In The Matter Of:

Jackson, et al. v.
Wartanian, M.D., et al.

Robert Ryan Clancy, M.D.
March 10, 1997

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IN THE CIRCUIT COURT
FOR BALTIMORE CITY
BARBARA JACKSON, Grandmother
and Next Friend of KYRSTEN
ELLIOTT, Infant, et al. :
Plaintiffs :
vs. :
GHEVONT WARTANIAN, M.D., et al.:
Defendants : NO. 96061014
Philadelphia, Pennsylvania
Monday, March 10, 1997

Deposition of ROBERT RYAN CLANCY, M.D., taken pursuant to notice, at the offices of Vincent Varallo Associates, Eleven Penn Center, 1835 Market Street, Suite 600, on the above date, beginning at approximately 2:35 p.m., before Joseph McCauley, Court Reporter and Notary Public.

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...ROBERT RYAN CLANCY, M.D., The Children's Hospital, Division of Neurology, 324 South 34th Street, Philadelphia, PA 19104, having been first duly sworn, was examined and testified as follows:

BY MR. FEDERICO:

Q: Doctor, your full name for the record?

A: Robert Ryan Clancy.

MR. CROSS: Phil?

MR. FEDERICO: Yes.

MR. CROSS: Just let me give you a couple things here. There's a CV that Dr. Clancy gave me today which is dated February 1997. I can use that one if you want to attach it to the transcript.

MR. FEDERICO: Thank you, Mike.

MR. CROSS: To sort of focus things for today, I think Dr. Clancy's opinions are going to be limited to some opinions he has after looking at the CT and the ultrasound, some opinions that he has with regard to the age of this baby from a neurological perspective, and life expectancy. That is basically it.

MR. FEDERICO: Okay.

BY MR. FEDERICO:

Q: Doctor?

A: Yes, sir.

Q: I think we need to put you under oath; did we do that yet?

A: Yes, we have.

Q: Have you ever had your deposition taken before?

A: Yes, I have.

Q: Just a reminder, if I ask you any question that you don't understand, don't try and understand them. Just let me know you didn't understand and I will rephrase my question. If you do answer I'm going to assume you understood the question.

A: That's fair.

Q: Now, Mr. Cross was just kind enough to give me a summary of the areas in which he anticipates you expressing opinions in this case at the time of trial. Are there any issues or opinions in general, areas in general, that you anticipate addressing other than those set forth by Mr. Cross, which would include the CAT scan, the ultrasounds, the age of the child from a

neurological perspective, and life expectancy?

A: No, that's it.

Q: Do you know Herb Grossman?

A: Yes, I do.

Q: Are you a fan of his? Let me rephrase that. Are you a pediatric neurologist who subscribes to Dr. Grossman's beliefs regarding life expectancy in children with cerebral palsy?

A: I actually didn't hear all that. Grossman as opposed to what?

Q: Are you a pediatric neurologist who subscribes to Dr. Grossman's beliefs and philosophy regarding the life expectancy of children with cerebral palsy?

A: I believe I am. Are you referring to the paper that is so widely-circulated and so forth?

Q: That's one of his many works, I guess, in the area.

A: You're talking about Herbert Grossman?

Q: Herb Grossman, yes.

A: Yes.

Q: So is it fair to say that with regard to this case you will not be addressing any issues on the standard of care?

A: That's correct.

MR. FEDERICO: Mike Cross has been kind enough to – I guess you have been even kinder – to provide us with an up-to-date CV. I'd like to have marked as Deposition Exhibit 1, I'd like to have it attached to the transcript so that everybody gets a copy.

(Document marked Exhibit No. 1 for identification.)

BY MR. FEDERICO:

Q Dr. Clancy, do you know Ed My-

A Yes, I do.

Q How do you know him?

A Just through professional relationships.

Q I think he used to be at Hopk- did he not?

A I'm not sure of that. I've c- known him since he's been at M- cal College of Virginia.

Q Does he enjoy a good reputat- in the pediatric neurology c- munity?

A I don't – I can't speak for them, I certainly hold him in high resp-

Q Do you know a gentleman by name of Abe Cutorian?

A: Only by name.

Q: Where have you heard his nam-

A: Medical/legal circles mostly.

Q: Has it been mostly as a defe- expert?

A: I don't know that I can say t- That's the general connotation - heard his name.

Q: Now, I take it you completed y- medical school training and y- postgraduate training in an - nterrupted fashion?

A That's right.

Q After your postgraduate train- at Stanford did you stay there f- while?

A No. When I finished trainin- moved to Philadelphia, and I've b- here ever since.

Q Do you know Larry Brown?

A Yes.

Q How do you know him?

A His office is next to me.

Q No kidding?

A Yeah.

Q Is he an adult neurologist c- pediatric neurologist?

A He's pediatric.

Q What is his title?

A: Larry is an assistant professor c- neurology.

C You are?

A Professor of neurology.

C So have you been there longer than [6] Brown?

A Yes, I have.

C Who is your chairman?

A We don't actually have a chairman [10] now. He –

[1] C: Who was your chairman?

[2] A: What was his name? Ely Schwartz

[4] C: Where did he go?

[5] A: DuPont, A.I. DuPont Institute

[7] C: No kidding?

[8] A: Yes.

[9] C: Do you know Michael Alexander, [10] who is the [11] director there?

[12] MS. BOYCE: What is this, an alumni [13] meeting?

[14] THE WITNESS: No, I don't know [15] Michael.

[16] BY MR. FEDERICO:

[17] C: Who is the acting chair of your [18] department

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[1] or your division?

[2] A: I'm trying to think of his name. For [3] some reason his name has escaped me [4] right now. He's [5] very much an interim [6] appointee.

C Did you first obtain a license to [7] practice [8] medicine by way of a national [9] board? Was it a [10] flex?

A: I think it was the flex, actually.

C Did you pass all portions on your [11] first [12] attempt?

[13] A: Yes, I did.

[14] C: I take it you've never had your [15] license in [16] any way suspended, restricted, revoked or [17] conditioned?

[18] A: That's correct.

[19] C: I take it you've never had your [20] privileges [21] in any way suspended or [22] limited or acted upon [23] unfavorably?

[24] A: That's correct.

[25] C: I take it you have never been

[1] convicted of [2] a crime?

[3] A: No.

[4] C: I take it you have never been a [5] defendant [6] in a malpractice case?

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[1] A: I have been a defendant in a [2] malpractice case, yes.

C On how many occasions?

A Three.

C Let's talk about those in chronological [6] order, if we can, starting [7] with the most recent. [8] What was the [9] name of the patient?

MR. CROSS: Let me just ask, are they [1] ongoing or closed?

[2] THE WITNESS: Ongoing – two are [3] ongoing.

[4] BY MR. FEDERICO:

[5] Q: I don't need any details, just a general [6] description. The most recent case, the name of [7] the patient?

[8] A: Yeah, I'm trying to think of that. Give me [9] a second. My anomia is flaring up. Well, I think [10] the last name of the child is Cross, C-r-o-s-s, [11] and there from Tennessee, something like that.

[12] Q: Have you been deposed in that case?

[13] A: No.

[14] Q: What is the allegation, very generally, the [15] allegation of malpractice?

[16] A: Well, the child was born with a heart

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[1] defect, a congenital heart defect, and was [2] transferred to our Children's Hospital to have [3] surgery. And it went very poorly the whole [4] condition of the child was very poor and the child [5] died after surgery, and we're all being sued [6] because of that.

[7] Q: Let's go back to the case prior to the [8] Cross case, what is the name of that patient?

[9] MR. FEDERICO: Off the record.

[10] (Discussion off the record.)

[11] BY MR. FEDERICO:

[12] Q: Doctor, do you remember the name of the [13] patient in the second case?

[14] A: Yes, patient's name is Lisa Slowik.

[15] Q: Have you had your deposition taken in that [16] case?

[17] A: Yes, I have.

[18] Q: Generally what is the allegation of [19] negligence?

[20] A: Basically, I saw the child as a neurologist [21] because she we fainting, and they wanted me to [22] rule out seizures was it a seizure or a faint? [23] It turned out to be a faint. Then I referred the [24] child to a cardiologist, and they did a test

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[1] called a tilt table test to check to see if their [2] blood pressure falls when they stand up and things [3] like that. An IV was started for that test and [4] the doctor who started the IV allegedly injured [5] the nerve in the arm when that happened.

[6] Q: An IV infiltration?

[7] A: I think just the needle itself when they [8] did venepuncture. I guess it's the captain of the [9] ship theory by which I'm being sued.

[10] Q: I guess so.

[11] MR. CROSS: You would never bring [12] such a case, Phil?

[13] BY MR. FEDERICO:

[14] Q: No, I wouldn't and I certainly wouldn't [15] include Dr. Clancy under those circumstances.

[16] But in any event, let's go back to the [17] first case. What was that case about?

[18] A: The first case was a child that I had taken [19] care of for many years for Tourette's syndrome, [20] and had independently developed a brain tumor. It [21] was a malignant brain tumor and the child died [22] within a few months. That case was – again, it [23] was the neurosurgeon who removed the tumor was [24] sued. The neuropathologist was sued and I was

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[1] sued.

[2] Q: The patient's name?

[3] A: Paul. I think it's Paul Elliott.

[4] Q: Do you remember the outcome of the case?

[5] A: Well, the child died, and I guess –

[6] Q: The outcome of the legal case.

[7] A: Yeah, the legal case, everything was [8] dropped.

