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IN THE FOURTEENTH JUDICIAL DISTRICT OF TEXAS

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GREGG KIRKPATRICH, et al, *

Plaintiffs, *

* CIVIL ACTION NUMBER

vs. *

* 87-8955-A

BERNARD F. ADAMI, M.D., *

et al., *

Defendants. *

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The testimony of ELIAS GEORGE CHALHUB, M.D, taken at the Hilton, 3101 Airport Boulevard, Parlor A, Mobile, Alabama, on the 9th day of October, 1990, commencing at approximately 3:30 o'clock, p.m.

## APPEARANCES

| | |
|---|---|
| FOR THE PLAINTIFFS: | MESSRS. HARDY, MILUTIN & JOHNS<br>ATTORNEYS AT LAW<br>909 FANNIN, SUITE 500<br>HOUSTON, TEXAS 77010<br><br>BY: W. J. HARDY, ESQUIRE |
| FOR THE DEFENDANT, MEMORIAL HOSPITAL OF GARLAND: | MESSRS. COWLES & THOMPSON<br>ATTORNEYS AT LAW<br>4000 FIRST REPUBLIC BANK PLAZA<br>DALLAS, TEXAS 75202<br><br>BY: CYNTHIA SHEA, ESQUIRE |
| FOR THE DEFENDANT, NURSE BOWMAN: | MESSRS. STRADLEY, SCHMIDT, STEPHENS & WRIGHT<br>ATTORNEYS AT LAW<br>ONE CAMPBELL CENTRE<br>DALLAS, TEXAS 75206<br><br>BY: C. L. MIKE SCHMIDT, ESQUIRE |
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| ALSO PRESENT: | S. DEBBIE JAEGLI<br>LYNN ROBINSON-DYKES<br>COURT REPORTER |

# I N D E X



# E X H I B I T S

(There were no exhibits marked to this deposition.)

MR. HARDY:

Put on the record we're taking this pursuant to the Texas Rules of Procedure.

ELIAS GEORGE CHALHUB, M.D.,

the witness, after having first been duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. HARDY:

Q State your name, please.

A Elias George Chalhub.

Q Dr. Chalb, my name is--

A Chalhub.

Q --G. Hardy.

MS. SHEA:

It's Chalhub.

A Chalhub.

BY MR. HARDY:

Q Chalhub?

A Right.

MS. SHEA:

C-h-a-l-h-u-b.

BY MR. HARDY:

Q C-h?

A A-l-h-u-b.

Q C-h-a-l-h-u-b?

A Correct.

Q All right. What's your national origin?

A Lebanese.

Q Lebanese? I asked that only because I've never heard the name Chalhub before.

A I was born in Boston.

Q Yeah, I thought that was Lebanese.

(WHEREUPON, THERE WAS AN OFF-THE-RECORD DISCUSSION.)

BY MR. HARDY:

Q Well, we are here today, Doctor, to find out what your opinions are about this Kirkpatrick case.

A Sure.

Q I am not going to take long with you. I basically just want to get down a little information that will be helpful to me in analyzing the situation. When were you first contacted about this case?

A I believe in May of 1990.

Q And who contacted you?

A I can't remember whether it was Debbie Jaegli or one of the attorneys she works for. So, I don't know.

Q Do you know where they got your name?

A No, I don't.

Q Or who suggested they contact you regarding this case?

A No, I don't.

Q Have you talked to anyone other than people from the Cowles & Thompson law firm about this case?

A No, I haven't.

Q Okay. May I see the correspondence?

A Sure.

Q You don't know how they heard of you one way or the other?

A No, I really don't. I'm sure you could ask them.

Q Well, I'm asking you.

A No, I don't know.

Q I'm asking you whether somebody recommended you to them or --

A Well, they may have, but they didn't tell me that.

Q They didn't share that with you?

A No.

Q Do you often get calls like this out of the clear blue sky from Dallas lawyers or Houston lawyers or New York lawyers or California lawyers, we would like for you to testify in a case for us?

A Well, I get lots of calls. I am a Board Examiner for the American Board of Pediatrics and Neurology, and, you know, I am a known expert in this area. So, I do get lots of calls, yes.

Q Okay. Just out of the clear -- I guess they get your name out of that source of Information?

A No. I have published. You know, I'm known in this area. My colleagues respect me. And so, you know, I suppose they would like somebody who's responsible, who will give an honest, unbiased opinion.

Q Sure. Do you know Dr. Elton?

A Yes, I do.

Q Have you talked to him about this case at all?

A No.

Q Bo you know whether he recommended they call you?

A I have no idea.

Q What materials -- I guess they are all listed here, that you received in order for you to form whatever opinions you've arrived at in this case?

A Correct. And I have -- I don't know whether the CT and MRI scan are on that. And then there is a report from a Dr. Cccheran that I've looked at, also.

Q Dr. Cocheran?

A Yes. Rehab coordinator.

Q May I see that?

A Sure.

MS. SHEA:

That's that rehab guy.

BY MR. HARDY:

Q Dr. Cocheran. He's not a doctor, I take it?

