

In The Matter Of: The transcript of

*JOSEPH STALMA, ET AL v.
TOLEDO HOSPITAL*

*JAY P. GOLDSMITH, M.D.
December 13, 2000*

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[1] IN THE COURT OF COMMON PLEAS
[2] LUCAS COUNTY, OHIO
[3]
[4]
[5] JOSEPH STALMA, A MINOR, BY
AND THROUGH HIS MOTHER AND
[6] NATURAL GUARDIAN, NORMA
STALMA
[7]
[8] VERSUS CASE NO. C199-1762
[9] TOLEDO HOSPITAL JUDGE LANZINGER
[10]
[11] Deposition of JAY P. GOLDSMITH, M.D.
taken at the Hilton Hotel, Kenner, Louisiana,
[12] on the 13th day of December, 2000.
[13]
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[25]

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[1] JAY P. GOLDSMITH, M.D., 1516
[2] Jefferson Highway, New Orleans, Louisiana,
[3] 70121, after being first duly sworn in the
[4] cause, testified as follows:
[5] BY MS. BAER:
[6] Q: Good afternoon.
[7] A: Good afternoon.
[8] Q: Doctor, as you know, my name is
[9] Lisa Baer, and I am legal counsel for the
[10] Toledo Hospital in the case brought by the
[11] Stalma family.
[12] A: I do.
[13] Q: Would you state your full name for
[14] the record?
[15] A: Jay Paul Goldsmith.
[16] Q: Professional address?
[17] A: 1516 Jefferson Highway, New
[18] Orleans, Louisiana, 70121.
[19] Q: Is that a group practice?
[20] A: It's a multispecialty group
[21] practice called the Ochsner Clinic.
[22] Q: What areas of practice are run in
[23] the Ochsner Clinic?
[24] A: It's a group of 450 doctors, and
[25] all areas of practice from well baby care to

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[1] any kind of transplant you want are
[2] accomplished there.
[3] Q: You are a neonatologist?
[4] A: A neonatologist and a
[5] pediatrician. About 10 percent of my
[6] practice is general pediatrics now.
[7] Q: Any particular area of interest
[8] and/or expertise in neonatology?
[9] A: In neonatology my areas of
[10] interest have been in ventilation, use of the
[11] respirator in brain injury and now in ethics.
[12] Q: Licenses in any other state than
[13] where we are presently?
[14] A: Not at the current time. I have
[15] had licenses in other states previously when
[16] I was there either in training or working,
[17] and I have voluntarily relinquished those
[18] because of moving.
[19] Q: Are you board certified?
[20] A: Board certified in pediatrics in
[21] 1975 and in neonatology in 1981. No
[22] recertification required.
[23] Q: You anticipated my next question.
[24] A: I'm too old.
[25] Q: Where do you have hospital

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[1] privileges currently?

[2] A: At Ochsner Foundation Hospital,
[3] East Jefferson General Hospital, Touro
[4] Hospital, Children's Hospital, and Tulane
[5] University Medical Center. I have courtesy
[6] privileges in probably 30 to 35 other
[7] hospitals for transport purposes. When we
[8] move children from one institution to another
[9] and we send a transport team, we have to
[10] cover them in that setting, but I don't
[11] actively practice, nor do I attend meetings
[12] or have anything else to do with those
[13] hospitals.

[14] Q: Of the — and I probably missed
[15] one — of the five or six hospitals where you
[16] have active privileges, is there a particular
[17] hospital where you spend more time than the
[18] others?

[19] A: I would say I spend 60 to 70
[20] percent of my time at Ochsner; 20 to 30
[21] percent of the time at East Jefferson; and 5
[22] to 10 percent of my time at the others
[23] combined. Generally just occasional
[24] consultations, educational things that I do
[25] at Tulane for the residency program, those

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[1] kinds of things.

[2] Q: What percentage of your practice
[3] is spent in inpatient care as opposed to
[4] outpatient care?

[5] A: Ninety percent is inpatient. Ten
[6] percent is outpatient.

[7] Q: I assume that at Ochsner and East
[8] Jefferson your role is as an in-house
[9] neonatologist?

[10] A: As a neonatologist. We don't, for
[11] example, keep neonatologists full time at
[12] East Jefferson. We are there on a
[13] consultative basis, but we have an ICU there
[14] that runs a census anywhere from 6 to 18
[15] babies, but we are not there full time. We
[16] have a group of nurse practitioners who are
[17] there full time.

[18] Q: So there is not a 24-hour in-house
[19] neonatologist at East Jefferson?

[20] A: Correct. Nor is there at Ochsner.
[21] That has been surveyed in the United States
[22] recently, and about 20 percent of hospitals
[23] that have NICUs now have neonatologists
[24] in-house full time. The rest either have
[25] residents, practitioners or a combination.

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[1] Q: What is the census on an average
[2] at Ochsner?

[3] A: At Ochsner, 35.

[4] Q: Are there residents at either
[5] Ochsner or at East Jefferson?

[6] A: There are at Ochsner.

[7] Q: Do you function in a supervisory
[8] capacity at all with the residents?

[9] A: Yes. But I think in our setting
[10] we are more hands-on than most academic
[11] institutions.

[12] Q: Any academic positions that you
[13] hold currently?

[14] A: Yes. I'm professor of pediatrics
[15] and vice chairman at Tulane University. We
[16] have an integrated residency program with
[17] them, and their residents spend time at both
[18] places. I'm also a clinical professor of
[19] psychology at the University of New Orleans
[20] mainly because of projects we have been doing
[21] for many years with their graduate psychology
[22] students, PhD psychology students, on
[23] cortisol levels and different infantile
[24] states, prachtl states. When those graduate
[25] students come to Ochsner, they are under my

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[1] supervision. I don't teach any active
[2] courses there.

[3] Q: The roughly 10 percent of your
[4] practice of general pediatrics, on what types
[5] of issues or for what conditions do you
[6] typically see and treat children?

[7] A: Well, as you know, all
[8] neonatologists are first general
[9] pediatricians, and when I first got here 25
[10] years ago, I just decided to have a small
[11] practice; mainly friends, doctors' children,
[12] some graduates from the NICU.

[13] The average general pediatrician
[14] would have 3,000 to 4,000 families or
[15] patients in his practice. I probably have a
[16] hundred. It's a very small practice.

[17] Q: For general pediatric needs,
[18] infants up through age 16 to 18?

[19] A: Correct.

[20] Q: Did you conduct any literature
[21] search, Medline search, any research of any
[22] sort related to this case?