[9] Q: Were you deposed in that case?

[10] A: I don't think so, no.

[11] Q: I see that you're Board-certified in [12] pediatrics, child neurology, and –

[13] A: EEG, basically.

[14] Q: Did you pass all of those board [15] examinations on your first attempt?

[16] A: No.

[17] Q: Which one did you not pass on your first?

[18] A: The oral EEG examination I had to repeat a [19] section, one of the four sections.

[20] Q: Are there any other professional [21] examinations which you have ever taken where you [22] have been unsuccessful on your first attempt?

[23] A: No.

[24] Q: I'm just going through your CV. Bear with

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[1] me. Bibliography, starting on Page 5, Original [2] Papers. Are any of your original papers related [3] to group B strep?

[4] A: Might be. Just bear with me one second. I [5] think on page – well, what I have as Page 7, [6] Article 33 is a paper called the Prognostic Value [7] of EEG and Neonatal Meningitis. I believe some of [8] those patients had group B strep; I'm not [9] absolutely certain of that. But that is really an [10] EEG paper. That is not

standard of care, that [11] sort of thing.

[12] **Q:** Any other original papers related to group [13] B strep?

[14] **A:** Only insofar that children with group B [15] strep can have brain damage at birth, they can [16] have seizures; and that's in a general sense what [17] I write about. But I don't think I have any that [18] specifically is the neurology of group B strep, [19] anything that direct.

[20] **Q:** Do you have any papers, original papers or [21] any publications that relate to the issues of this [22] case? Why don't I make it easy and say, do you [23] have any papers that relate to the issues in this [24] case regarding CT and ultrasound?

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[1] **A:** No, not really.

[2] **Q:** Do you have any that relate to the issues [3] of this case regarding gestational age?

[4] **A:** No, not really.

[5] **Q:** Did you have any that relate to the issues [6] in this case regarding life expectancy?

[7] **A:** No.

[8] **Q:** Do you have any regarding issues in this [9] case that would relate to group B strep other than [10] what you have told me about?

[11] **A:** No.

[12] **Q:** Is there any area of pediatric neurology in [13] which you have a particular interest?

[14] **A:** Yes.

[15] **Q:** What is that?

[16] **A:** The neurology of the newborn infant.

[17] **Q:** Is there any area of neurology in which you [18] have had a particular research interest?

[19] **A:** Same, the newborn infant.

[20] **Q:** What about the newborn infant, anything in [21] particular?

[22] **A:** Well, I basically – in our group at [23] Children's Hospital there is 13 child [24] neurologists, and within that group everyone has

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[1] their own little specialty within child [2] neurology. Mine is critical care and newborn [3] neurology. So I'm the consultant that goes to the [4] newborn nursery when children have strokes or [5] seizures or comatose states, things like that.

[6] My research right now is with infants [7] who have congenital heart disease, because there [8] is a very high incidence of undesired neurologic [9] sequela from the heart disease or the surgery that [10] is needed to fix it. That is what my research is [11] in.

[12] **Q:** Do you hold yourself out as an expert in [13] neuroradiology?

[14] **A:** No. I do not.

[15] **Q:** Do you hold yourself out as an expert in [16] neonatology?

[17] **A:** No, I do not.

[18] **Q:** When was the first time you ever reviewed a [19] medical/legal case?

[20] **A:** 1981.

[21] **Q:** From 1981 to the present can you estimate [22] the number of cases that you have consulted on; [23] not necessarily testified or written a report, but [24] reviewed?

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[1] **A:** I would say about 60 cases.

[2] **Q:** Of those 60 cases can you tell me how many [3] have progressed to either a written report or [4] deposition?

[5] **A:** Perhaps a quarter of those.

[6] **Q:** How many times do you think you have had [7] your deposition taken?

[8] **A:** Fifteen times.

[9] **Q:** When was the last time?

[10] **A:** January, this year.

[11] **Q:** Do you remember the name of the plaintiff [12] or defendant in the case?

[13] **A:** I remember the lawyer's name.

[14] **Q:** Who were the lawyers?

[15] **A:** Gerald Mitchell from Washington D.C., [16] Stein, Mitchell, Mezines.

[17] **Q:** Were you testifying on behalf of Mr. [18] Mitchell or his client?

[19] **A:** It was on behalf of his client, the [20] plaintiff.

[21] **Q:** In the past 12 months how many depositions [22] have you given?

[23] **A:** Maybe three.

[24] **Q:** The case with Gerry Mitchell, do you

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[1] remember generally what the allegation was or what [2] the issue was?

[3] **A:** Yes, it was basically a, quote, bad baby [4] case, and the mother had contracted this disorder [5] called acute fatty liver pregnancy, and it's a – [6] basically, it's a lethal condition. It just [7] worsens and worsens until either the mother or the [8] baby or both dies.

[9] **Q:** Let me stop you there in the interest of [10] time. I just wanted to get a general idea.

[11] Now, in the past year have you [12] testified in court at all?

[13] **A:** Yes, I think really one time last year, and [14] it was a suit against a pediatrician for a child [15] who died during a seizure. It was like a [16] 7-year-old child. It was not a newborn case.

[17] **Q:** The defendant?

[18] **A:** The defendant, yes.

[19] **Q:** Do you remember the name of plaintiff [20] or defendant?

[21] **A:** I remember the name of – may don't. [22] Let me think. I can't think right now.

[23] **Q:** Do you remember the name: any of the [24] lawyers involved in case?

Page

[1] **A:** No, I've managed to suppress from [2] memory, too.

[3] **Q:** Where was the case pending?

[4] **A:** It was in Camden, New Jersey. T is [5] where the courtroom was. Tha where I went to [6] give testimony.

[7] **Q:** Was one of the lawyers nar Jeffrey [8] Kaiser?

[9] **A:** Not that I recall.

[10] **Q:** Of all the cases that you h reviewed, [11] can you tell me w percent have been on behalf [12] of plaintiff, what percent on behalf of [13] defendant?

[14] **A:** Probably about 60 percent d nse, 40 [15] percent plaintiff, someth along that line.

[16] **Q:** Can you give me the names of [17] plaintiff's attorneys you have wor with in the [18] past other than Ge Mitchell?

[19] **A:** Yes. I should prepare a list these [20] questions. I never have swers. There is a firm [21] in Nc Caro'ina that is a plaintiff's firm, basically, that I've dealt with sev times. [23] I'm just trying to think of name. It's [24] something Roberts f Char'otte, North Carolina.

Pag

[1] I have done several cases with th

[2] **Q:** Have you dealt with any attorn or law [3] firms in Maryland other t this particular case [4] that we're dea with today?

[5] **A:** I think I have. I certainly don't h any [6] recollection of their identi right now.

[7] **Q:** Have you ever worked with Cross or the [8] people at Smith, So rville & Case before?

[9] **A:** I don't think I have worked v Mr. Cross [10] before. It's possible I something with Smith [11] Somerv whatever, but I don't recall doing that.

[13] **Q:** Do you know how they got y name as [14] somebody who may willing to help them in this [15] case

[16] **A:** No.

[17] **Q:** Do you charge for your time a expert?

[18] **A:** Yes, I do.

Q: How much do you charge?

A: $300 an hour.

Q: How many hours do you have into this case?

A: Originally, back in '95 or '96 when I got this first, I think it was like three hours to review the first batch of medical records. Since

then I have got a whole stack of depositions that I read, so forth and probably another eight hours.

Q: Now, in this particular case, would it be fair to say that you're not basing your opinions on any of the depositions?

A: Correct.

Q: When were you first contacted?

A: I believe it was in '95. Just let me look and see if I can get my first letter here.

Q: Why don't you pull out all your letters, if you could?

A: You want to hear the dates on them, basically?

Q: I want to hear the date of the first letter.

A: I don't actually know I have that, but I think the first bill I sent to them was like November of '95, something like that order. So I'm going to take it that it was within a few months of that date.

Q: Okay.

A: I don't think I had any depositions then. It was just the medical records.

Q: Have you ever done any work with an expert

witness service?

A: No, I have not.

Q: Have you ever discussed this case with anybody other than Mr. Cross?

A: Well, I reviewed the CAT scan with the neuroradiologist.

Q: What is the name of your neuroradiologist?

A: Bob Zimmerman.

Q: Why did you review the films with Bob Zimmerman?

A: Well, it's an unusual film. I just wanted his thoughts about the nature of the injury.

Q: What did Bob Zimmerman tell you?

A: That it was most consistent with disseminated intravascular coagulopathy.

Q: Can DIC result from group B strep infection?

A: Yes, it does.

Q. Is that what you think happened in this case?

A. Yes, I do.

Q: Have you discussed the case with anybody else other than Dr. Zimmerman?

A. No.

Q. Have you issued a written report?

A: No. I have not.

Q. Have you looked at any literature related to the issues in this case?

A: I read a little bit about the incidents of colonization, the rate of infection, and the relationship between colonization and premature onset of labor in a book by Phil Sunshine. It's in my CV as a matter of fact, because I have a chapter in there. But there's a lot of good stuff in there, but that's really the only literature source I looked to. I also reviewed the Grossman article to look up some of those tables that they cite life expectancies from.

Q: Other than Dr. Grossman's article and the book by Phil Sunshine, anybody else?

A: No.

Q: Where in your CV is that book referenced?