A I think -- I guess he's not. Mr. Cocneran.

Q So, what you have reviewed here, just so that we can go through this, are the medical records of Cynthia Kirkpatrick from Memorial Hospital of Garland?

(Pause)

Q And ycu have reviewed the medical records of

Joshua Kirkpatrick, I take it, then, from virtually all sources, all of his medical records since his birth?

A Yes. There are a lot of records -- I mean, a lot of depositions, too.

Q Okay. And all of these depositions you have read? And I haven't counted them up, but there are a lot of them?

A There's a bunch of them.

Q You've read them all?

A Well, as many as I could get through. I'm not sure I've read every single one of them cover to cover.

Q Well, I was going to say, if you've read them all since May, and I started in May, you are a hell of a lot faster reader than I am. Because some of them are long, aren't they?

A They sure are.

Q Which ones have you read and really studied in detail?

A I can't tell you that. I mean, I've tried to go through every single one of them. Mow, some of them, I -- you know, I turned quicker than others,

which seem to be somewhat redundant.

Q Dr. Chalhub, we know Joshua Kirkpatrick has a form of what is called cerebral palsy. Do you agree with that?

A Yes, I do.

Q Cerebral palsy is really kind of a catchall term, isn't it? I mean, it's not a disease in itself or a problem: it's kind of a catchall term?

A Well, I think it depends on who you read and what your understanding is of the disease.

Q Well, is it a disease?

A Well, it's a situation or syndrome which is characterized and defined as a static motor and/or intellectual deficit. And depending on what literature you are familiar with and what type of practice you have, some people define cerebral palsy being related to infection, congenital malformations, poor lack of oxygen, blood flow or birth trauma.

Q Right. But it is a static encephalopathy that you have described?

A Yes.

Q In other words, at some point in time, some damage occurs to the brain of that person? And it's a

static problem, but the damage is there and it's going to affect either their motor or intellectual function for the rest of their lives?

A No, I don't think that's true.

Q Well, this child's motor and intellectual function will be affected for so long as chis child fives?

A Yes, I agree with that.

Q All right. Now, I assume that you have read Dr. Elton's deposition. It's listed here.

A Yes.

Q Was that one that you read cover to cover?

A Yes.

Q Okay. Now, incidentally, you looked at the rest of these records here on Joshua Kirkpatrick, some of his later treating pediatric neurologists. Has the diagnosis changed?

A In terms of what diagnosis?

Q Well, Dr. Elton's diagnosis of quadriparesis, or -- I don't know how to pronounce that.

A You did pretty well. That's not a diagnosis. I think that's a description more.

Q Description. Has his diagnosis changed at all,

according to these later records from the Scottish Rite or these other treating doctors?

A You know, I don't know which exactly you are talking about. So, I really can't tell you which has changed and which isn't.

Q Well, have the doctors -- since Dr. Elton made his diagnosis of the problems existing in chis child?

A Okay. Which problems are you talking about? And then maybe I can comment on it.

Q We are talking about the quadriparesis, the manner in which his body is affected by virtue of the brain damage that occurred to him?

A Well, I don't know which report you are referring to. He is still quadriparetic, to my understanding, if that's what you mean.

Q Did you read where Dr. Elton had made any kind of diagnosis?

A Well, he's assessed his physical findings and come to a conclusion as to what his symptoms are. And I think he's stated what he felt they were caused by.

Q Okay. I understand. Not in his records did he state that: he stated that in his deposition; correct?

A Well, I think he's made some statements in his

records. You know, I would just have to go back all the way through them.

Q What statements in his records did he make with respect to what he thought caused the problem?

A No, Now, you were talking about what his diagnosis was and what his symptoms were which he said.

Q No, sir. No, sir.

A You didn't: ask me about what he said about cause.

Q Excuse me. We are going to go a whole lot faster here if -- when I ask a question, I will try to give you an opportunity to answer it. And by the same token, when I'm asking a question, you know -- in other words, she can't take us both down at the same time.

A Oh, okay.

Q You've done this before, I know.

A (Witness nods head affirmatively.)

Q So, you know she can't take us both at the same time. Okay?

Now let me ask you this question: You made the statement that Dr. Elton had said -- that he stated

what his diagnosis of the symptoms were and, you know, the cause?

A No, I don't think I said that.

Q Okay. Did he ever establish any cause of this child's brain damage except and when he gave his deposition?

A There are a lot of records. Okay? So, I can't tell you that by memory, but I will be glad to go back and look through them again for you.

Q Well, you have those records here?

A No. I mean, I couldn't -- there are three boxes of records. I could not carry all of them,

Q But you did read what he thought was the cause in his deposition?

A Yes, I did.

Q Now, you understand that this child was being treated by Dr. Elton for some period of time?

A Yes.

Q There was a CAT scan, of course, done on Josh Kirkpatrick?

A That's correct.

Q And I assume you had the report. Did you have the films?

A Yes.

Q Did you have the films of the MRI?

A Yes.

Q Do you agree that the films show a partial agenesis of the corpus collosum?

A I do.