[23] A: I didn't do any research, but
[24] there are some papers that I will refer to,
[25] and I pulled out a file just this morning to

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[1] bring here that may or may not have relevant
[2] papers, but it's about fever in infants, and
[3] I know one or two papers that are in that
[4] file. I keep files. I have been keeping
[5] files for 30 years, and I will give you the
[6] references of papers that I think are
[7] appropriate here.

[8] Q: Okay. Perhaps now would be a good
[9] time —

[10] MS. BAER:

[11] You have had a chance to look at
[12] these materials?

[13] MR. KULWICKI:

[14] I pulled the correspondence out,
[15] but that was it.

[16] MS. BAER:

[17] Off the record for a minute.

[18] (Off the record.)

[19] BY MS. BAER:

[20] Q: I'm pulling out and showing you a
[21] page of the nursing records. Is this your
[22] writing? It appears to be the longhand
[23] nurse's notes for the 23rd to the 24th.

[24] A: No, it's not. There's another
[25] copy of that that is maybe duplicative. I

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[1] think it's tabbed here. I may have some
[2] writing on it, but for some reason I was sent
[3] duplicates of stuff and I don't know why.
[4] That is probably the most important page in
[5] the chart, so it's tabbed. There are only
[6] three depositions, the parents and Buganski.

[7] Q: Just for the record, it appears as
[8] though you received the obstetrical and
[9] prenatal records of Dr. Folley for Mrs.
[10] Stalma?

[11] A: Correct.

[12] Q: Mrs. Stalma's delivery records
[13] from Toledo Hospital?

[14] A: That's correct.

[15] Q: And I haven't looked for
[16] completeness sake but the newborn record for
[17] Toledo Hospital for Joey Stalma?

[18] A: Correct.

[19] Q: And the depositions that you have
[20] reviewed are Joseph Stalma, Norma Stalma and
[21] Dr. Buganski, correct?

[22] A: Correct.

[23] Q: There are a handful of pages,
[24] maybe a dozen or so pages, that appear to
[25] be —

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[1] A: Those are some follow-up issues,
[2] which I don't think pertain, but
[3] hospitalization for otitis and tubes, PE
[4] tubes, an emergency room visit for a
[5] laceration and a psychological evaluation at
[6] two years of age.

[7] Q: In this folder is this then a
[8] second copy of Joey Stalma's birth admission?

[9] A: Correct. That's probably my
[10] working copy, which I put some tabs on it and
[11] also I thinned, which means the things that I
[12] don't think are pertinent or may not be
[13] pertinent in my judgment have been thinned.

[14] Q: To your recall and to the best
[15] that you can gather, did you receive a
[16] complete copy of this admission at one time?

[17] A: I did.

[18] Q: So what I have here that was bound
[19] with a rubber band in this manila folder is
[20] what you feel are in some respect the
[21] pertinent records of this admission?

[22] A: Correct.

[23] Q: And you have got a few tabs that
[24] you have placed on what you feel are
[25] pertinent pages?

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[1] A: Correct.

[2] Q: Other than the tabs, are there any
[3] actual notations or markings in this working
[4] copy of the chart?

[5] A: I don't remember putting any in,
[6] but there may be.

[7] Q: Was this a full-term baby?

[8] A: Yes.

[9] Q: I'm showing you a consultation
[10] page from Joey Stalma's admission. Where it
[11] says "Second LP" and there is a square around
[12] it about halfway down the page, is that your
[13] writing?

[14] A: Yes.

[15] Q: Is this a second copy of Norma
[16] Stalma's labor and delivery record?

[17] A: It is. Again, thinned by me.

[18] Q: Other than these materials, is
[19] there anything else that you have reviewed
[20] for this case?

[21] A: No, ma'am.

[22] Q: Have you reviewed any other cases
[23] for Mr. Kulwicki or his law firm in the past?

[24] A: Not in the past. There is another
[25] current case that I think came after this.

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[1] Q: Is it for Mr. Kulwicki or for
[2] someone else in his office?
[3] A: For Mr. Becker. Mr. Becker was,
[4] probably 10 years ago, an associate attorney
[5] on another case that I did out of Cleveland
[6] that came from another lawyer, and for some
[7] reason he got involved in it. I don't know
[8] what that relationship was.
[9] Q: Is it a case that you were an
[10] expert witness for?
[11] A: It is.
[12] Q: On behalf of the plaintiff or
[13] defense?
[14] A: It was on behalf of the plaintiff.
[15] It went to trial.
[16] Q: Do you recall who the defense
[17] lawyer was in that case?
[18] A: No. I recall the case very
[19] vividly because I flew to Cleveland. Well, I
[20] don't know if you want to hear this.
[21] Q: Sure.
[22] A: It was a case about a baby who was
[23] born and needed to be intubated at Cleveland
[24] Metro Health, I think. The tube was placed
[25] in the esophagus and x-rays showed it in the

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[1] esophagus, and it was, and the baby died.
[2] For some reason I was never
[3] deposed until Friday before the Monday when
[4] the case started. I remember the deposition.
[5] It was by phone. I said the tube was in the
[6] esophagus. That's all I'm going to say if I
[7] come there. If you can find any
[8] neonatologist at Case Western that says the
[9] tube is in the trachea, I promise I won't
[10] come. On Wednesday morning, I flew up and
[11] Mr. Becker met me at the airport and gave me
[12] a ticket to go home. He said, "They heard
[13] you were coming, they couldn't find a
[14] neonatologist to testify, here is your ticket
[15] to go home, thanks very much."
[16] Q: You arrived in Cleveland but never
[17] made it to the courtroom.
[18] A: They settled the case that morning
[19] and I was supposed to testify that afternoon.
[20] That is very vivid in my mind. That has
[21] never happened to me.
[22] Q: I imagine that it would be. The
[23] current case that you are reviewing for Mr.
[24] Becker, what is at issue in that case?
[25] A: I really don't remember.

