific time. Would have expected the child to have pulmonary hyperplasia of the smooth muscle for a number of days prior to birth.

73/3 Pulmonary hyperplasia of the endothelia muscles, In this particular situation, not certain what caused it.

73/10 Possibilities - bacterial infection - viral infection, uteral placental insufficiency, toxemia, hypetension, vaginal infection, metabolic disease secondary to acidosis, etc. - None of the possibilities had occurred.

75/20 The cause of this baby's neurological deficient is postnatal asphyxia, hypoxia and ischemia.

76/9 In my opinion, no. (Did this child suffer any asphyxia in utero?)

77/15 No. That this child suffered brain damage in utero.

77/25 The brain damage that this infant suffered as in the postnatal period.

78/11 The post natal asphyxia occurred both over a number of days and again on the 25th.

80/6 I said it is my opinion that in all probability that irreversible brain damage' did not occur in that short period of time,

80/21 Doesn't know how anyone can tell specifically at what point became irreversible.

82/3 While on the ventilator, there was little question that the child was exposed to high risk for permanent neurological deficits.

82/17 The aspiration of meconium contributed to the development of this postnatal asphyxia - by making oxygenation more difficult.

82/23 Without a doubt, if the meconium was not aspirated, the child would still have developed post-natal asphyxia.

85/25 At least several days (when the pfc first developed in utero).

87/9 Does not only assume it, there is nothing in the records to suggest it occured, (rupture of membranes at 11:05 to 11:56 showed no signs of distress.)

89/9 Yes. The meconium aspiration did result.

89/15 I don't know the pathology of the cleaning events in the meconium aspiration. Best answered by a neonatologist,

89/21 Yes. The persistent fetal circulation resolves itself.

89/24 It results sometimes after the 25th.

91/17 Yes. As a result of persistent fetal circulation, meconium aspiration, pneumothorax, pneumomediastinum, lack of oxygen, lack of blood flow,

98/25 Would have to look at the CAT scans and send in writing his opinion.
(Was agreed this could be done, time, by next week.)

100/6 No. I have not had a chance to see Dr. Hodson's report. Plaintiff's Exhibit 2.

100/19 Yes. I examined the child today - approximately 30 minutes or longer.

100/23 The purpose was to give an opinion in terms of causation.

101/6 No. Bas not had the occasion to review the pediatrician's on-going records, that is, Dr. Chiu. Has not reviewed the records from Nemours, no records concerning the orthopedic procedures performed.

102/10 Yes. I would categorize the child with the condition as microcephaly.

102/17 Yes. I do have an opinion as to whether or not this child has severe psychomotor retardation - it is irreversible - she does have a seizure disorder.

103/7 He (Dr. Hodson) maybe a pediatrician also but he is classified as a child neurologist.

103/22 It is absolutely absurd that this child if given appropriate medical care, will have a normal

life expectancy.

104/1 Due to the nature of the severity of her neurological deficit, the life expectancy is between 10 and 20 years maximum.

104/21 Relies on studies from the National Institute of Health which is going to be published shortly - some of the articles are Herb Grossman, Ballsirinia, Ferrindelli.

105/21 In my experience, its usually the case that one of these infections will ultimately kill this child, The incidence of sudden, un-expected death and epilepsy is extremely high.

106/13 The child clearly is at risk for many things which could take its life,

107/9 Thinks within reasonable medical probability, she will not develop language skills - will not develop independent ambulation - but totally agree that she would never achieve any form of employment status.

107/18 Thinks they are best suited with their families to take care of them and not be institutionalized.

108/23 No, on the contrary, it isn't cheaper to institutionalize a child with this condition.

109/18 No. (Have an occasion to review the life care plan as formulated by Paul Deutsch, marked Plaintiff's Exhibit 3.)

112/22 Its correct that in his opinion, continuation of services will not continue beyond the 20th year.)

113/7 Up to a certain point, he disagrees that any effort and expense should be given as to speech and occupational therapy.

113/13 Disagree with psychological evalutions. When IQ has already been established.

114/6 Do not have an opinion on any architechtural renovations, indicating ramping, flooring.

114/12 If the child increases in size, will require a wheelchair and will require transportation.

114/24 Heel cord lengthening the child will need; that would only be a last resort, because child will never be ambulatory. No reason for back fusion - no sciolosis.

115/16 Heel cord lengthening only if feet are painful and not able to be put in appropriate position with posterior splinting.

115/25 Doesn't have any problem with the recommendation regarding wheelchairs and travel chair.

116/14 If child's IQ is 20 and remains 20 for 3 years, there is no benefit to continue the test of the child's psychometric testing,

OCCUPATIONAL THERAPY

Child not going to be educatable. It would be a waste of the mother's time to carry out the occupational therapy.

SPEECH THERAPY

Once child reaches 7 or 8 years of age, has not achieved speech, speech therapy makes no sense,

117/14 If child's needs at that time are similar to what is now - would be a chronic care facility.

118/23 Not certain, would have to go back and look over the records.

119/8 Spent approximately 10 to 12 hours on this case prior to testimony.

119/17 $250.00 an hour for deposition - $125.00 for reviewing - $200.00 during the time testifying

119/21 $1,500.00 - would be his fee for going to Jacksonville, spend the evening and testify the next day.

120/1 If there's more information to review, will review this.

120/7 Has not been a Defendant in a medical malpractice suit,

4-261> Estate of Ashley Carr

DEPOSITION OF ELIAS CHALUB, M.D.
[Estate of Diane Greene]

TAKEN ON MAY 29, 1987
by MR. DON KEENAN

Pg/Ln	
2/21	`76 to `83 - in charge of residency program
25/6	"I do not consider myself of the necessary expertise **to,** one, testify as to the interpretation of that" (chest film)
25/24 - 26/2	Not competent or experienced **to** review and interpret findings on slides
32/11 Defines Asphyxia	**"Asphyxia.** is an alteration in blood gases in the delivery of oxygen and carbon dioxide..."
93/14	"when you have ongoing asphyxia and hypoxia, one develops a certain amount of cerebral edema which will swell the endothelial cells of the cerebral blood vessels and impair cerebral blood flow."