Q Now, a partial agenesis of the corpus -- that's not saying that the corpus collosun isn't there, is it, both sides?

A No, it's that it's not all there.

Q Well, it's not fully developed?

A Well, that's -- yes, I mean, that may be true.

Q And you do know, don't you, that this was a thirty-three week fetus: this was not a full term baby?

A What does that have to dc with the development of the co11osum?

Q Well, it's not unusual to find partial agenesis of the corpus collosum in a thirty-three week fetus, is it?

A It's unusual for me to find that, sure.

Q Partial agenesis of the corpus callosum does not relegate any child to cerebral palsy, does it?

A I don't know, are you making a statement or asking me a question?

Q I'm asking you a question.

A No, that's not true either.

Q Does -- every child that has partial agenesis of the corpus callosum, is that child going to have cerebral palsy?

A No.

Q As a matter of fact, a large percentage of people with incomplete or partial agenesis of the corpus callosum are completely asymptomatic; isn't that true?

A No, that's not true.

Q Are there any that are asymptomatic with partial agenesis of the corpus collosum?

A Well, what do you mean by asymptomatic?

Q They don't have brain damage: they function like normal human beings. That's what I call asymptomatic.

A Well, it depends, because most people that would have a brain scan, you know, would not be asymptomatic. So, they would have to have some reason for having a brain scan. So, I can't -- the majority

C/C

of the people I see with partial agenesis have a problem and a neurological problem.

Q Yes, sir. But, Doctor, people have partial agenesis of the corpus callosum and have no problems and function like normal human beings; is that a true statement or not?

A That's possible, but it's unusual.

Q Okay. Now, is it unusual, Dr. Chalhub, for a thirty-three week fetus that is deprived of oxygen to the brain to suffer cerebral palsy?

A I'm sorry. State that again.

Q Is it unusual for a thirty-three week fetus that is deprived of oxygen to the brain to suffer cerebral palsy? Is that unusual?

A Now, are you talking about hypothetically and unrelated to this case?

Q I'm asking YOU, Doctor, this question. And if you have trouble answering it, please tell me. Is it unusual for a thirty-three week fetus that has suffered oxygen deprivation to the brain to have cerebral palsy? Is that unusual? You can answer that yes or no and then I will let you make whatever explanation you would like.

A No. I mean, I have to answer the questions the way I can, okay, not the way you want me to.

Q I'm not asking you to answer the way I want you to answer them, Doctor. The question is very, very simple. Is it unusual for a child that is a thirty-three week fetus that has suffered oxygen deprivation to the brain to develop cerebral palsy? Is that unusual?

MS. SHEA:

And, G., I would just request that -- when he is answering, he may be nonresponsive. If you want to object nonresponsive, please do that. But I think there have been a couple of times you've cut him off in the middle of an answer. And I would request you extend him the same courtesy he's trying to extend you and let you both finish your sentences before y'all go on.

**BY MR. HARDY:**

Q Is that unusual, Doctor?

A Well, to answer your question yes or no is difficult, because you have to tell first of all what the degree of hypoxia is, what the distribution and the cause is, and then I can tell you whether that's

unusual or not. Just to say that somebody has hypoxia and then has brain damage is probably unusual. Most babies tolerate hypoxia quite well.

Q Sure.

Now, you've got your pad there. If you would start on a fresh sheet for me. I would like for you to write down something for me, because I'm asking you a question.

A No, I'm not --

Q Because I'm going to give you a hypothetical question.

A Wall, I'm not going to write anything down for you.

Q You are not going to write anything down?

A No.

Q You don't want to know about this?

A No, I do want to know about it, but I don't have to write it down.

Q Well, let me ask you this: You know this lady was a PROM patient, don't you?

A Was a what?

Q PROM patient. You know what a PROM patient is?

A No, I don't know what a PROM patient is.

Q Premature rupture of the membranes?

A We don't refer to people as PROM patients, but --

Q Well, that's the way it's referred to in the literature, because it's premature rupture of the membranes. So, they shorten it to the initials, you know, a lot of times so you don't have to say all those words.

A Yes, but that's not the way we refer to patients. Okay? That is a description of the membranes. You don't call people PROM patients.

Q Well, we will call this one a FROM patient, if you don't mind, just so we can shorten the deposition. She's premature rupture of the membranes, at approximately between thirty-one and thirty-three weeks. She's put in the hospital with premature labor. She is put into the labor and delivery. She experiences variable decelerations, early decelerations and some late decelerations, by some of the ttstimony. That for some period of time after she's taken off of her fetal heart monitor, during the delivery process, they have no fetal heart rate, as noted in the records. And I'm sure you've seen those

You've told the jury here that it's a perfectly normal circumstance?

A No. You've mischaracterized my statement.

Q Tell me what a variable deceleration is.

A A variable deceleration is due to cord impingement and will have decreasing heart rate at variable times during the contraction.

Q Okay. What is an early deceleration?

A It's due to head compression.

Q Do you know what -- is early deceleration always due to head compression?

A Well, the majority of the time that's what it's thought to be due to.

Q Well, how about -- I want you to tell me -- you can't define late deceleration for me?