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[1] Q: Have you reviewed any x-rays?
[2] A: No, ma'am.
[3] Q: Have you issued any written
[4] reports of any fashion to Mr. Kulwicki or
[5] anyone in his office?
[6] A: No.
[7] Q: Did you make any handwritten notes
[8] to yourself in terms of your review?
[9] A: No. Other than what you have seen
[10] on the charts.
[11] Q: Before we move on, this brown
[12] folder that you have brought with you, as I
[13] understand, has some medical literature in it
[14] which may in one fashion or another relate to
[15] the issues that we are going to talk about
[16] today?
[17] A: Correct.
[18] Q: By my count, there are 10
[19] separate pieces of information in this file.
[20] Have you had an opportunity to look at this
[21] information to tell me whether or not you
[22] feel all of these 10 pieces of information
[23] relate in some way or are there only
[24] particular articles that relate to this case?
[25] A: I grabbed that on my way out of

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[1] the office. I brought it basically for the
[2] first article because I knew it was in there,
[3] which post dates this, but it is what is
[4] called a practice guideline or practice
[5] parameter. There are hundreds in the last 10
[6] to 15 years, literally hundreds of articles
[7] written about fever in babies zero to three
[8] months or zero to two months depending on how
[9] you define it. It's an ongoing question
[10] among pediatricians and problem. Some of
[11] those articles may be reflective of that.
[12] The practice parameter that we are
[13] now practicing under is the 1993 Practice
[14] Parameter. There are some statements in
[15] there such as administration of antibiotics
[16] or whether or not a fever is real based on
[17] bundling and how you handle that that I think
[18] predated the publication of this, and I'm
[19] sure there are references that go back to
[20] those cases, but it was just as kind of a
[21] general reference.
[22] Q: For the record, the first article
[23] is from Pediatrics, Volume 92, No. 1, July
[24] 1993, correct?
[25] A: Correct.

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[1] Q: Lead author is Larry Baraff?

[2] A: Correct.

[3] Q: As I understand the comment that
[4] you just made, do you feel that this, even
[5] though it was dated 1993 and we are dealing
[6] with a situation in 1991, do you feel that
[7] this is an applicable reference guide?

[8] A: There are some things in there
[9] that are applicable. There are some things
[10] that were changing at that time that I would
[11] not hold a physician responsible for. And
[12] mostly different from this thing. For
[13] example, our biggest issue is a child with a
[14] fever coming to an office as an outpatient or
[15] emergency room and how you handle that, and
[16] that's what that deals with mostly, but there
[17] are things in there, general principles, that
[18] are pretty I think standard and would have
[19] applied two years previously.

[20] Q: Would you do me the favor as we go
[21] through your testimony and your opinions in
[22] this case, if there is anything in your
[23] opinions that you feel are supported by this
[24] reference, would you let me know that?

[25] A: Sure. I will reference other —

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[1] if I can't give you the cites because I don't
[2] remember them, but I will reference other
[3] authors that we use to teach. This is a very
[4] common teaching point in the training
[5] program, and so we send the residents to the
[6] literature, and we literally find the same
[7] papers again and again and again and again
[8] because there are certain papers that are
[9] very important in terms of how you handle
[10] this in your office.

[11] I was telling Mr. Kulwicki that in
[12] a day a general pediatrician sees 30 to 40
[13] children five days a week, 200 to 300 kids a
[14] week, probably half of them have fevers, many
[15] of them are under three months of age. How
[16] does he pick out the one or the two or the
[17] three that need to be hospitalized? It's a
[18] very small fraction, but that's why we have
[19] pediatricians and why I believe that
[20] pediatricians are the appropriate people to
[21] take your child to and not a family doctor
[22] because we get repeated experience of that,
[23] and we have to be able to tell the
[24] difference.

[25] Q: Let me ask you the next logical

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[1] question. How would a pediatrician in an
[2] office setting who encounters multiple
[3] children under the age of three months with
[4] fever, how would that pediatrician make a
[5] determination to hospitalize or send a child
[6] to the emergency room as opposed to allowing
[7] the family to monitor or something of that
[8] nature?

[9] A: Well, that is the question and it
[10] does have applicability here and it goes back
[11] to a paper by McCarthy in 1982 in which she
[12] looks at the observation or observational
[13] states, and I think it's referenced in this,
[14] and I can give you the exact cite.

[15] Q: Fine. Why don't you do that?

[16] A: McCarthy, Observation Scales to
[17] Identify Serious Illness in Febrile Children,
[18] Pediatrics, 1982, pages 802 to 809.

[19] Now, in general, what Dr. McCarthy
[20] was saying was that the way the baby
[21] interacts with either the examiner or the
[22] parent is the most important thing that you
[23] can tell in a baby that's ill, more important
[24] than the laboratory, more important even than
[25] the height of the fever, although there's

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[1] some controversy about that. Many people
[2] believe the higher the fever, the more likely
[3] this is going to be a bacterial infection
[4] that needs treatment, but that the
[5] observation — and when we talk about that
[6] it's color, hydration, ability to get en face
[7] contact where you have face to face with the
[8] baby. He or she doesn't turn away, ability
[9] to cuddle and to soothe, and in general, I
[10] would call this a Gestalt, feeling that the
[11] baby has good tone and is interactive with
[12] his or her environment and is not
[13] disinterested, and a baby who is
[14] disinterested won't eat, won't interact, not
[15] soothable, irritable. That's a baby who is
[16] at a high risk of having a significant
[17] infection, and that's what the McCarthy
[18] scales try to quantify. We don't teach it as
[19] a quantification. It's hard to teach that as
[20] a quantification. It's after many years of
[21] observing child after child after child, you
[22] can categorize him "That child is well, that
[23] child is mildly ill, that child is sick."

[24] Q: By looking at the child and
[25] interacting with the child?

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[1] A: Correct.

[2] Q: Do you agree that interaction or
[3] observation is more important than laboratory
[4] studies?

[5] A: In very small babies, especially
[6] babies less than a month of age, yes, because
[7] the laboratory studies may be delayed in
[8] their response to a reaction to the action.

[9] Now, there is another part of that
[10] and that's called the Rochester Guidelines.
[11] I think they are the Rochester Guidelines.
[12] If you are going to do laboratory studies on
[13] these small infants and it meets all of these
[14] criteria, then you have a certain safety net
[15] that you can send the child home to the
[16] parents to be observed, and those include a
[17] white count between 5 and 15,000, an absolute
[18] band count less than 1,500, a urinalysis
[19] that's clear, and a stool, if the baby has
[20] diarrhea, that does not have white cells in
[21] it, and there may be one or two others, but
[22] that's basically it.

[23] The Rochester Scales did not
[24] include what we call an acute phase
[25] reactant. An acute phase reactant is a

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[1] protein that responds to infection;
[2] c-reactive protein or CRP is one. There are
[3] a ton of them, but we are using those more
[4] and more now because we understand that those
[5] acute phase reactants are more important in
[6] very small babies, and Dr. Sol Adler years
[7] ago had one that he used for newborns called
[8] a mini sed rate, a sedimentation rate, but it
[9] was done literally in a hematocrit tube, and
[10] if it fell more than 10 millimeters in an
[11] hour, that was an indication that the baby
[12] had increased proteins in the blood which
[13] means almost like a fever; that this was a
[14] non-specific response to infection.