A: I'm looking for that now. Okay, it's in the newer CV – maybe the same in the old one – Page 15, Reference 12. My specific reference is on neonatal seizures. The name of the book is Fetal and Neonatal Brain Injury: Mechanisms, Management, and the Risk of Practice, D K

Stevenson and Phil Sunshine, editors, 1989.

Q. Have you made any notes?

A. Yes. I have a couple pages of notes.

Q. How many pages?

A. Five.

Q. Would you be kind enough to hand those to the court reporter? I'd like them marked Deposition Exhibit No. 2 and I'd like a copy to be attached to the transcript.

A. Sure.

(Documents marked Exhibit No. 2 for identification.)

MR. FEDERICO: Mike, as I did this morning, I'll ask you for your expert opinion on the legibility of those notes. Can we read them?

MR. CROSS: Yes. I think these are also legible. If you have any questions you can certainly reopen it to ask. But I think you'll be okay.

BY MR. FEDERICO:

Q: Doctor, have you ever testified in a case like this before involving similar issues as the Elliott case?

A: No, not really.

Q: Now, can you list for me the materials that you have reviewed upon which you will be basing all of your opinions or any of your opinions in this case? I know you were sent a lot of different stuff. I'm only interested in having you flip through and just tell me, if you could, extract the materials that you were relying on, specifically for purposes of arriving at and expressing any and all of your opinions in this case.

A: All right. The actual medical records themselves I got in one big binder, sort of.

Q: Do they contain records from various places?

A: Yes.

Q: Does it have an index?

A: Yes, it does.

Q: How many pages is the index?

A: One page.

MR. FEDERICO: I'd like to mark it Deposition Exhibit No. 3 and attach a copy of it to the transcript.

(Document marked Exhibit No. 3 for identification.)

BY MR. FEDERICO:

Q: Now, Doctor, the materials listed on that index, are you relying on all those materials for purposes of your opinion or just some of them?

A: Really some of them.

Q: Can you tell me which ones?

A: The main one would be the mother's records from Shannon Anderson. On the index here it says, Dr. Wartanian, Harbor Hospital Center, delivery 4/20/93. Then there is a list of what is in there: Prenatal records, fetal monitoring strips, admission notes, so forth on the list. The second major is the records of the baby, Kyrmen Elliott. The subheading is Harbor Hospital Center, 4/20/93 to 5/7/93, ending in subheadings of admission and discharge, newborn records, progress notes, and so forth.

There is other records in there that are not really terribly relevant.

Q: Okay. Anything else?

A: No. In terms of medical records the only other thing I got was a package of information from Maryland School for the Blind, which is largely forms and progress notes and goals of

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treatment and therapy, that sort of thing. This morning I read a letter from Dr. Cutorian, and I had received a report from Dr. Myers sometime in the recent month or so.

Q: Anything else?

A: No. Everything else I have is a stack of depositions.

Q: Have you seen a life care plan from either a Mona Yetcoff or life care plan from Cheryl Ransan?

A: Actually, yes. I have the plan from Mona Goldman Yetcoff in front of me here.

Q: Do you know her?

A: I'm not sure. I have a feeling she's married to one of the doctors that works at Children's Hospital.

Q: What hospital?

A: I think her husband works at the same hospital I do. I'm not sure of that, though.

Q: Do you consider yourself an expert in life care planning?

A: No, I'm not.

Q: Is it fair to say you will not be addressing issues regarding life care planning at

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the time of trial?

A: I hadn't been asked to do that.

Q: Now, with regard to your involvement in other malpractice cases in the past, when you are addressing life expectancy in the past, when you have been asked to address life expectancy in the past, and the case has deeded to trial, first of all, have you ever done that? Strike that.

Have you ever addressed life expectancy in a case where the case went to trial?

A: I don't actually think I have. I know I have been asked in depositions, but I don't remember standing in a courtroom and talking about it.

Q: So the cases that you have addressed life expectancy on where the case proceeded at least to a deposition of you, had you examined the patient?

A: Sometimes, yes. Sometimes, no.

Q: In cases where you have been asked to address that issue on behalf of a plaintiff, have you typically seen the patient?

A: Not necessarily. Obviously, before going to trial I would want to do that, but the records were rather clear from your expert neurologist,

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Dr. Myers and so forth, that it painted a pretty clear picture, as well as the developmental information from Kennedy Krieger Institute.

Q: Why would you want to see the plaintiff before going to trial on that issue?

A: Just personal comfort level.

Q: Is it fair to say that based on your review of the medical records in this case you do not have any disagreement with the contents of the reports from Dr. Myers or Dr. Cutorian?

A: No. I thought their reports were very explicit. I read them clearly to describe a very handicapped child with a great many neurologic-based problems.

Q: Is there anything in the reports of Dr. Myers or Dr. Cutorian that you found to be inaccurate?

A: Well, not having seen the child it would be hard to say inaccurate, but I didn't really take exception to anything they had in there.

Q: Now, what I'm going to do is cover the areas that I think Mr. Cross mentioned earlier that you're going to be expressing opinions on.

Let's first talk about CAT scans and

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ultrasound.

A: Okay.

Q: First of all, would you commonly defer to a neuroradiologist with regard to the interpretation of CAT scans and ultrasound in a neonate since you're not an expert in neuroradiology?

A: Well, I would commonly confer with them. I don't know – I mean, it's my practice. Since that is what I do in my daily life in medicine is to examine these babies, I go to them with information, look at the scan with them, and try to make sense out of it, because it still is an interpretation. You're still looking at black and white images or whatever.

If it was something very subtle, artifacts, those sorts of things, yes, I would defer to them. It turns out this is a pretty distinctive CAT scan. This is not what I'm used to seeing in everyday practice. It just – it's a peculiar scan; that's all.

Q: What I'd like to do at this point, Doctor, is go through the films in this case. First of all, do you have the films with you?

A: No, I left them in my office.

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Q: I don't think we actually need to put them up on a view box unle very unique opinion comes to here. Why don't we go through th reports, go through them in c nological order? Feel free to refe the reports.

A: All right.

Q: I believe the first radiological st done on Kyrsten Elliott's head wc be a neonatal sonogram on 4/22/

A: Let me just find out. I think yo right. Yes, I have that here.

Q: Do you see that report by Goodman?

A: Yes, Lee Goodman.

Q: Does your interpretation of particular film comport with Goodman's interpretation?

A: Yes, it does. By the way, thoug have – what I've got in my hanc was in my office was this scan and CT. I don't have the other h ultrasound, so I'm relying on ot reports at this point.

Q: For the head ultrasound of 5/3 which was read by, I think it's Skrenta, you haven't seen the film that correct?

A: That's right.

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Q: Would it be fair to say since have not seen the film you're not position to disagree with Dr. Skren report?

A: That's right. I'm not in a positio disagree with the report.

Q: Now, the following day, Ma 1993, a dry head CT was done, ar was interpreted by Dr. Gelman. D your interpretation comport with of Dr. Gelman?

A: In general it does. By that, the descriptive terms that he uses I think pretty accurate. For example, w he calls, quote, decreased attenua of the periventricular white ma end quote, yes, that is there. There is hemorrhage associated with the area infarction. That is there. So I think basic observations are valid ones

Q: I believe or I bet I can predic area where you don't necessa agree, and that would be ur Impression. Would it be fair to say tha you're of the opinion that these find would be most compatible with ischemic encephalopathy as posed to a hypoxic ischemic e. phalopathy?

A: Well, I'm not so worried ab that. Let

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me just say if you want to use the t HIE in a very generic sense,

curring in the course of [5] labor and livery hypoxia ischemia, but just a [6] erbance in circulation, then I don't ve any [8] trouble with it.

Q: Let me see if I understand that [1] [2] regard to the CAT scan, above Impression are [3] really the findings rrect, Dr. Gelman's [9] findings?

[4] **A**: Yes, the findings, the description what [11] he sees, agrees with what I and Dr. Zimmerman.

[5] **Q**: Fair enough. Now, under Im ession, do you [13] have anything under pression that you disagree [14] with or at you would add, you and Dr Zim erman?

[15] **A**: Yeah, what I would add is that the e'll [16] picture is that which I have ntered before [17] with DIC, spec ly DIC as a named type of [18] HIE

[1] **Q**: Now, with regard to the CAT scan d [20] ultrasounds in this case, generally aking, how [21] do they play into your inions?

[22] **A**: Well, to me, you know, I think this [23] trying to understand what actually maged this [24] child's brain. Let's just y that there is three

specific mechanisms by which any fection could [2] cause the physical ain damage that results in [3] her ondition right now.

[4] For example, the first would be, well, was it just plain old meningitis of some pe? [6] Was it really damaged because e covering of the [7] brain, the men ges, was infected? Of course, I m [8] ure they were unable to do the spinal p [9] because of the fragility of the ild, but when [10] that was done a week so later, I don't really [11] think there as evidence that the child had [12] eningitis. So that is one way group B rep can [13] cause brain damage is rough the mechanism of [14] menin gitis. But that wasn't the case.

[15] Second would be basically related id [16] that is called cerebritis. In there it eems that [17] the infection is not just e meninges, but the [18] infection is of e brain tissue itself. So [19] again the rm is directly attacking the tissues [20] the brain. It's right there in its face and [21] it's chewing away at brain tissue gain, I don't [22] think – judging by the T scan, it doesn't look [24] to be really hat's going on here.

[1] What makes the most sense to me ased

on the scan and on the clinical picture that [2] the infection gave rise to this oagulatory [3] condition called DIC but we see in the scan [5] now, the scan, e CAT scan from 5/4/93, is a [8] quote DIC brain or type of pattern of injury you [9] would expect with this DIC.