A I have.

Q Well, what is a late deceleration? You say it's a slow return to baseline?

A Correct.

Q Is that your understanding of what a late deceleration is?

A Well, it -- you know, again, I'm not an obstetrician, okay, and I don't read fetal monitors.

And a late deceleration, you know, is a prolonged deceleration coming after the contraction with a late return to baseline.

Q What causes a late deceleration?

A Well, it's thought to be due to hypoxia to the heart.

Q How about placental insufficiency?

A How about it?

Q Is a late deceleration caused by placental insufficiency?

A Well, I suppose indirectly it could be caused by placental insufficiency. But in terms of saying that placental insufficiency causes late decelerations, no. That's not a one to one correlation.

Q Well, what is the correlation?

A What is what correlation?

Q What is the correlation? You say it's not a one to one correlation. Tell me what the correlation is.

A I don't understand your question.

Q Well, if it's not one to one, is it two to one, five to one, ten to one? What is the correlation

between late deceleration and placental insufficiency?
A Well, I mean, you can see a late deceleration with placental insufficiency; you may not. You can have a baby that has problems or you can have a baby that does not. And they vary from all kinds of problems and none of which may be related at all.
Q Would you agree with me, Doctor, that a thirty-three week fetus has less reserve than a term baby?
A I don't think I know the answer to that.
Q You know what I mean when I say reserve?
A No.
Q All right. You know what a decel is, a deceleration?
A Yes.
Q What happens to the baby in a deceleration?
A Well, usually nothing.
Q Does the baby -- is there less oxygen flowing to the baby's brain in a deceleration?
A You mean in terms of the fetal heart tones being decreased? You know, again, the heart rate decreases, but there may or may not be, because there are compensatory mechanisms in the baby and in the

baby's body.

Q Now, are those compensatory mechanisms in the baby and in the baby's body as functional in a thirty-three week fetus as they are in a term baby?

A I would think so.

Q So, a thirty-three -- there is no difference in the labor and delivery of a thirty-three week fetus and a term baby?

A No, that's not what you asked.

Q No. I asked if a thirty-three week fetus has less reserve than a term baby?

A But that's not the same question.

Q Well, it's all leading to the same question.

A But I can't answer it the same way, because there are different answers.

Q Does a deceleration affect a thirty-three week fetus the same as it would a term baby?

A Well, what kind of deceleration and what situation and -- you know, it's too general to answer. I can't answer it.

Q All right. Let's start with an early deceleration. Does an early deceleration affect a thirty-three week fetus the same as it would a term

baby?

A You know, again, in general, as a pediatric neurologist, my understanding is no. But, again, you are not defining, you know, what situation you are in. But in general, no.

Q Does a variable deceleration affect--

A No.

Q --a thirty-three week fetus any differently than it affects a term baby?

A Not to my knowledge.

Q Does a late deceleration affect a thirty-three week fetus any differently than it affects a term baby?

A Well, it depends on the late deceleration, the cause of the late deceleration, the extent of them and then the symptoms of the baby after birth.

Q Would you agree with me that any time you have a late deceleration the baby is stressed?

A No.

Q Okay. You are, of course, aware that this child was born with the cord around its neck?

A Yes.

Q Would that explain the variable decelerations

throughout the labor of this child?

A It could.

Q Now, you do -- I assume you did look at the fetal heart monitor tracings?

A I looked. I don't read them. So, I don't --

Q But you don't know what they say. So, you don't know whether the child had one or fifteen variable decelerations or one or three late decelerations, because that's not your field of expertise?

A That's correct.

Q Is that correct?

A That is correct.

Q Now, have you read Nurse Thompson's deposition?

A I believe so.

Q Have you read Nurse Davis' deposition?

A Yes.

Q Have you read the deposition of Nurse Bowman?

A Yes.

Q Okay. Now, of course, you do know that Nurse Bowman delivered this child?

A That's correct.

Q Okay. Now, what was the condition of the baby

at birth, if you know, based on what you've read?

A Well, it looks to me like the baby was in excellent condition, with Apgars of eight over eight.

Q Are you using the Apgars as a measure of this -- a one and a five minute Apgar as a measure of this baby's brain condition at birth?

A No. You asked me what condition the baby was in. And the Apgar is used to describe whether a baby needs to be resuscitated or not immediately after birth. And this baby had good Apgars.

Q Would you agree or disagree with me that Apgars of one and five minutes are nondiagnostic?

A Nondiagnostic of what?

Q Of whether or not a child has suffered brain damage?

A Oh, I agree with you.

Q Okay. Because cerebral palsy may not show up in a child for several months?

A No, that's not true.

Q Well, it's not unusual that it won't show up for several months, is it?

A Yes, it is unusual.

Q It is unusual? Okay. How soon would you

expect it to show up?

A Well, if you, you know, knew the situation, the cause and the factors surrounding it, babies that sustain -- and I assume you mean intrapartum causes. Now, obviously if you mean genetic causes or congenital malformations of the brain or problems prior to birth, then they may take a longer period of time, depending on the observer, to be diagnosed. But if it's an intrapartum condition, meaning during the birth process. then the symptoms are there and they are serious symptoms.