[15] Q: You had made a comment earlier
[16] that there is perhaps some debate on whether
[17] or not how the child looks and what the
[18] interaction is like with the child is more
[19] important than the height of the fever.

[20] A: There is some debate that the
[21] higher the fever, the more likely it is that
[22] it's bacterial. In other words, a fever of
[23] 104 is more important than fever of 101.

[24] Q: What is your thought on that?

[25] A: I probably don't make that much of

[1] a distinction.

[2] Q: As you know, this case involves
[3] care that was rendered to this child nine
[4] years ago.

[5] A: Correct.

[6] Q: Is there anything that was
[7] different in 1991 in terms of monitoring or
[8] managing a newborn's fever as opposed to
[9] today or three or four years later?

[10] A: Only as an outpatient, not as an
[11] inpatient. I don't think it — well, in
[12] terms of treatment as an outpatient, there is
[13] a big difference. We now are preaching in
[14] questionable cases for outpatients to give
[15] them a shot of a cephalosporin medicine
[16] intramuscularly, after doing a blood culture,
[17] follow up the blood culture, and get the baby
[18] back if we need to within 24 hours.

[19] Q: That's current mode of teaching?

[20] A: That's current mode of teaching.
[21] We didn't teach that in 1991. Secondly, I
[22] would say that acute phase reactants are
[23] probably more used today than they were in
[24] 1991 despite Dr. Adler's mini sed rate and
[25] some other people using things. I don't

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[1] think they were used as actively as they are
[2] now because the neonatologists have been
[3] pushing them, or at least pushing them up
[4] till 1996, for the diagnosis of all kinds of
[5] beta strep infections. As you probably know,
[6] beta strep has fallen off dramatically.
[7] Two-thirds to three-quarters of the cases are
[8] gone because we have the new screening of the
[9] mothers and a protocol given to us by the CDC
[10] in 1996.

[11] Q: From your review of this file, did
[12] Mrs. Stalma have a negative Group B strep
[13] screen at any point during her pregnancy?

[14] A: She had a Group A strep positive
[15] culture once. I'm not aware if she had any
[16] Group B testing at all.

[17] Q: Is that reflective of the
[18] difference in prenatal management back in
[19] 1991 as opposed to now?

[20] A: It wasn't required in 1991. In
[21] fact, I reviewed that recently for a
[22] conference. In 1992 there were 19 published
[23] different approaches that I could find to
[24] managing Group B strep in mothers and
[25] babies. Everybody was all over the map.

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[1] Q: On the second page — and I will
[2] hand it over to you. On the second page of
[3] this article from Pediatrics, the 1983
[4] article that we have been talking about,
[5] under Definition of Fever, someone has
[6] underlined, "The panel concluded that 38
[7] degrees Celsius, 100.4 degrees Fahrenheit,
[8] should be used as the lower limit of the
[9] definition of fever." Do you agree with
[10] that?

[11] A: Yes, I do. That's a rectal
[12] temperature.

[13] Q: How would rectal temperature
[14] equate or are you able to equate with
[15] axillary temperature?

[16] A: That's a good question. Generally
[17] we think that a rectal temperature is going
[18] to be one to two degrees higher than an
[19] axillary temperature. However, we are not
[20] sure. So in our institution, we don't want
[21] nurses to routinely take rectal temperatures
[22] because bad things happen taking a lot of
[23] rectal temperatures. The thermometer can
[24] break. We have had one baby who had a
[25] perforated rectum from a temperature probe

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[1] being put in. We have them take them all by
[2] axillary, but any temperature above 99
[3] axillary gets repeated rectally, and if it
[4] meets the criteria of 100.4 Fahrenheit or 38
[5] degrees centigrade, then it must be reported
[6] immediately to the pediatrician.

[7] Q: Was that the way things were done
[8] in your institution in 1991?

[9] A: Pretty much.

[10] Q: Also underlined in the same
[11] article, it says "Fever may be result of
[12] overbundling of a small infant." Do you
[13] agree with that?

[14] A: Yes.

[15] Q: Also underlined, continuing on,
[16] "When this is suspected, the child may be
[17] unbundled and the temperature retaken in 15
[18] to 20 minutes." Do you agree with that?

[19] A: Yes. There is a nice study that
[20] looked at fever curve after unbundling and
[21] environmentally warm baby and they were all
[22] back to their standard temperatures, core
[23] temperatures, in 15 minutes. That's pretty
[24] good, pretty good evidence for that.

[25] Q: Is that a time frame then, 15 to

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[1] 30 minutes, that you would expect to see a
[2] change as a result of an environmental factor
[3] in the child's temperature?

[4] A: Yes. In other words, it should be
[5] back to a normal level, and if it's not, then
[6] you would assume it's not an environmentally
[7] induced fever, that it is a real fever.

[8] Q: Once we are all done, I'm not
[9] going to take the time now, we will go
[10] through and make sure I have got the cites on
[11] these particular articles. I am going to
[12] give these back to you. As our discussion
[13] continues, if there is anything that I ought
[14] to have reference in terms of this
[15] literature, you let me know.

[16] A: Let me just add that many of these
[17] probably in here, I think I looked at it a
[18] little while ago, are throwaways. They are
[19] kind of throwaway magazines that are sent to
[20] pediatricians about this very controversial
[21] issue, and so you may not be able to get
[22] them.

[23] Q: Would you put out if I asked you
[24] to copy those for me?

[25] A: I would be happy to send them to

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[1] you.

[2] Q: Since we are on the subject of
[3] throwaways, is the scale published by
[4] McCarthy something that would be a reliable
[5] source in terms of monitoring, managing,
[6] treating fever?

[7] A: Well, if you said the McCarthy's
[8] observation scales to most pediatricians,
[9] they wouldn't know what you're talking
[10] about. What she did was try to quantify it
[11] and give it a scientific basis. What the
[12] importance of that paper was and what you
[13] will see in every paper probably in here, and
[14] I haven't reviewed them recently, is the
[15] importance of the Gestalt, of the observation
[16] of the baby, the examination of the baby, and
[17] different people use different things. How
[18] does that baby look to an experienced
[19] pediatrician? If that baby looks good,
[20] there's probably very little chance the baby
[21] is septic. If that baby doesn't look good,
[22] for whatever reason, a higher probability
[23] that the baby is septic, and so that exam
[24] becomes very important.