[17] **Q**: Could a DIC result in hypotension? Are [18] they related?

[19] **A**: Well they're related in the sense that if [20] you could somehow peek inside the blood vessels in [21] a person who has DIC, it turns out that the blood [22] is being sludged or stuck to the walls of the [23] blood vessels, and it's as though things like the [24] platelets are being consumed by the process. So [25] the blood is trying to flow through the blood [26] vessels, but it's being blocked by these deposits [27] inside.

[28] Now the other side of the sword is [29] that those same platelets that are sludging and [30] clogging the blood vessels up are not available to [31] do their normal job of stopping bleeding. That is [32] why they have these secondary hemorrhages. For [33] example, when you look at the scan on this baby [34] there is dozens – I shouldn't say dozens; there

[1] is multiple separate areas of infarctions of [2] tissue death, but they all have bleeding into [3] them, and that is sort of the hallmark of the DIC [4] is that first it causes a stroke, then it bleeds [5] into the stroke.

[6] So for example, this does not really [7] look anything like a, quote, preemie, you know [8] IVH, typical run-of-the-mill, everyday [9] intraventricular hemorrhage just from prematurity; [10] nor does it look like birth asphyxia that was just [11] a matter of a baby with a cord prolapse of [12] abruption of the placenta. But it's a very [13] distinctive looking CAT scan.

[14] Again, knowing that the child had [15] infection, knowing that the child had DIC and [16] seeing the scan, I think that's the smoking gun, [17] if you would, or the mechanism by which the [18] infection caused the brain damage.

[19] **Q**: So if I may summarize in a layman like [20] fashion would it be fair to say that you believe [21] based on reasonable medical probability what [22] happened here was that Kyrsten Elliott developed a [23] group B strep infection which resulted in DIC and [24] hypoxic ischemic encephalopathy?

[1] **A**: Yes

[2] **Q**: Before I move on, let me ask you this. Are [3] there any other opinions you have about the films [4] in this case that you anticipate discussing at the [5] time of trial that we haven't talked about?

[6] **A**: No

[7] **Q**: Now, let's talk about the group B strep in [8] general, and what I'd like to do is try to sort of [9] construct with you, if I can, a time line with [10] regard to Kyrsten Elliott and her mother and what [11] was going on.

[12] Can we agree that on April 20, 1993, [13] prior to delivery, Kyrsten Elliott's mother, [14] Shannon Anderson, certainly had group B strep [15] colonization?

[16] **A**: Well, speaking as a child neurologist, I'm [17] not really sure that is in my purview. But it [18] certainly makes sense to me that the mother was [19] colonized. I didn't really see anything that [20] would say she had a visible infection, you know, [21] with respect to tenderness, fever, and all that [22] sort of thing. It makes sense to me, but I don't [23] want my opinion on that to be the last word, [24] because it shouldn't be.

[1] **Q**: There are a lot of people that are going to [2] have words.

[3] **A**: I'm sure

[4] **Q**: Let's shift gears and talk about Kyrsten [5] Elliott. At what point in time do you believe, [6] based on reasonable medical probability, she [7] became colonized with group B strep?

[8] **A**: I don't know. I think – it's my [9] understanding that the membranes were ruptured by [10] the physician, so-called artificial ruptured [11] membrane around 8 o'clock, if I'm not mistaken?

[12] **Q**: I believe that is accurate. Delivery was [13] at 11:20.

[14] **A**: Right. Like I say, I think if the mother [15] actually had an infection of the womb, I would [16] have thought there would have been something more [17] to show for that, and there wasn't. So I'm going [18] to take it that after the membranes were ruptured [19] the child became colonized after that point.

[20] **Q**: But sometime between that point and the [21] time of delivery?

[22] **A**: Yes.

[23] **Q**: Fair enough. Do you have an opinion based [24] on reasonable medical certainty of what point in

[1] time Kyrsten Elliott became infected?

[2] **A**: That is very interesting. If you'll bear [3] with me, I just want to go to a specific part of [4] the medical records, because to me they're [5] relevant.

[6] **Q**: Sure

[7] **A**: This is the very first nursing notes on [8] Kyrsten. The title of this page is Newborn [9] Nursery Nursing Observations. It's pretty much [10] when the kid first shows up in the well nursery, [11] they go through all their checklists and describe [12] the baby.

[13] **Q**: Roughly, what time is that, according to [14] the record?

[15] **A:** 11:45 in the morning.

[16] **Q:** Okay.

[17] **A:** So for example, the date here is 4/20. The [18] time is 11:45 in the morning. As best as I can [19] tell, these are nursing notes. Looks like D. [20] Jacobson, R.N. is the author of this form. And [21] here's what strikes me. Under General Appearance, [22] the first thing it says is Cry. It says - circle [23] Weak, then it circles, Only with simulation.

[24] Again, not to make too big a deal out

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[1] of that, but it's potentially neurologic. A weak [2] cry and a baby only cries to stimulation is a [3] little concerning. Right above that it's [4] recognized that the mother was given Demerol, so [5] they had that information when this was made.

[6] **Q:** Demerol could have that effect on the baby, [7] could it not?

[8] **A:** Yes, it could. The color of the skin was [9] circled in the following ways. Circled cyanotic. [10] Circled oral cyanosis and peripheral cyanosis and [11] then the word dusky was written in. Under [12] comments it says, Poorly perfused, left arm was [13] bruised, and the left groin and the left leg and [14] thigh and the right leg also bruised.

[15] **Q:** Do you have an opinion as to what the most [16] likely cause of the bruising was?

[17] **A:** Well, I say this, I suspect that it's DIC, [18] and the reason I say that is that it's the same [19] idea that DIC is a disorder of blood vessels. [20] It's a clogging. It's a disorder of blood [21] vessels, and one easy place to see that is on the [22] skin. There is plenty of blood vessels on the [23] skin.

[24] What it basically says is that those

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[1] blood vessels are very fragile. Whatever the [2] dates, this is not a big baby. It sounds like [3] it's a lot of bruising. So all I'm saying is this [4] is consistent with DIC even at that point.

[5] **Q:** Now, would you say based on reasonable [6] medical probability we certainly can agree that [7] the child was affected at 1:00 p.m. on that date [8] when they took the culture?

[9] **A:** Yes, to have the germs grow out of that [10] culture they had to be there. So she was not just [11] colonized but infected at that point.

[12] **Q:** Do you have an opinion based on reasonable [13] medical certainty whether or not Kyrsten Elliott [14] was infected at the time of delivery at 11:20 on [15] that day, or are you unsure?

[16] **A:** At 1 o'clock was she infected?

[17] **Q:** No, at 11:20, time of delivery.

[18] **A:** Oh, at the time of delivery?

[19] **Q:** Yes. Do you know based on reasonable [20] medical certainty at the time of delivery, 11:20 [21] a.m., whether or not Kyrsten Elliott was infected [22] as opposed to just colonized?

[23] **A:** Well, my opinion is she probably was early [24] in her phase of delivery. Let me just tell you

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[1] why, if I could. First of all, we're going to do [2] this backwards a little bit. We know today this [3] child has a lot of brain injury. I don't think [4] anybody is disputing that. I know from the scan, [5] the CAT scan, that this isn't just low blood [6] pressure. There is a lot of hemorrhage in there. [7] The child did have DIC. So that the mechanism of [8] the brain injury seems to be DIC.

[9] Now we have the very first description [10] of the child at 11:45, and there is a lot of [11] neurologic things in here: weak cry, only cries [12] at stimulation, poorly perfused, the bruises that [13] could be DIC.

[14] Now, I'm aware of the other issues. I [15] know the child was given Demerol, but remember [16] that they tried to reverse that by giving Narcan. [17] So that's a narcotic antagonist. So I don't think [18] you can blame Demerol at that point for the [19] child's neurologic appearance.

[20] The other issue was the trouble with [21] the breathing, which originally was from they [22] said, Plus, plus amniotic fluid below the cords [23] and the wet chest X-ray and the poor pulse ox and [24] that sort over thing. So I know that there are

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[1] medical factors going on that can make the [2] neurologic picture confusing.

[3] But what I'm saying is, if you don't [4] look at just one day, but look at what turns out [5] to be a DIC picture on the CAT scan and then the [6] current condition of the child, this may very well [7] be the first clinical sign of infection.

[8] **Q:** So is it fair to say that you believe based [9] on reasonable medical probability the infection [10] began sometime between the time of birth at 11:20 [11] and the culture that was drawn at 1:00?

[12] **A:** Well, yeah, I mean even here at 11:45 [13] they're already describing a neurologically sick [14] child.

[15] **Q:** Let me ask you this: Do you believe at [16] 11:45 based on reasonable medical certainty [17] Kyrsten Elliott was already infected?

[18] **A:** Well, I suspect so. That is really the [19] most honest way I can answer that.

[20] **Q:** I hear you, and I'm just trying to understand if your suspicion meets level of [22] what a medical opinion ne to be from a [23] medical/legal s dpoint.

[24] So do you believe that at 11:45 a

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[1] or April 20, 1993 it is more likely t not [2] Kyrsten Elliott was already fected?

[3] **A:** I actually do.

[4] **Q:** That's fine. I'm just making sure understand. Do you believe she already [6] infected at 11:20 at the tim delivery?