Q Well, it would, of course, depend upon the level of brain damage, wouldn't it?

A No, that has nothing to do with it.

Q It has nothing whatsoever to do with the amount of brain tissue that has been injured or is injured?

A I don't think I understand your question,

Q Well, the question is simple. Does it have -- whether or not or how -- how long it takes to diagnose the problem, does it have anything whatsoever to do with the amount of brain tissue that has been injured?

A Again, I don't understand. Does what have anything to do with it?

Q The ability to diagnose the problem?
A No. The ability to diagnose the problem has to do with the examiner and the studies that are done.
Q Could you automatically diagnose cerebral palsy in a two week child, no matter what the level of injury to the brain is?
A Well, you will have to tell me more about the situation, when the insult occurred, the degree, the factors surrounding it and the symptoms, and then I will be able to tell you that.
Q Well, say it's not a significant degree of brain damage but enough to affect the child's developmental process?
A Again, I'm having a very hard time understanding you, because you are using things that are not --
Q Sure.
A Not equal or consistent.
Q Sure.
Now, was there any evidence in these records that this child had any kind of hypoxic event, that you could find?
A When and what record?

Q Either during labor or delivery or immediately after delivery?

A No.

Q Nothing you could find?

A That's correct.

Q Now, you've said and talked about this Apgar of eight is that right?

A That's correct.

Q What was the color of the child at birth, if you recall?

A The child was dusky.

Q Okay. And the child -- when was the child put on oxygen, if you remember?

A I think shortly after birth.

Q And how long did the child remain on oxygen?

A I will have to go back and look exactly. Somewhere around twenty minutes. Maybe longer, but I will have to -- I will be glad to look if you want me to.

Q If a child is dusky at birth and then given thirty percent and then reduced to twenty-five percent oxygen, Doctor, would you expect the child to pink up?

A It may or may not. It depends on the

gestation. It depends on the type of infant, It depends on the circulatory status.

Q Let's talk about the Kirkpatrick baby. Now, you know what the gestation was, don't you?

A Yes.

Q What was it?

A Thirty-three weeks.

Q Okay. Would you expect a thirty-three week fetus to pink up after being on oxygen for however long you said he was on oxygen?

A Well, it may or may not. It depends on the baby's overall condition.

Q Well, you've already said the baby's overall condition was good; he was in good health at birth.

A I'm sorry. What's your question?

Q My question is: You've already said that the baby's overall health was good at birth; he was in good condition, Apgar of eight, at birth. How long is it going to take that good healthy thirty-three week fetus, given oxygen, to pink up?

A Well, you know, it's variable. Again, depending on the premature infant, I would expect it to take probably some length of time.

Q She said the baby was pink?

A Well, it was pink at 5:30. Which I think is ample time.

Q Did you read her deposition?

A Yes.

Q She said it was pink in the delivery room?

A Okay. Well, then, let's get it out and look at it. You know, there are over thirty depositions.

Q That's an important deposition.

A Weli, I mean, they are all important.

Q Well, she's the one that delivered the baby. You don't remember her deposition?

A Well, you know, I can't remember everything.

It's not a memory contest.

Q Why don't you get it out?

A I don't have it. But I will be glad to look at it if you want me to comment on it.

Q Well, I don't have it with me. I assumed you would bring all your records with you.

A I can't carry three boxes of records.

Q Well, you don't consider a dusky baby to be hypoxic at birth?

A No, absolutely not.

Q Even though thirty percent oxygen is necessary to revive that baby and bring it to the status of pinking it up, so to speak?

A Well, in the first place, we don't know whether that's what was required. Oftentimes premature babies will appear dusky just by their color and their peripheral circulation and they are not hypoxic.

Q Now, I understand what you are saying. But dusky can be evidence of hypoxia; would you agree or disagree with that?

A Well, it can be consistent with a lot of things.

Q I'm asking you, Doctor, is it consistent with

hypoxia?

A No, not unless there are other symptoms that go along with it.

Q How can you recognize those symptoms in a thirty-three week fetus?

A Well, because they usually require intubation. They usually have ventilatory failure. They have renal failure, heart failure, have seizures, have an extended hospital stay. And that's not what you're seeing in this situation.

Q Would you agree or disagree with me that the seizure activity in a thirty-three week fetus might be very subtle?

A No, I would disagree with you.

Q It would have to be profound?

A No, I didn't say that either.

Q It would take a trained person to recognize seizure activity; would you agree or disagree with that?

A Well, what do you mean by trained person, now?

Q Someone as skilled as yourself?

A No, certainly not.

Q You think a nurse could recognize seizure

activity?

A Or recognize activity that might be consistent with it, sure.

Q Well, they would have to know what to look for, wouldn't they?

A Well, any unusual activity in a baby could be construed as seizure activity. And that would then have to be looked at by other studies.

Q Well, in this hospital, had this child needed ventilation, they would have been in a heap of trouble, wouldn't they?

A I don't know what you mean.