[25] Unfortunately, in this case, the

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[1] child wasn't examined, so we don't know, and
[2] that becomes a major issue, but the McCarthy
[3] scale kind of just quantified different
[4] parameters that she thought were important,
[5] such as suitability and ability to cuddle,
[6] interest in environment, ability to make eye
[7] contact, and she gave them point scores, and
[8] I don't remember what it was, but that wasn't
[9] what was important. Examination of the child
[10] and the state of the child is probably the
[11] most important thing to make a diagnosis.
[12] Q: Do you in your clinical practice
[13] and assessment of newborns follow — and I'm
[14] not talking in terms of giving a point
[15] grading system, but follow and look for the
[16] same categories of findings that McCarthy
[17] outlines?
[18] A: Probably not, because I don't even
[19] remember all the ones she outlined. It's not
[20] like an Apgar score where you have to give a
[21] score to five parameters. What it is is a
[22] general impression, and what I remember, you
[23] know, interaction with environment and
[24] ability to soothe and cuddle and interest in
[25] feeding and being able to make eye contact.

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[1] Those kinds of things. So it's a general
[2] impression.
[3] Q: You have mentioned a number of
[4] times what would be important in a
[5] pediatrician assessing the newborn. Do you
[6] think that likewise nursing personnel over
[7] the course of time and seeing baby after baby
[8] after baby can also develop the ability or
[9] can have the ability to do that type of
[10] assessment on a newborn?
[11] A: Yes. I think that's probably one
[12] of the most important skills they bring. I'm
[13] very opposed to floating nurses, and because
[14] of malpractice issues we don't see nurses
[15] floated to OB any more because they can't
[16] read fetal monitor tracings, but we do see
[17] nurses floated all the time to the nursery to
[18] rest their feet and feed babies, and I think
[19] that's a real negative. If a nurse calls me
[20] and says, "Doctor, I don't know what is wrong
[21] but this baby does look right," to an
[22] experienced nurse, that's a flag. You go
[23] running in and see that baby.
[24] Q: Would the flip be true to that
[25] that in their assessment they feel that the

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[1] baby is interacting and that the baby looks
[2] okay, that that would be a reliable indicator
[3] to you on what's going on with the baby?
[4] A: Yes. Assuming, both sides of that
[5] coin, that they have adequate experience.
[6] Again, I don't want a nurse who is floating
[7] from another area or a nurse who has not had
[8] adequate experience, but whatever you
[9] consider adequate experience.
[10] Q: Can you tell from your file when
[11] it was that you were first contacted in this
[12] case?
[13] A: Yes. Because I wrote it. 5/16/00
[14] was the first correspondence. I was probably
[15] contacted a week or two before that by phone.
[16] Q: Do you have any recall of that
[17] particular phone conversation?
[18] A: No, ma'am.
[19] Q: Do you know who it was that you
[20] were called by?
[21] A: I'm not sure whether it was Mr.
[22] Kulwicki or Mr. Becker.
[23] Q: I'm assuming then subsequent to
[24] that phone conversation you received some
[25] materials by mail?

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[1] A: Correct.
[2] Q: Do you recall what it was that you
[3] were first sent?
[4] A: I was first sent the charts.
[5] Q: That being mother's labor and
[6] delivery record and the child's newborn
[7] record?
[8] A: Correct.
[9] Q: Were you also sent the prenatal
[10] care?
[11] A: Yes.
[12] Q: In the course of any of your
[13] discussions with anyone from Mr. Kulwicki's
[14] office or through correspondence, were you
[15] ever given any particular assignment or given
[16] any instructions as to what they wished for
[17] you to do in this case?
[18] A: Yes. There was a work product
[19] document that they generated that laid out
[20] specific questions vis-a-vis issues that they
[21] thought might be important, some of which
[22] turned out, in my opinion, to be important
[23] and some of which I thought were, to use the
[24] medical terminology, red herrings or
[25] unimportant.

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[1] Q: Was this by letter that there were
[2] issues outlined for you to review and pay
[3] attention to?
[4] A: Yes, ma'am.
[5] Q: And I take it then that you
[6] undertook to review the medical records, and
[7] perhaps subsequently depositions, to answer
[8] those questions?

[9] A: Correct.

[10] Q: Did you then have a discussion on
[11] each particular issue as to whether it was
[12] significant to this case or a red herring?

[13] A: I did.

[14] Q: What particular issues were you
[15] asked to look through that you felt were red
[16] herrings in this case?

[17] A: The bilirubin issue. In my
[18] opinion, the child never even needed
[19] phototherapy. The bilirubin never rose to a
[20] significant level. The child was sensitized
[21] or the mother was sensitized to Rh disease
[22] and had numerous amniocenteses, which showed
[23] her level in the stage level 2 on the Liley
[24] curves, and I think the highest bilirubin the
[25] child had was eight. Obviously you don't

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[1] know that when the baby is born and it has a
[2] positive Coombs. You don't know how high
[3] it's going to be, but the baby had a normal
[4] hematocrit at birth, which meant that there
[5] was very little hemolysis going on in the
[6] previous weeks, and you could anticipate
[7] there would be probably very little bilirubin
[8] breakdown in the subsequent days. I don't
[9] think it was wrong to put on the Bili light,
[10] but it obviously led to a cascade of events
[11] where they thought the light was causing the
[12] overheating, and in my opinion, the baby
[13] never even needed the light. I don't think
[14] bilirubin in was an issue.

[15] There was a question regarding low
[16] Apgar scores. They were six and eight, and I
[17] felt the Apgar scores were normal for a baby
[18] of this gestation, and I felt that that was
[19] not an issue.

[20] Q: Anything else?

[21] A: I don't think so. Everything else
[22] was in one way or another related to the two
[23] major opinions that I eventually came up with.

[24] Q: That begs the next question. What
[25] were the issues that you were asked to look

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[1] at that you feel have any significance in
[2] this case?

[3] A: My feeling is that had the child
[4] been examined between 3:00 and 6:00 p.m. on
[5] the 23rd, that the child would have
[6] demonstrated to a reasonably prudent
[7] pediatrician or neonatologist adequate
[8] changes in their personalities or
[9] observational states, as it has been called,
[10] to warrant a septic workup and the
[11] administration of antibiotics certainly by
[12] 6:00 p.m. on the 23rd. Had that been done,
[13] then that would mean that the child had
[14] received antibiotics 10 hours approximately,
[15] 9 to 10 hours, prior to the time that he
[16] eventually did get antibiotics, and I believe
[17] that his disability today, his handicap,
[18] would have been lessened because of a less
[19] intense or less severe infection. I can not
[20] say with probability that meningitis would
[21] have been prevented. Ninety-five plus
[22] percent of these cases start with a
[23] bacteremia and then go on to meningitis, and
[24] the child was demonstrating, even on the
[25] 23rd, signs of central nervous system

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[1] irritability. I can't say that meningitis
[2] would have been prevented, but it is my
[3] opinion that a 10 hour earlier administration
[4] of antibiotics would have lessened the
[5] severity of the infection and thus the
[6] handicaps that the child now suffers.