[7] **A:** That's hard to say. I don't h enough [8] description of the child.' note at 11:45 [9] paints this whole pic of the child who is not [10] crying a

[11] **Q:** I understand.

[12] **A:** Yes, so I can't really speak sooner [13] than that.

[14] **Q:** Fair enough. Would it be fair to [15] then, at the time of delivery cannot say with [16] reasonable mec certainty Kyrsten Elliott was [17] fected?

[18] **A:** That's true.

[19] **Q:** Now, let's talk a little bit abou you [20] ever prescribe antibiotics septic neonates?

[21] **A:** No.

[22] **Q:** Do you generally agree that soon er the [23] antibiotics are given in setting of a group B [24] strep in a neot the better the outcome?

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[1] **MS BOYCE:** Objection.

[2] **BY MR. FEDERICO:**

[3] **Q:** You can answer.

[4] **A:** Well, with respect to treating group B, [5] I think that is true. But a the reason I'm [6] concerned in specific case is that I don't [7] think group B was the direct mechar again, [8] it wasn't a direct brain infec

[9] **Q** Right, it was the group B caused the [10] DIC that caused isch emia that caused the brain [11] jury?

[12] **A:** Right. But see, the behavior of is not [13] like one to one connecte the infection. So to [14] some extent i a mind of its own, if you [15] would, has its own time line. Once tha process is started, it's already set motion [17] like a domino effect, if would.

[18] So treating the infection at tha point certainly is necessary and irab'e, but [20] the DIC kind of has a l its own.

[21] **Q:** First of all, I think you

sulted[22] you can't ignore the infect n. The sooner you [23] treat it with gard to the infectious process [24] itself ? Better that is. But infection is not

s only thing you're worried about is ar, [2] in this case?

A: Yes, it's the systemic manifestations at [3] are really brought on by the mune system of the [5] baby that really what attacked the nervous [6] system

Q: When you have a patient, a baby e this [8] who has DIC, there are odalities with which to [9] treat and/or port a patient like this as it [10] relates their DIC; correct?

A: Well, I mean, there are recommended [12] treatments, obviously, as was one here to try to [13] maintain blood essure. But in other words, [14] think out the nature of DIC, again, is that [15] side the blood vessels, they're clogging . So [16] even if you have a good heart te and good blood [17] pressure the ood still can't go through.

Q: For example, in the first, that first [19] ght of Kyrsten's life, there were lots of roblems with what they call tissue 'o sion. So [21] even when they had a cent blood pressure, she [22] still was icotic, because blood just couldn't go through those clogged blood vessels

Q: So it's like they were treating her

infection through that night and she ntinued to [2] deteriorate, because ain, once the DIC is set [3] into motion, pretty much has a time course of [4] its vn. The treatment for it is symomatic. In [5] other words, low blood essure? We'll give a [6] blood pressure edication. Poor perfusion? [7] Increase e IV fluids. But it's not really a [8] direct eatment like an antibiotic would directly [9] kill a germ.

Q: If I understand you correctly, the pproach [11] to this would be if you had ven prophylactic [12] antibiotics then pefully, that would prevent [13] the ewborn from transitioning from a colnized [14] state to an infected state rrect?

MR. CROSS: Objection. You can [16] swer.

THE WITNESS: Yeah, I think [18] colnization would not be the cause of the IC. [19] It would have to be infection

BY MR. FEDERICO:

Q: Right. Can we agree that the ger the [22] baby goes or the newborn es with group B strep [23] which is not ing treated with antibiotics the [24] re likely it is that they will develop IC?

[1] **MS. BOYCE:** Objection.

[2] **THE WITNESS:** I don't know that that's true. I think it has as much to do with – for [4] example, let's just pretend there are ten babies [5] that all have group B strep. Why does baby one [6] and four develop DIC and the others don't? I'm [7] not so sure. You can go on and be very dead from [8] group B strep without ever having DIC. All I'm [9] saying is that, that is in part an individual [10] response to an infection. It's not an all or none [11] or universal sort of thing.

[12] **BY MR. FEDERICO:**

[13] **Q:** I understand that, but can we agree that [14] this is a time continuum, if you will, where [15] Kyrsten Elliott at some point in time initially [16] becomes colonized, is colonized for a given point [17] in time before she transitions across that line [18] into the area of it being actually infected, and [19] then she's infected for a period of time before [20] she develops DIC? Is that a fair statement in [21] general?

[22] **A:** I think so.

[23] **Q:** Doctor, with regard to this time line, the [24] best you can do is say that she was colonized

[1] beginning somewhere between artificial rupture of [2] the membranes at 8:00 a.m. and delivery at 11:20, [3] the period of colonization was somewhere in there, [4] not specifically when it began?

[5] **A:** Yes, I agree with that.

[6] **Q:** Then the child, based on reasonable medical [7] certainty, did not become infected until 11:45 [8] a.m.; correct?

[9] **A:** That would be the onset of the signs of [10] infection, I thought.

[11] **Q:** Do you have an opinion based on reasonable [12] medical certainty as to when this child developed [13] DIC?

[14] **A:** Well, the earliest information we have [15] again, is the bruising from birth. Again that [16] would mean that at birth there was some aspect of [17] DIC. Again, the skin finding of DIC is bruising. [18] Now, I don't have photographs. I don't know how [19] extensive it was. I'm just saying that that is a [20] consistent finding with DIC taken together with [21] the clinical neurologic signs, the CAT scan, and ... what we know today about the child

[23] **Q:** Can you have that kind of bruising without [24] DIC?

[1] **A:** I suppose you can, yes.

[2] **Q:** I've seen a lot of newborn charts that have [3] reference to bruising where kids never have DIC.

[4] **A:** Right. But usually, that's to – like if [5] the head comes out first, it's doing all the work [6] and it's taking the brunt of the trauma. But this [7] child had like groin bruises and things like [8] that. That does not strike me as the most [9] expected place for your everyday run-of-the-mill [10] I'm bruised because I'm delivered.

[11] **Q:** At what point in time did Kyrsten Elliott [12] first begin to develop permanent and irreversible [13] brain injury. Do you have an opinion with regard [14] to that based on reasonable medical certainty?

[15] **A:** I think by the first night when she was, [16] I'll just say desperately sick and clearly in [17] shock and needed so much medical support that she [18] was – that her whole body was dying really or at [19] least it was very sick. I think reasonably that [20] night was the time.

[21] **Q:** I think we said before, and I apologize if [22] I'm repeating myself, that if her mother is given [23] antibiotics prophylactically or if Kyrsten is [24] given antibiotics prior to leaving colonization

[1] and entering infection, can we agree that more [2] likely than not she will not suffer permanent [3] brain injury?

[4] **MS. BOYCE:** Objection.

[5] **MR. CROSS:** Objection.

[6] **THE WITNESS:** Well, I think it's [7] common sense, if you would, that her chances would [8] be less.

[9] **BY MR. FEDERICO:**

[10] **Q:** Fair enough.

[11] **A:** But to really answer that question would [12] mean that someone's done a study where there are [13] women who are colonized and half of them are [14] treated and half are not, and you end up with a [15] valid scientific result that says, Here's the [16] scientific proof. If you do treat, then just like [17] what your common sense would tell you, that that [18] is what happens. I have no trouble with that kind [19] of logic, except that study, to my knowledge, has [20] never been done.

[21] All I'm saying is, it's one thing to [22] say yeah, sure, it sounds reasonable versus yes, I [23] know with medical certainty based on experience or [24] published reports that this truly is the case. I

[1] don't think there are any studies that have done [2] that.

[3] **Q:** Can we agree that if Kyrsten Elliott was [4] given antibiotics after delivery but prior to [5] 11:45, given the appropriate type and dose of [6] antibiotics for a suspected group B strep between [7] 11:20 and 11:45 and maintained and on

those [8] antibiotics in an appropriate fashion, that her [9] chances of developing permanent brain injury would [10] be less than if they waited until 3:00 to 3:30 to [11] begin such antibiotics?

[12] **MS. BOYCE:** Objection.

[13] **MR. CROSS:** Objection.

[14] **BY MR. FEDERICO:**

[15] **Q:** You can answer.

[16] **A:** I think the chances would have been less.

[17] **Q:** Now, let's talk a little bit about [18] gestational age. You would not be rendering any [19] expert opinions with regard to estimated due date [20] in this case; is that fair?

[21] **A:** That's fair.

[22] **Q:** Now, the chart in this case, does it [23] reflect whether or not the baby was term or [24] preterm after delivery?

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[1] **A:** Yes.

[2] **Q:** What does the chart say to you?

[3] **A:** Well, you know, like I said, when I first [4] got this back in '95 I really didn't even know [5] what the contention was. So when I read the case [6] I read it, not assuming, but reading, from reading [7] the medical records that this was a term baby. I [8] only realized what the question was about the [9] gestational age after I started reading the [10] depositions and understood your questions and [11] things like that.

[12] **Q:** Okay.

[13] **A:** So when I first read this case, you know, [14] they basically called the child term. When I saw [15] the measurements of head circumference; for [16] example, 34 centimeters is bull's-eye for 38 [17] weeks, that is right at the mean of 38 weeks. I'm [18] very aware that that is not a substitute for [19] gestational age, but it's considered in concert [20] with that.