Q They didn't have the equipment to do it, did they?

A Well, many hospitals don't have the equipment, but you intubate a baby and Ambu them and then you transfer them.

Q I see. Why not transfer them ahead of time?

A What do you mean?

Q Say, a week, a week ahead of time, if you've got a problem pregnancy?

A I'm not an obstetrician. You will have to ask them.

Q And may I take it from your testimony that you put no stock whatsoever in the labor progress of Mrs. Kirkpatrick?

A I don't think I understand that question either.

Q Well, you know what labor progress is?

A No. I mean, what -- just why don't you tell me what you are referring to?

Q Well, you are a practicing physician and I don't think I'm using words -- her labor progress means from the time she is supposedly in active labor, as that labor progresses and she's on a fetal heart monitor strip. And that fetal heart monitor strip has a purpose and that is to show what's going on with the baby's hearcbeat. Would you agree or disagree with that?

A I don't have any problem with that, but that's not labor progress.

Q Well, labor progress also has to do with dilation and so forth of the cervix; correct?

A I would think so.

Q But when I'm talking about the labor progress - because Cynthia Kirkpatrick is not hurt; this baby is

the one that's hurt - I'm talking about what's going on with the baby's heartbeat during the labor process. You put no stock whatsoever in the decelerations noted on the fetal heart monitor strip?

A Sure. I consider all of the facts, but the facts have to be all consistent, you know, with a problem and not inconsistent.

Q Well, on any of the films that you observed, did you see periventricular leukomalacia?

A Yes.

Q Tell me what that is.

A Periventricular leukomalacia is a distal field infarction in the periventricular germinal matrix of premature babies.

Q Would you agree or disagree with me that that is -- the most common cause of periventricular leukomalacia is hypoxia?

A No, I disagree with you.

Q What is the most common cause of periventricular leukomalacia? The most common cause?

A Well, the pathogenetic mechanism is ischemia.

Q Okay. What is ischemia?

A It's decreased blood flow.

Q Now, you are going to have to describe that to me. What do you mean decreased blood flow?

A Just what I said. There is no other way to describe it.

Q No. Well, I don't understand how you've answered that question. I want you to tell me what decreased blood flow is. Does that mean less blood to the brain?

A Yes.

Q Well, what causes that?

A Well, infection, hypotensive episodes, toxins, systemic diseases, placental insufficiency, ruptured uteruses, abruption of the placenta, placenta previa, toxemia.

Q Okay. And of all of these things chat you have mentioned, number one, there is no evidence of infection, intrautero infection, is there, at all in any of these records?

A Well, most of them are silent. So, I can't tell you about it.

Q I say, there is no evidence whatsoever in any of these records of intrautero infection, is there?

A I'm saying I don't know because most of them

are silent.

Q I'm asking you if any -- in any of the records that you have reviewed, is there any evidence? I'm not asking you if they are silent. I'm asking you if there is any evidence there?

A Well, the evidence is of periventricular leukomalacia. I mean, that's one of the causes.

Q Well, I know. We are going to come to the causes. But is there any evidence of infection?

A Well, that is the evidence. That certainly could be the evidence.

Q It can also be evidence of hypoxia, can't it?

A No. I've told you the answer to that and you don't seem to believe me.

Q Well, you are right about that.

Now, we are going to go to number two. Is there any evidence at all of toxic exposure of this lady?

A Evidence where?

Q Ever, anywhere in the records, that she was exposed to any toxic substance that would cause periventricular leukomalacia to this child?

A I don't know that. There is not a detailed

history about toxic exposure.

Q Is there any evidence that she took any drugs that would have caused this fetus to suffer periventricular leukomalacia?

A I don't know of any.

Q And is there any evidence that there was ever any, number one, placental insufficiency during the progress of labor to the child?

A Well, the baby has periventricular leukomalacia, has partial agenesis of the corpus callosum, has aspastic quadriparesis, optic atrophy and micrencephaly.

Q All these words are nice. I'm asking you if there's any evidence -- other than the net result of a brain damaged baby,--

A No.

Q --is there any evidence of hypoxia, an ischemic event, placental insufficiency during the labor process?

A No, there is no evidence during the labor process. There is considerable evidence of a prepartum insult to the baby.

Q Well, I thought we had said that if she had a

late deceleration during the progress of her labor, that could very well be caused by placental insufficiency?

A That may be what you said. I mean, I don't understand what you are talking about.

Q Do you disagree with that?

A I don't understand your question and what a context it is in.

Q is a late deceleration evidence of placental insufficiency?

A Hypothetically it's possible, yes, if everything else is consistent and the pattern is consistent, the symptoms are consistent, the x-rays are consistent and the baby has the neurological problem that's consistent.

Q Doctor, if the baby -- if there was a late deceleration, would there have been placental insufficiency?

A I don't understand that at all.

Q Can placental insufficiency cause the ischemic event that you are talking about?

A Sure.

Q How about a VRD, cord compression?