[7] Q: Are these two opinions — and as I
[8] understand them, the first being that if the
[9] child was examined between 3:00 and 6:00
[10] p.m., the child would have demonstrated
[11] changes in his observational state to warrant
[12] a septic workup and antibiotic treatment by
[13] 6:00 p.m.

[14] A: Correct.

[15] Q: That's the first opinion?

[16] A: Correct.

[17] Q: The second opinion that if
[18] treatment had been initiated, antibiotic
[19] treatment, 10 hours earlier, the central
[20] nervous system damage to this child would
[21] have been lessened?

[22] A: Correct.

[23] Q: Do you have any other opinions in
[24] this case?

[25] A: No. All the other opinions are

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[1] corollaries based on those two.
[2] Q: Okay. All right. Let me back up
[3] for just a moment. We talked a little bit
[4] earlier about any red herrings in this case.
[5] You have indicated that perhaps this child
[6] didn't even need to be under the
[7] phototherapy. Was it still within standard
[8] of care to institute phototherapy on this
[9] child when it was done?
[10] A: Sure. In general, phototherapy is
[11] a fairly benign procedure, except if it
[12] prevents you from making a diagnosis of fever
[13] as it is in this case. In anticipation of a
[14] baby with a positive Coombs whose mother is
[15] Rh negative, why not? But, in general, we
[16] don't initiate phototherapy until the
[17] bilirubin is at least above 10, and in 1992,
[18] the bilirubin, I think February of 1992
[19] Pediatrics, the entire change of bilirubin
[20] treatment came out, post dates this case,
[21] probably not relevant, but an article given
[22] what our new president today entitled "A
[23] Kinder Gentler Approach —
[24] Q: This is Dr. Misell's article?
[25] A: Misell's and Newman's. "A Kinder

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[1] Gentler Approach to Bilirubin Management,"
[2] which really changed phototherapy to now it
[3] is given at 15 or 20 in babies.
[4] So to initiate phototherapy here
[5] at 3 wouldn't have been what I would do, but
[6] it's not below the standard, and you could
[7] make a good argument we are anticipating a
[8] problem in the future.
[9] Q: Can bilirubin lights be an
[10] environmental source of temperature increase
[11] in a child?
[12] A: They can, but it's probably over
[13] done in terms of using that as a reason.
[14] It's much more likely, for example, if the
[15] baby is under phototherapy inside of a
[16] isolet. The isolet, which is a plastic box,
[17] acts as a hot house effect and can warm the
[18] infant. The larger the infant, the more
[19] likely, but, for example, in this case there
[20] is some indication that there was an order to
[21] unwrap the baby in order to see if the
[22] temperature came down, but a baby under
[23] phototherapy wouldn't be wrapped, so I don't
[24] understand that. We would want as much skin
[25] exposed to the light as possible because

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[1] that's the way the light works by breaking
[2] down the bilirubin to a phototherapy isomer
[3] that is not toxic and it can be excreted by
[4] the kidneys.
[5] Q: Do you have any information one
[6] way or the other as to whether or not this
[7] baby had nothing on, a diaper on, a light
[8] blanket on, at any time during the
[9] phototherapy?
[10] A: I don't know. If he had a light
[11] blanket on, he wasn't getting phototherapy.
[12] It's my understanding from the chart that the
[13] child was in an open bassinet, and for
[14] phototherapy to be operational on a near
[15] naked baby in an isolet in a reasonably kept
[16] room, it would be very unusual for that to
[17] cause environmental heating in my experience
[18] and opinion.
[19] Q: If a child is under — and I think
[20] there is some testimony and information in
[21] this case that this baby was under double
[22] phototherapy, under two lights. If it is
[23] suspected that an increase in the child's
[24] temperature is due to the double phototherapy
[25] lights and both of those lights are turned

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[1] off, over what period of time would you
[2] expect the child's temperature to decrease?
[3] A: I think that this speaks to that.
[4] That's basically environmental overheating,
[5] the same as you would get from bundling, and
[6] the Pediatric 1993 article speaks to that
[7] from a paper that was done I think 10 years
[8] previously that it takes 15 minutes or so, at
[9] max 30 minutes.
[10] Q: How about if, as is indicated in
[11] the notes in the order in this case, the
[12] child is under two phototherapy lights and
[13] one is turned off? Is there any way to
[14] determine the time frame that the temperature
[15] would drop?
[16] A: That study has never been done. I
[17] can't tell you. Again, it also depends on
[18] the lights used, the actual type of light,
[19] how much heat they generate. They are not
[20] supposed to generate a lot of heat. The
[21] older the light gets it generates more heat.
[22] That's why we change them. Is it a white
[23] light? Is it a blue light? There's studies
[24] done on heat generated by certain types of
[25] lamps. We are really kind of glossing over

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[1] this whole thing and not looking at it
[2] scientifically, but what makes this
[3] suspicious to me is, number one, the baby
[4] shouldn't be dressed; number two, he is in a
[5] bassinet, not in an isolet, and I wouldn't
[6] expect an elevation of temperature certainly
[7] with one phototherapy light, and it's very,
[8] very rare in my experience to have
[9] overheating from phototherapy in an open
[10] crib. Going from two to one, I don't know if
[11] it makes any difference at all. There is
[12] certainly no science that I know that has
[13] looked at it.

[14] **Q:** Do you have any criticisms of any
[15] of the pediatricians — and, for your
[16] reference purpose, Dr. Gladdio and Dr.
[17] Buganski were the two pediatricians within
[18] the same practice who saw this child. Do you
[19] have any criticisms of any of their
[20] management or care of this child?

[21] **A:** I have a problem with that. I
[22] think that there is some responsibility of
[23] the pediatrician in the afternoon in
[24] question. I have no problem from 2:00
[25] o'clock on or 2:30 on in the morning when the

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[1] pediatrician was called, and the care up to
[2] that seemed superb. I have some issues with
[3] what happened in the phone calls or lack of
[4] phone calls or the follow-up or the
[5] responsibility of the pediatrician who was
[6] told once that the baby has a fever, at least
[7] once, and another time that the baby has — I
[8] would have to go in and get the exact
[9] phrasing.