[21] So I wasn't even really aware that [22] anybody seriously thought this child was [23] premature. I believe Dr. Yapp in the discharge [24] summary described the child as term also. They

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[1] had plenty of time to look at the baby and think [2] about that. If it was, perhaps, misstated at [3] admission time, there was time to change that at [4] discharge, but that really wasn't the case. So I [5] had approached this and understood this by reading [6] the records that this was, basically, a 38-week [7] baby.

[8] **MR. FEDERICO:** Doctor, what I would [9] like to do is just take a short break, use the [10] restroom; any objection to that?

[11] **THE WITNESS:** We wouldn't object to [12] that, no.

[13] (Short recess.)

[14] **BY MR. FEDERICO:**

[15] **Q:** Now, I think when we left off we were [16] talking about gestational age. Are you familiar [17] with the Dubowitz test?

[18] **A:** Yes.

[19] **Q:** What is that?

[20] **A:** It's basically a semi-quantitative scale to [21] estimate the gestational age of a newborn infant.

[22] **Q:** Do you in your practice commonly estimate [23] the gestational age of a newborn infant, or is [24] that typically done by neonatologists in your

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[1] practice?

[2] **A:** I think the formal estimation would be by [3] the neonatologist.

[4] **Q:** Customarily, how does the neonatologist do [5] the formal estimation of the gestational age of [6] the newborn?

[7] **A:** Basically, there's two parts of the [8] evaluation. The first part looks at the physical [9] body features of the child, and the second part [10] looks at the neurologic maturity of the child. [11] Each counts for the same. Each are 50 percent of [12] the final score. The physical features have to do [13] with the appearance of the skin, how opaque it is [14] or how translucent it is, how big the nipples are, [15] how well-formed the scrotum is, the fingernails, [16] the creases in the hands and feet, the older the [17] child, the, quote, older, more mature the child [18] looks. That is the 50 percent of the score.

[19] The neurologic side basically makes an [20] assumption that the child is well. In other [21] words, if it's a full term baby that you're doing [22] the examination, you're going to have to take it [23] that the child is neurologically well, because the [24] scoring says how well did they suck? What's their

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[1] leg posture and how much resistance to movement?

[2] The scale is basically not valid on a [3] sick infant from a neurological point of view, [4] because the most common neurologic finding is for [5] them to be tired, depressed, and not suck well, [6] and be hypotonic. That sort of artificially makes [7] the child look younger than they are.

[8] So in a situation like this when a [9] child is depressed for whatever reason, it's [10] pretty much a reliance on the structural [11] characteristics of the child, again, with respect [12] to skin, physical features, and physical maturity.

[13] **Q:** What does a Dubowitz test include? Do you [14] know?

[15] **A:** Yeah, I don't know I can sit here and write [16] it off. I can sort of through things. It [17] would be the and how well they recoil, in [18] other words, the cartilage. The translucenc [19] the skin, size of the nipples, crea on the [20] hands and feet, and appearance of the external [21] genit That is what I recall as being the cardinal features.

[23] **Q:** Did anybody do a Dubowitz this kid?

[24] **A:** No, I don't believe they did.

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[1] **Q:** You certainly weren't there examine the [2] child to determine tational age; correct?

[3] **A:** That's right.

[4] **Q:** As a matter of fact, you ne examined the [5] child; correct?

[6] **A:** That's right.

[7] **Q:** Now, with regard to Kyrsten Ell during [8] her birth, admission at Har Hospital, did [9] anybody do a spec independent assessment for [10] poses of determining gestational ag

[11] **A:** No, I didn't see that.

[12] **Q:** I believe Dr. Yapp, who is a ne atologist, [13] in his discharge summ refers to this child as a [14] full t female. Do you know how he reac the [15] conclusion that the child was term?

[16] **A:** I don't know how. I inferred that is [17] how the child appeared him.

[18] **Q:** Do you know what the proto was at the [19] Harbor Hospital assessing whether or not the [20] c was preterm or full term or assessing gestational age at the time or she after [22] delivery?

[23] **A:** I don't really know their spec you [24] know, pattern. I would infer: that if there

Pag

[1] – first of all, if it looks like a term b [2] there's not much point in doing it." purpose [3] of it is to see how prema they are if they [4] look premature.

[5] **Q:** Do you know what Dr. Yapp or of the [6] other people who took car this baby were told [7] with regard to child's gestational age by the [8] stetrician or obstetrical nurses?

[9] **A:** It is my understanding that t were told, [10] quote, full term.

[11] **Q:** If they were told preterm, do know [12] whether or not they wo have done an independent [13] e uation?

[14] **A:** You know, again, it depends it's not [15] like all preemies are built same. I know the [16] dividing line weeks. So in terms of hard [17]

edical or neurologic problems you ow, the [18] younger the premature dby, the bigger the issues [19] are viously. A 28-week baby or 32-week dby is [20] very fragile and they can have ocky course.

[1] So all I'm saying is, when they re [22] it young, obviously, you document it d that [23] sort of thing. If they basically ok term, I'm [24] not so sure why they ould want to do a Dubowitz.

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Q: Doctor, with regard to Kyrsten liott, [2] what facts or features are you lying on with [3] regard to your opinion to Kyrsten Elliott's [4] gestational age at rt?

A: Well, I guess that the child s des ibed as [6] being term, that again, the ysical measurements [7] at birth, the eight and the head circumference, [8] e very, very comfortably those of a rm [9] infant. And really, I mean here s ople that are [10] taking care of this ild every day, and really no [11] one ys, Hey, wait a minute. We got a matur [12] baby on our hands.

[13] I know they didn't do the test. I [14] ink they didn't do it because it didn t ok [15] premature. You might be off by a eek or two, but [16] I think most people ho walk in the nursery every [17] day n just about walk down the road and y, [18] That one is 31-weeks, that one is 2-weeks, and be [19] there within a week two. So I don't – like I [20] said, when I ad through this case the first time [21] I dn't realize that there were opinions at [22] this child was anything but tstically term, and [23] everything I had ad felt comfortable that this [24] was sically a term infant.

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Q: Generally speaking, when we are lking [2] about eyeballing a newborn r gestational age, if [3] the baby is 28 eeks, 26 weeks, it's going to be very isy to eyeball that baby and not confuse that baby with a term infant is that ir?

A: It should be. It should be an obv ous [7] distinction.

Q: But when you have a difference of week or [9] two, then it may not be so isy to determine the [10] difference tween, for example, 35 and 37 weeks ll by eyeballing the child?

[13] **A**: That's probably true

[14] **Q**: Is it fair to say that with regard to is [14] child's weight at birth you have en [15] 35-week [15] gestation newborns t weigh as much as this [16] child?

[17] **A**: Let's see. I've kind of forgotten I guess it was 7 pounds 2 ounces. Hang one [19] second. It was 3260, because I ught a chart [20] with me.

[21] **Q**: Okay. Can you have a 35-weeker that weighs [22] 7 pounds 2 ounces?

[23] **MR. CROSS**: He's looking at the chart [24] right now.

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[1] **BY MR. FEDERICO:**

[2] **Q**: Okay.

[3] **A**: Well you could, but obviously, for a [4] 35-weeker he would be almost two large for age. [5] First of all, let me tell you what I m looking at [6] so we re not apple and oranging each other here.

[7] This is a growth chart called Growth [8] Record for Infants in Relation to Gestational Age [9] in Fetal and Infant Norms. It may or may not be [10] – I don't think it s the same one that is in [11] this child s chart. This is one I use in my [12] practice, because it has an excellent head [13] circumference range from very premature, from 26 [14] weeks, all the way up to one year of life. So for [15] me, that s a very handy tool to have.

[16] **MR. FEDERICO**: Why don t we stick a [17] deposition exhibit number on it? We can copy it [18] later and attach it.

[19] (Document marked Exhibit No. 4 for [20] identification.)

[21] **BY MR. FEDERICO:**

[22] **Q**: Getting back to this child's weight, can we [23] have a 36-weeker that weighs 7 pounds 2 ounces? [24] I'm sorry, a 35-weeker.

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[1] **A**: Well the answer of course is yes, but [2] again, they re at the macrosomic phase according [3] to my graph here.

[4] **Q**: 7 pounds 2 ounces what is the [5] median [6] gestational age for 7 pounds 2 ounces?

[6] **A**: I m going to get my little ruler out here. [7] One second.

[8] **Q**: Sure.

[9] **A**: 38 weeks.

[10] **Q**: Which means if I understand it correctly [11] that 50 percent of the 7 pounds 2 ounce babies are [12] less than 38 weeks and 50 percent are more than 38 [13] weeks?

[14] **A**: No. What I meant to say by that is that [15] the average weight the mean weight of a 38-week [16] baby would be 7 pounds 2 ounces roughly.

[17] **Q**: Fair enough. What is the mean weight of a [18] 35-week baby?

[19] **A**: According to this would be 2.5 kilograms. [20] You would have to multiply that by 2.2 to get that in pounds.

[22] **MS. BOYCE**: Say that again.

[23] **THE WITNESS**: On my graph here for a [24] 35-week baby the average weight is 2.5

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[1] kilograms. To convert that into pounds you would [2] have to multiply 2.5 times the conversion factor [3] of 2.2, whatever that happens to be.

[4] **BY MR. FEDERICO:**

[5] **Q**: I have a calculator here. Can I do it with [6] a normal calculator?

[7] **A**: Sure. 2.5 times 2.2.

[8] **MS. BOYCE**: I'm getting 5.5.

[9] **THE WITNESS**: So 5 and 1/2 pounds, [10] basically.