A How about it?
Q Huh?
A How about it?
Q Can that cause an ischemic event?
A Sure. If -- you mean as an intrapartum event or a prepartum event or what?
Q Intrapartum event?
A Yes.
Q During labor?
A Hypothetically, sure it can.
Q Now, we do know the baby has periventricular leukomalacia?
A No question about it.
Q And you would agree that one of the causes of periventricular Leukomalacia is an ischemic or hypoxic event that might have occurred to the child?
A When?
Q During the course of labor?
A No, that's not possible in this case.
Q At delivery?
A No.
Q Why is it not possible in this case?
A Because the baby has absolutely no symptoms

consistent with that.

Q And you are talking about the eight Apgar again; right?

A No. I'm talking about all of the symptoms.

Q Well, he was dusky at birth?

A So? The majority of premature babies are dusky at birth.

Q And that's the way you explain that away?

A No, that's not the way I explain that away. What are you talking about? Explain what away?

Q I'm asking you. Is that the way you explain that away, because premature babies are dusky at birth?

A I don't understand what you mean.

Q Well, is duskiness evidence of hypoxia to some degree?

A I've already answered that. No.

Q Okay. Never?

A No, I didn't say that.

Q I want to pin you down. Never or--

A No.

Q --sometimes or always?

A When the facts are supportive and the

laboratory data, the x-rays, the clinical course of the infant is supportive, then they may be.

Q Well, tell me about the laboratory data.

A What about it?

Q Well, what did the laboratory data show when they drew blood from this baby? I want you to tell me what it showed.

A The baby had perfectly normal blood gases.

Q All of them?

A Sure.

Q Blood sugar perfectly okay?

A Yes.

Q Everything okay? No abnormalities at all?

A Well, I don't know which -- you want me to turn the pages? Which would you like to see?

Q Doctor, I'm asking you what -- you've said everything was hunky-dory when that blood was taken. I just want to know what you thought these first -- this first blood showed that was taken from the baby?

A I don't think I used the term "hunky-dory." So, what are you referring to?

Q I'm referring to the first blood eest that was drawn. How was the baby's blood sugar?

A Well, there is a report here of forty, which is normal for a newborn.

Q What is the date on that report or what time was it drawn?

A Okay. 7/14 at 1:36 a.m.

Q 7/14?

A Yes.

Q That's not right after birth, is it?

A Okay. Well, I mean, tell me what you are referring to and I will be glad to look at it.

Q Look at a report of 7/13/'85 and the lab tests that were drawn.

MS. SHEA:

Blood gas or sugar? Which one do you want him to look at?

BY MR. HARDY:

Q What is thyroxine?

A It's a thyroid hormone.

Q Low or high?

A I don't understand what you mean.

Q Was the report low or high?

A Well, I will have to find it.

Q Does it show was it low or high?

MS. SHEA:

You mean back on the 13th now?

MR. HARDY:

(Nods head affirmatively.)

A It's in the low normal.

BY MR. HARDY:

Q Is that meaningless?

A That doesn't mean anything.

Q How about blood sugars?

A Okay. I mean, the only one that I have is a forty, which is normal for a premature infant.

Q How about calcium?

A Seven point seven. As -- for a premature infant would be on the low normal side.

Q Those don't mean anything to you?

A Well, sure, they mean a lot of things to me. I mean, what it means is in the context of the situation.

Q Well, the child was acidotic at 4:45 a.m., was he not, when the blood gases were taken?

A Which blood gases?

Q It says minimally acidotic?

A Where does it say that?

Q You've got the records there. I don't have the records.

THE WITNESS:

Let me see if yours are clearer.

**BY MR. HARDY:**

**Q** I believe the report said he was -- there was minimal metabolic acidosis?

**A** Well, that's the interpretation, but the -- I thought that was seven point three eight. Is that --

**MS. SHEA:**

It's the second one there. Weren't there two that day?

A Seven point three? Three? I don't have mine clear. Anyway, seven point three is normal.

**BY MR. HARDY:**

Q Well, I'm just going by what that report says.

A Well, I understand, but that's normal.

Q Minimally acidotic.

A We accept seven point two or greater to be normal.

Q I was just going by whatever that doctor said. That lab says the child was minimally acidotic?

A I understand.

Q Metabolically acidotic?
A Well, I understand what you're saying. But with a base excess of minus point five -- five point five and minus point two, there is no significant acidosis.
Q Acidosis, is that evidence of hypoxia?
A It can be or it could not be.
Q Of course, you did review the CAT scan reports that were returned from the radiologist that read the original CAT scans?
A Yes.
Q You do recall, of course, that that radiologist said that all of this is consistent with an hypoxic, ischemic event?
A I have no problem with that.
Q That was his feeling about what was reported on that CAT scan?
A Sure. I mean, that's what causes periventricular leukomalacia in terms of the pathogenesis.
THE WITNESS:
Let's just take a two minute break.
(BREAK)

BY MR. HARDY:

Q We are just about through here.

What is the most common cause of periventricular leukamalacia?

A Prematurity.

Q Prematurity?

A (Witness nods head affirmatively.)

Q Whether it's a hypoxic, ischemic event or toxicity or -- what causes the brain to bleed?

A It's not due to bleeding.