[10] **Q:** By all means, reference the chart
[11] or anything that would assist you.

[12] **A:** In that nursing page that is the
[13] one that has the tab on it.

[14] **Q:** Are we looking at the nursing note
[15] for the 23rd to 24rd of March?

[16] **A:** Correct. At 1430 it says, "Dr.
[17] Buganski notified of increased temp. Orders
[18] received." And then at 2100 hours, it says,
[19] "Dr. Buganski notified of above episode."
[20] The episode I'm assuming is the cyanotic
[21] episode which required oxygen. So at least
[22] twice during that day he was notified. I did
[23] not get from his deposition an indication
[24] that he called back between 1430 and 2100. I
[25] did not get that he queried the nurse at 2100

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[1] about all the other things that had been
[2] happening in between. I understand just
[3] today, I did not know that, that he was not a
[4] defendant in this case, but I think that he
[5] has some responsibility. I can't give a
[6] percentage.

[7] **Q:** Do you feel that Dr. Buganski had
[8] an obligation to call back at any point after
[9] 1430 to inquire about the child's condition,
[10] which seemed to be one of the things that you
[11] mentioned in looking through all of this?

[12] **A:** Well, either that or he has to
[13] make an assumption that his orders, standing
[14] orders, that he will be called every time a
[15] temperature was above 99 will be followed.
[16] When he is called back at 2100 hours, I don't
[17] know the content of that conversation. The
[18] question is was he made aware of everything
[19] that occurred from 1430 to 2100, and that
[20] would have cut possibly the delay time in
[21] getting the child on antibiotics
[22] significantly.

[23] **Q:** Do you have information which
[24] allows you to determine what Dr. Buganski was
[25] made aware of at the time of the 2100 phone

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[1] call?

[2] **A:** The only deposition I have read is
[3] Dr. Buganski's. I have not read the nurse's
[4] depositions.

[5] **Q:** What information do you feel
[6] either should have been elicited by Dr.
[7] Buganski at 2100 or offered by the nurse at
[8] the time of that phone call?

[9] **A:** Basically observation, the thing
[10] that we have been talking about for so long.
[11] "What is this baby like?" "What does this
[12] baby look like to you, Nurse?" Or Dr.

[13] **Buganski:** "This baby doesn't look good to me.

[14] He's having cyanotic episodes, he's not
[15] feeding well, he's spitting up." Spitting up
[16] is generally nothing in a baby, but if a baby
[17] is spitting up, especially more than an hour
[18] after he has been fed, that indicates, and he
[19] has some abdominal distension, that indicates
[20] an ileus. Well, there are multiple reasons
[21] for an ileus. That could be a brain problem,
[22] it could be an obstruction in the intestine,
[23] or it could be infection.

[24] In general, studies show that the
[25] stomach should clear of food in 45 minutes or

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[1] so after a baby has been fed. So more than
[2] an hour after a baby has been fed, he's still
[3] bringing up formula, that means he is
[4] refluxing formula that is not moving out of
[5] the stomach. That's a sign of ileus.

[6] So you have got three things, none
[7] of which are good, that could be going on
[8] with this baby. I mean, some of the
[9] intestinal obstruction things, such meconium
[10] ileus, are relatively benign most of the
[11] time, but this child could be under narcotics
[12] from the mother and have an ileus on that
[13] basis, although at three days of age it's
[14] doubtful; could have a brain injury, could
[15] have infection. Those are things that you
[16] would like to know about, and what happens
[17] between 1430 and 2100 I think is, in that six
[18] and a half hour period, is very important,
[19] and the doctor needs to know about it.
[20] Either the nurse needs to tell him or he
[21] needs to ask.

[22] Q: Fair enough. Let's look at that
[23] time frame, 1400 to 2100. One of the things
[24] you have mentioned that either should be
[25] elicited from the nurse or offered by the

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[1] nurse is whether or not there is any cyanotic
[2] episodes. At any point in time did this
[3] child have a cyanotic episode?

[4] A: 1835. "Mom states baby has arched
[5] back." Arching is a very unusual posture.
[6] "Stiffened extremities" — that indicates to
[7] me, if not a seizure, then certainly central
[8] nervous system irritability — "while
[9] feeding." "Cyanosis around mouth and hands
[10] noted. Baby suctioned at bedside mouthful of
[11] formula and mucous." That depends on whether
[12] that is a wet burp or how far after the
[13] feeding that is. "Continues to have
[14] difficulty breathing and expiration." Well,
[15] to me, that's a grunt. What that means is
[16] the baby is making that sound where you close
[17] your epiglottis over your trachea and you
[18] make that sound to bear down to get a little
[19] extra "umf" in your breathing, and it's a
[20] common sign of babies who are either in
[21] respiratory distress or sepsis. It's a sound
[22] of um, um, um. (Indicating) And it's a very
[23] common sign in infection and nursery nurses
[24] know that.

[25] Q: If this child, in fact, was

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[1] grunting, having difficulty in expiration and
[2] was grunting, would you expect that to
[3] continue up to the point in time where
[4] treatment was instituted and became effective
[5] or is it something that would come and go?

[6] A: It comes and goes. It can be
[7] continuous, but in babies like this,
[8] especially babies who are septic, it comes
[9] when the baby is somewhat a little stressed.
[10] He may be stressed by feeding, stressed by
[11] trying to nipple, stressed because of being
[12] handled, but then the grunting will come out,
[13] and then when he is quiet, he goes back, and
[14] he's not having problems with his lungs
[15] necessarily. He's having problems basically
[16] with his entire body responding to this
[17] infection.

[18] Q: If the child subsequent to that
[19] time was fed, would you expect that a nurse
[20] would be able to pick up that grunting in the
[21] course of feeding the infant?

[22] A: Possibly, yes, depending on if
[23] she's listening and how loud or soft it is.
[24] It may be quite soft, but sure, the next time
[25] he is stressed, I would expect more likely

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[1] than not that you would see it again.

[2] Q: Any other cyanotic episodes
[3] between 1835 and 2100?

[4] A: "Baby returned to nursery. Color,
[5] cyanotic again." I don't know if that is a
[6] new episode or the same. "DeLee suctioned
[7] again. Passing phallitis and mucous." Then
[8] it says by 1845 the lungs are clear and the
[9] color improving with facial oxygen. 1850.
[10] The color is pink. 2100 hours. Then it says
[11] Dr. Buganski is notified.

[12] Q: Was it appropriate to suction this
[13] baby?

[14] A: Sure.