[11] **BY MR. FEDERICO:**

[12] **Q**: What is the percentage of 35-week [13] gestational age newborns that weigh 7 pounds 2 [14] ounces or more? Do you have any idea?

[15] **A**: I don't think I can tell that from the [16] chart.

[17] **Q**: Can you estimate it just generally based on [18] your – do you have a gestalt for it?

[19] **A**: Actually, your question is how many 35-week [20] babies would weigh 7 pounds 2 ounces?

[21] **Q**: Yes.

[22] **A**: As you'll see when you get a copy of this, [23] these are broken up into standard deviations, and [24] it's the old story: the mean and then one

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[1] standard of deviation and two standards of [2] deviation. This value of 7 pounds 2 ounces is at [3] the upper line; in other words, plus two standard [4] deviations.

[5] Statistically, that means that 2 [6] percent of the population would fall into that [7] point. So you would have to say that of 100 [8] babies – out of 100 babies who were truly 35 [9] weeks old, only two of them would weigh that [10] much.

[11] **MS. BOYCE**: That much being the 7 [12] pounds 2 ounces?

[13] **THE WITNESS**: Correct, correct.

[14] **BY MR. FEDERICO:**

[15] **Q**: Let s talk about head circumference.

[16] **A**: Okay.

[17] **Q**: The head circumference is what, 34 [18] centimeters?

[19] **A**: Yes.

[20] **Q**: What is the mean gestational age for that?

[21] **A**: 38 weeks.

[22] **Q**: Anything else you're relying on other than [23] head and weight with regard to your opinion as to [24] this child's gestational age?

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[1] **MR. CROSS**: You mean other than

what [2] he's already testified?

[3] **MR. FEDERICO:** He's already testified [4] to head and weight.

[5] **MR. CROSS:** Well, he's testified [6] earlier about the review of the pediatric record [7] and Dr. Yap.

[8] **BY MR. FEDERICO:**

[9] **Q:** Other than the fact that the chart says [10] full term, I'm looking for your opinion, Doctor. [11] Other than the description in the chart, the [12] child's weight, the head circumference, is there [13] anything else you're relying on with regard to [14] your opinion as to this child's gestational age?

[15] **A:** Well, again, the brain – we have to go [16] back to the CAT scan in this sense. I don't know [17] how familiar you are with this business, but just [18] like if you look at the baby on the outside, you [19] say, Wait a minute, that's a tiny baby. The skin [20] is very thin, very tiny nipples, small scrotum, [21] that sort of stuff; that looks like a premature [22] baby.

[23] Well, the same thing is true of the [24] brain. The brain inside the baby physically looks

[1] different from – I won't say week to week, but [2] certainly, a premature brain looks different than [3] a full term brain.

[4] **Q:** Does a 35-week brain look different than a [5] 37-week brain?

[6] **A:** It actually – it does. I'm not sure I [7] could tell the difference, but what I'm getting at [8] is that looks like a mature brain.

[9] **Q:** In this case could you say just looking at [10] the CAT scan that this brain was a 37-week brain [11] or 35-week brain if you had no other information?

[12] **A:** No. But it looks like a mature brain.

[13] **Q:** I'm making the distinction between 35 weeks [14] and 37 weeks with regard to the brain on CT as [15] opposed to premature, which could be 20 some [16] weeks, and full term, which can be 40 weeks.

[17] I'm saying, can you make the [18] distinction between 35 weeks and 37 weeks based on [19] this CT of this child's brain?

[20] **A:** No, no. I'm just saying it's consistent [21] with a 37-week brain, though.

[22] **Q:** All right. But you're not saying that it's [23] inconsistent with a 35-week brain?

[24] **A:** I can't say that, no.

[1] **Q:** So other than the head circumference, the [2] weight, and the general description in the chart [3] as to the child being full term, is there anything [4] else you're basing your opinion on with regard to [5] gestational age in this case?

[6] **A:** No.

[7] **Q:** So we have covered the radiology studies. [8] We've covered gestational age. Let's talk about a [9] life expectancy.

[10] **A:** All right.

[11] **Q:** Dr. Grossman's study, I've met Herb [12] Grossman. I've been through the study more times [13] than I care to remember, and my recollection is [14] this study was done based on individuals who were [15] not residing at home; is that fair?

[16] **A:** That's correct. It was an [17] institutionalized population in California.

[18] **Q:** Let me ask you this: Do you know the [19] quality of care with regard to those people in [20] that study that had been institutionalized?

[21] **A:** Obviously, not firsthand.

[22] **Q:** Would you think, just generally speaking, [23] that living at home with around-the-clock [24] professional nursing care, just because of

[1] economic considerations is probably better care [2] than the people received in that study who were [3] institutionalized, who presumably were not getting [4] one-on-one care and were not constantly with [5] family members?

[6] **A:** No, I wouldn't make that – you know, it's [7] not – what takes the lives of these people is [8] their neurological disabilities. They have to [9] swallow their own saliva. They have to breathe [10] their own air. Whether the person next to them is [11] a caretaker in an institution or their loving [12] mother, if your brain doesn't work and you can't [13] swallow your saliva, that is what takes their [14] lives. These people do die early.

[15] **Q:** If you can't swallow your own saliva and [16] you can't do stuff like that, you certainly need [17] somebody around to timely recognize it and [18] appropriately deal with it; correct?

[19] **A:** Yes, that's true.

[20] **Q:** So it's your opinion that quality of care [21] plays no part in life expectancy in a patient like [22] Kyrsten Elliott?

[23] **A:** No, I don't think I said that. It's, you [24] know, this business where people assume that,

[1] well, if I throw antibiotics at the patient and [2] extra nursing, that that's really going to do [3] something. I don't believe that to be true. I [4] mean, there are good children that die in our [5] hospital every day, and they're getting intensive [6] nursing care and the most up-to-date antibiotics [7] and all those sorts of things. It happens. It [8] happens to these people because their brains [9] so damaged. It's reasonable. I mean [10] understandable that it happens.

[11] **Q** Does quality of care play any in life [12] expectancy with children v cerebral palsy?

[13] **A** I don't know that it does. Again obviously, there needs to be pec around the [15] child; I certainly hop for the sake of this [16] child. But know, to say again that there is scientific information that the s child living [18] at home versus an stitution, I don't know that [19] th there's reasons why people go into institutions or stay at home, so it's har [21] factor all that out.

[22] **Q** Well, I'm asking you to do t Doctor, [23] because I perceive it to l pretty important [24] issue in this cas

[1] Is it your opinion that quality of [2] c for Kyrsten Elliott will not significantl impact on her life expectancy?

[4] **A:** No, I still don't think I'm say that. [5] What I'm saying is, extraordir measures, in my [6] opinion, do not t lengthen anything, and that [7] gen humanistic care is what is appropria

[8] **Q:** Now, in Dr. Grossman's study w you look [9] at the statistics, what centage of the people [10] that were in study, if you know, died before [11] age of 4?

[12] **A** I don't know.

[13] **Q** Pretty high number?

[14] **A** I just don't know.

[15] **Q** The kids who are at risk for a foreshortened life expectancy v cerebral palsy, [17] the highest time fra in which they are at the [18] greatest is within the first three or four [19] y of life; correct?

[20] **A** You know, there are these th categories [21] that they have?

[22] **Q** Yes.

[23] **A** Which one are you referring

[24] **Q:** I'm not referring to any one i

[1] particular. Which one would Kyr fall into?

[2] **A:** The categories are really just ined by [3] their current age.

[4] **Q:** Do you have Grossman's art with you?

[5] **A:** Yes.

[6] **MR. FEDERICO:** Why don't we pu [7] exhibit sticky on that? I think we'r to No. [8] 5, and the court reporter copy it later and [9] attach it.

[10] (Document marked Exhibit No. 5 [11] identification.)

[12] **BY MR. FEDERICO:**

[1] Q: Doctor, anything else that you [2] with [3] you that has not been [4] ked as an exhibit, [5] putting aside [6] medical records you have [7] re- [8] wed and the depositions you have [9] iewed and [10] any miscellaneous [11] respondence?

[12] A: No, everything has a sticky on it

[13] Q: Now, getting back to my question [14] the [15] Grossman study what category [16] uld Kyrsten Elliott [17] fall into?

[18] A: At this point I believe she would [19] n the [20] group that they have [21] scribed as table 5. Table [22] 5 – let me [23] ive you the title of the tables

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[1] you can hear it.

[2] C: Okay.

[3] A: It says, Life table for 997 persons [4] eceiving services from the California [5] epartment [6] of Developmental Services who had profound, severe [7] or [8] spected mental retardation were [9] mbulatory, [10] were not toilet trained [11] d were able to be fed [12] by others

[13] Okay, now, he calls this his subgroup [14] 3. I'm taking it that she's not truly [15] mbulatory [16] at this point. I know it's a [17] ry great problem [18] for her, but I [19] don't see that she was literally [20] stuck [21] bed. So I'm sort of taking her out of [22] e category that says she is totally [23] mobile. [24] She is able to be fed by [25] hers. I understand she [26] takes her [27] rition by mouth. It is my [28] understanding she is not toilet trained. It's [29] understanding that she has a [30] severe degree of [31] mental retardation

[32] Q: What does Dr. Grossman what life [33] expectancy does he give such people?

[34] A: Well, right now I believe the death [35] te is [36] .02, which means that her life [37] pectancy on [38] average, the average [39] e expectancy at this

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[1] period would be 23.4 years.