Q It's not due to bleeding at all?

A No.

Q All right. It's due to an ischemic event?

A Yes.

Q I take it you've done this before; you've given your deposition before?

A Sure.

Q How many times have you testified on behalf of defendants in cases like this?

A The vast majority.

Q Well, how many times?

A Oh, I don't know. I can give --

Q Give us a rough ballpark guess.

A I give five to fifteen depositions a year.
Q Okay. And how many years have you been doing this?
A Eight years.
Q And the vast majority are on the behalf of the defendants?
A Yes, that's the vast majority.
Q How many states have you testified in?
A Ten or twelve states.
Q How many times in Texas?
A Three times, maybe four times.
Q What cities?
A Houston and Texarkana.
Q Do you remember who the lawyers were?
A I believe Mr. Sartwell was involved and Mr. McFall. And Mr. Havlinka -- Lavinka.
Q Do you know who the plaintiffs' lawyers were, who represented the injured people?
A No, I really don't.
Q You don't recall?
A No.
Q When was it you testified in Houston?
A About three years ago.

Q You don't recall the style of that case, do you?

A No.

Q Or who the lawyers were? Was that Sartwell's case?

A Yes.

Q In Houston? And Don McFall?

A Yes.

Q Do you have dealings with Houston doctors frequently?

A Reasonably frequently. The Baylor Department of Pediatrics was principally the department at Washington University where I trained. So, I have a great deal of colleagues and the chairman is a very good friend of mine.

Q Okay. You know Dr. Rita Lee?

A No, I don't.

MR. HARDY:

Off the record.

(WHEREUPON, THERE WAS AN OFF-THE-RECORD DISCUSSION.)

MR. HARDY:

I think that's all I have this afternoon.

THE WITNESS:

Okay. Thank you.

MR. HARDY:

Perhaps we will see you in Dallas.

THE WITNESS:

I'm looking forward to it.

MR. HARDY:

So am i.

CROSS EXAMINATION

BY MR. SCHMIDT:

Q You weren't involved in those cases in Texarkana where the -- the incubator baby cases?

A No.

Q What's that term?

A Retrolental fibroplasia?

Q Yes.

A No, that's --

Q RLF. You weren't in the RLF cases?

A No. No, that's not an area of my expertise.

MR. SCHMIDT:

Okay. That's all.

REDIRECT EXAMINATION

BY MR. HARDY:

Q How many brain damaged baby cases have you testified in on behalf of defendants?

A I don't know.

Q Rough guess, over the years? Over the last ten years? A hundred?

A No. Thirty.

Q Thirty.

MR. HARDY:

Okay. That's all I have.

MS. SHEA:

Nothing else, Mike?

MR. SCHMIDT:

No.

MS. SHEA:

Okay. We will reserve our questions until time of trial.

FURTHER, DEPONENT SAYETH NOT.

# C E R T I F I C A T E

**STATE OF ALABAMA:**

**COUNTY OF' MOBILE:**

I do hereby certify that the above and foregoing transcript of proceedings in the matter aforementioned was taken down by me in machine shorthand, and the questions and answers thereto were reduced to writing under my personal supervision, and that the foregoing represents a true and correct transcript of the proceedings given by said witness upon said hearing.

I further certify that I am neither of counsel nor of kin to the parties to the action, nor am I anywise interested in the result of said cause.

LYNN ROBINSON-DYKES
COURT REPORTER

## CERTIFICATE OF WITNESS

I, ELIAS GEORGE CHALHUB, M.D., do hereby certify that on this, the ____ day of _____, 1990, I have read the foregoing transcript, and to the best of my knowledge, it constitutes a true and accurate transcript of my testimony taken on oral deposition on October 9, 1990.

_____

SUSCRIBED AND SWORN TO BEFORE ME ON THIS THE _____ DAY OF _____, 1990.

_____

STATE OF ALABAMA AT LARGE

**4-261> Estate of Ashley Carr**

**DEPOSITION OF ELIAS CHALUB, M.D.**
**[Estate of Gregg Kirkpatrick]**

**TAKEN ON October 9, 1990**
**by G.P. Hardy, ESQ.**

Pg / Ln

17/20 - 18/4 Because you have to tell what the degree of hypoxia is, what the distribution is and then I can tell you MOST BABIES TOLERATE HYPOXIA QUITE WELL

34/6 Symptoms: Hypoxia

HYPOXIA: require intubation.
renal failure
heart failure
seizures

38 CAUSES OF DECREASED PLOT (?) FLOW TO BRAIN:

- Infection
- Hypotensive episode
- Toxins
- **Systemic** diseases

47/13 7.3 **is** normal blood gas (7.2 or > accepted to be normal)

49/20 Vast majority of testimony is for defendants

**CHALHUB DEPOSITION (KIRKPATRICK) 10-9-90**

**18). Most babies tolerate hypoxia quite well**

**20). Not an ob - not his area of expertise**

**25-26). Cord around neck can explain variable decels.**

**27). APGARS are nondiagnostic of brain damage.**

**53). Testified in 30 brain damaged baby cases.**