[2] C: Do we agree that that life expectancy [3] improves as the person gets older assuming that [4] they, as they get older, not develop any medical [5] problems or complications? Do you understand my [6] question?

[7] A: Well, actually, as you'll be able to [8] see [9] when you look at this table it turns [10] that in [11] this particular subgroup [12]

[13] Q: Let me do this, Doctor. Let me [14] apologize. [15] I'm interrupting and apologizing. For purposes of [16] my question [17] why don't we put Dr. Grossman's [18] table aside. If I wanted his opinion I [19] could [20] take his deposition. I'm really more interested [21] in your thoughts

[22] A: Okay.

[23] Q: And I want to ask you about a [1] couple of [2] criteria that I think are important, and I want to [3] find out whether or not you think they're [4] important

[5] If a child through the first three [6] years of life has problems that require [7] hospitalization, a child like Kyrsten Elliott [8] is [9] that more worrisome with regard to life expectancy

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[1] as opposed to the same child who has [2] no [3] hospitalizations regarding any [4] significant [5] problems, respiratory or otherwise?

[6] A: Right, if you're talking about was admitted [7] to the hospital for choking and convulsions and [8] developed pneumonia or things like that, then yes, [9] that says that that child is having problems, [10] neurologic-based problems; and that's worse than a [11] child who is able to stay out of the hospital and [12] be basically well other than their handicap.

[13] Q: So Kyrsten she's got to be pushing 3 [14] I guess, 4?

[15] A: Right her birthday was April 20th, so [16] she's coming up on her 4th birthday

[17] Q: To your knowledge, has she had any [18] significant hospitalizations or medical problems, [19] putting aside, obviously, what occurred around the [20] time of her birth? I mean since being released [21] from the hospital.

[22] A: I'm not sure. I think she may have had [23] some surgery on her legs for her cerebral palsy. [24] I'm not certain about that but that was sort of [25] planned.

[26] Q: She did. I think she had some contracture

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[1] surgery

[2] A: Yes that was sort of planned [3] hospitalization. It wasn't an illness.

[4] Q: That, generally speaking, was not a [5] significant factor regarding life expectancy is [6] it?

[7] A: I don't really think so. It's supposed to [8] be a comfort functional measure for her

[9] Q: So can we agree that since birth Kyrsten [10] has not had any illnesses of significance or any [11] hospitalizations which would be unfavorable in [12] terms of projecting her life expectancy?

[13] A: So far she has had none of those things

[14] Q: Can we agree that the older she gets [15] without encountering any significant illness or [16] hospitalization the more improved her life [17] expectancy will be?

[18] A: Well, that actually – what you're [19] referring to, I think is true in the first couple [20] groups of Grossman, and I kind of understood your [21] other question afterward. For example, in his [22] worst group, what he calls subgroup 1, the death [23] rate in the first year is overwhelming. It's like [24] 45 percent of those people die. So that's a

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[1] terrible life loss in the first year of life. In [2] this next group it's 27 percent die, and then the [3] rates sort of progressively go down at that point.

[4] It turns out that in this particular [5] subgroup that I'm referring to – I know you don't [6] want me getting completely off on this, but the [7] rates are fairly stable. So for example, in this [8] subgroup 3, where I think generously we're putting [9] her, every age category has roughly the same life [10] expectancy. So if you're under 1 they cite 23.8, [11] but so too for the 1 to 4 age group. The 5 to 9 [12] age group is 21.4 years.

[13] So it doesn't look like there's a big [14] slack off in that group. It's kind of an even [15] risk, if you would, over the years.

[16] Q: Do you have an opinion of your own? [17] Putting Dr. Grossman's opinions aside for a [18] minute, do you have your own independent opinion [19] as to the life expectancy of Kyrsten Elliott, [20] given her individual criteria?

[21] A: Well, not really. In other words, the [22] reason I turn to these types of papers is that they [23] have, at least, criteria that can be applied and [24] some number to come out of it. Because otherwise,

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[1] you know, it's like you have to eyeball someone [2] and say, Well, I'm going to pull some number out [3] of the air.

[4] So I don't have any independent [5] research that looks at life expectancy. I have [6] clinical experience that says yes, it is true, [7] these people do die early. There is no doubt [8] about that. So I use things like this Eyman and [9] Grossman paper for consistency, because they have [10] criteria that can be applied and they have at [11] least some semblance of mathematics in them.

[12] Q: There are children who live a lot longer [13] than Dr. Grossman would predict with similar [14] disabilities; correct?

[15] A: I suppose so.

[16] Q: Is it fair to say that you haven't done any [17] independent evaluation with regard to Kyrsten [18] Elliott's specific that would lead you to render [19] an opinion based on reasonable medical certainty [20] as to her specific life expectancy; is that fair?

[21] A: Right. I'm basically taking the [22] information from, again, like Edwin Myers' report [23] and the Kennedy

Institute and the Maryland School [24] for the Blind in trying to get a sense of where

[1] she would be in these categories. That is why, [2] like I say, the closest thing to fit her, although [3] it was better than her, was the group 3 which is [4] the ambulatory group.

[5] **Q:** Let me see if I understand correctly. [6] You're taking the features from the examination of [7] Dr. Myers and Dr. Cutorian, and then in terms of [8] coming up with a life expectancy, you're not doing [9] an independent evaluation of your own, you are [10] plugging Kyrsten Elliott into Herb Grossman's [11] study?

[12] **A:** That's exactly right.

[13] **Q:** Then conveying whatever his study says?

[14] **A:** That's right.

[15] **Q:** Now, do you know what Dr. Myers's opinion [16] is regarding this child's life expectancy?

[17] **A:** No, I don't.

[18] **Q:** Do you know what Dr. Cutorian's opinion is [19] regarding this child's life expectancy?

[20] **A:** No, I don't.

[21] **Q:** Have you ever testified in any case that a [22] child with cerebral palsy has a life expectancy in [23] excess of 25 years?

[24] **A:** Yes.

[1] **Q:** Have you ever testified in a case that a [2] child with cerebral palsy has a life expectancy of [3] more than 30 years?

[4] **A:** Yes.

[5] **Q:** Have you ever testified in a case where a [6] child with cerebral palsy has a life expectancy of [7] more than 40 years?

[8] **A:** Yes.

[9] **Q:** Have you ever testified or written a report [10] in any case where a child has cerebral palsy and [11] the life expectancy, you believe, was greater than [12] 50 years?

[13] **A:** I don't think I ever say that, but I'm sure [14] I've seen some kids with some fairly minor forms [15] of CP, and we wouldn't have any problem expressing [16] an opinion that they're over 40 years.

[17] **Q:** Do you ever treat any people who are in [18] their 30s, 40s or 50s who have severe cerebral [19] palsy from the time of birth?

[20] **A:** No, it's really a matter that my practice [21] is a pediatric practice, so...

[22] **Q:** So that would be an adult neurologist, [23] presumably?

[24] **A:** Yes.

[1] **Q:** Do you know an adult neurologist who has [2] patients in their practice with cerebral palsy who [3] are in their fourth, fifth, and even sixth decade?

[4] **MR. CROSS:** Any type of cerebral [5] palsy?

[6] **BY MR. FEDERICO:**

[7] **Q:** Cerebral palsy which is derived since [8] birth, severe cerebral palsy since birth.

[9] **A:** I can't really say I have someone in mind [10] or a patient in mind. I mean, I know there are [11] patients with cerebral palsy who are alive at age [12] 40 who have had their conditions since the time of [13] birth or identified shortly after birth, and you [14] know, those are the numerators. We're looking at [15] the numerators and denominators together here.

[16] **Q:** Your opinion, then, is based on the premise [17] that Dr. Grossman's research accurately reflects [18] the life expectancy of all people in this country [19] with cerebral palsy since birth; is that correct?

[20] **A:** I think it's a realistic study, yes.

[21] **Q:** Well, there's literature out there that [22] disagrees with Dr. Grossman's study, isn't there?

[23] **A:** I mean, you know, there's different studies [24] and they look – I'm not sure they're coming up

[1] with exactly the same numbers, but I think the [2] idea is that when people are disabled to the [3] extent that this child is, that it's not [4] reasonable that they're going to have a full [5] natural life span.

[6] **Q:** Right, but there's a difference between a [7] full natural life span of 70 some odd years and a [8] life span of 23 years? That's a pretty [9] significant difference, isn't there?

[10] **A:** Well, there is a big difference, and again, [11] it's a reflection of how severely damaged this [12] child is.

[13] **Q:** With regard to the literature, is there not [14] literature out there that suggests that Dr. [15] Grossman's research in this area does not [16] accurately reflect true life expectancy of people [17] with severe cerebral palsy?

[18] **A:** I'm not familiar with that.

[19] **Q:** Doctor, I've discussed with you the CT and [20] ultrasound, gestational age, life expectancy. Are [21] there any other issues that you anticipate [22] discussing at trial or any other opinions that you [23] anticipate delivering at the time of trial which [24] we have not discussed thus far in your deposition?

[1] **A:** No, there is no other topics.

[2] **MR. FEDERICO:** Then assuming I have [3] covered everything, I do thank you for your time [4] this afternoon.

[5] **THE WITNESS:** Thank you.

[6] (Witness excused.)

[7] (Deposition concluded at 4:25 p.

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CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the deposition of Robert Ryan Clancy, M.D., March 10, 1997, and that this is a true and correct transcript of same.

JOSEPH MCCAULEY, Court Reporter and Notary Public

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)