[15] Q: At 1835?

[16] A: Sure.

[17] Q: Was it appropriate to take the
[18] baby back to the nursery?

[19] A: Absolutely.

[20] Q: Was it appropriate to give
[21] supplemental oxygen?

[22] A: Yes.

[23] Q: The next thing I have noted is —

[24] A: We didn't go through the
[25] temperatures during this period of time. So

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[1] from 1430 to 2100 a number of temperatures
[2] were taken. They were all taken, as far as I
[3] know, axillary. Again, using our rule of
[4] thumb, anything above 99 would be, I guess,
[5] presumed to be a fever unless the rectal
[6] temperature was taken. They are all pretty
[7] much above 99, some of them are 99.9, 100.6.
[8] Again, I would expect the nurse to tell that
[9] to the doctor since he has a rule, 99 he
[10] wants to know, and that's pretty consistent
[11] with ours, by the way. Dr. Buganski saying
[12] 99 temperature done axillary is probably
[13] somewhere over a hundred rectally. It might
[14] be as much as 101. It might be closer to
[15] 100. And I would want to know what the
[16] rectal temperature is. If she had called Dr.
[17] Buganski and said, "We are still getting
[18] temperatures above 99" and he says, "Take a
[19] rectal temperature" and it comes in above
[20] 100.4, you are immediately at the bedside and
[21] you do a septic workup.

[22] Q: When is the first normal
[23] temperature after the temperature elevations
[24] at around 2:00 or 2:30?

[25] A: Mine is a little cut off.

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[1] Q: I have one that is not. If you
[2] want to go ahead and —

[3] A: Okay. Again, these are all
[4] axillary. So for us, the 98.6 is probably
[5] okay and the 97.9 is probably okay at 2400.
[6] Recognizing that some babies respond to
[7] infections by becoming cold and having very
[8] low temperatures, there a bottom range as
[9] well.

[10] Q: Is that more often seen in
[11] newborns that are septic is that they become
[12] hypothermic?

[13] A: Correct. It's less commonly that
[14] they get hyperthermic or febrile, but it does
[15] happen, and so we have limits at both ends of
[16] what we consider to be the normal spectrum.

[17] Q: What would you consider then a
[18] normal temperature on an infant of this age?

[19] A: In general, 37 degrees centigrade,
[20] 98.6 plus or minus one degree.

[21] Q: Axillary? I want to make sure we
[22] are clear.

[23] A: Rectal.

[24] Q: The other thing that you have
[25] noted in terms of observing the baby and what

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[1] information should be conveyed in a phone
[2] conversation, you have talked about whether
[3] or not the baby is feeding well. Between
[4] 1400 and 2100, do you see any indication that
[5] the child wasn't feeding well?

[6] A: Well, they switched the baby to
[7] dextrose and water in the nursery, and again,
[8] I'm having trouble with my time.

[9] Q: Mine has the times.

[10] A: That's at 2200. So that's after
[11] Dr. Buganski had been called. Three-quarters
[12] of an ounce of dextrose water at 1830 is not
[13] great. Again, we are talking about a
[14] three-day-old. It's okay at day one. Might
[15] even accept it on day two. We are beginning
[16] to see here half an ounce to an ounce,
[17] three-quarters of an ounce. This baby is not
[18] a vigorous feeder at this point. That
[19] doesn't make a diagnosis. It just increases
[20] your index of suspicion, and they did change
[21] to a premie nipple which has larger holes and
[22] is easier. Instead of sucking the formula
[23] out, you are basically pouring the formula in
[24] and hoping that the baby swallows it.

[25] Q: The nurses in this case have been

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[1] deposited, and let me ask you to assume that at
[2] 1830 the three-quarter ounce dextrose water
[3] that was fed in the nurse was in response to
[4] this episode that this baby had to see how
[5] the baby did with taking fluid. Would that
[6] be appropriate?

[7] A: I have never heard of nurses doing
[8] that. If the baby had a low sugar,
[9] chem-strip or dextrose stick, and you wanted
[10] to feed the baby to give it sugar, fine, but
[11] it's like running a stress test on the baby.
[12] That's just generally not done by our
[13] nurses. I don't know how to respond to that.

[14] Q: Fair enough. Any other indication
[15] that the child between 1400 and 2100 was not
[16] feeding well? And let me preface that by
[17] saying, as I understand your opinions, you
[18] are looking at a decreased amount that the
[19] child is taking?

[20] A: Correct.

[21] Q: And a change in the nipple type
[22] that's used?

[23] A: Correct. And I think in the
[24] mother's deposition as well she indicated the
[25] baby was not feeding well and she was having

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[1] some difficulty at that feeding in her room.
[2] You have got some issues around feeding, you
[3] have got some issues around temperature, you
[4] have got some issues around state or
[5] observational state, and you have a cyanotic
[6] episode and a potentially CNS irritability
[7] episode and potentially abdominal distension,
[8] although it's not documented in the chart.

[9] Q: Let me stop you for just a
[10] moment. Do you have any information as to
[11] whether or not the mother's perceived
[12] difficulty in getting the baby to eat was
[13] ever reported to any of the nursing staff?

[14] A: I don't know.

[15] Q: Abdominal distension is another
[16] thing that you mentioned. At any time before
[17] 2100, is there any indication in the chart
[18] that the baby's abdomen was distended?

[19] A: Not in the chart.

[20] Q: Do you have any information from
[21] any of the depositions that you have read
[22] that indicate that to be so?

[23] A: Not that I have read. I was told
[24] by counsel that one of the nurses has
[25] testified that there was abdominal distension

[1] nurse to offer to the physician in the phone
[2] call or for the physician to elicit from the
[3] nurse other than what we have already talked
[4] about?

[5] A: No.

[6] Q: You are aware that on the morning
[7] of the 22nd and the morning of the 23rd Joey
[8] Stalma was seen by a pediatrician on both
[9] occasions, correct?

[10] A: Yes.

[11] Q: Do you have any information as to
[12] what those physicians were told or what they
[13] did in terms of reviewing the chart when they
[14] came to see the child?

[15] A: Only what Dr. Buganski wrote in
[16] the chart on the 23rd and a brief — I don't
[17] think he had any independent recollection by
[18] what his customary things were to do in the
[19] nursery when he was deposed. He has a brief
[20] one line about the child is doing well. Let
[21] me get to the doctor's notes, and then he
[22] goes ahead and does a circumcision. He says,
[23] "Baby alert. Good cry." This is 0800 on the
[24] 23rd. "Bilirubin 7.0 last night." Above
[25] that he writes some things about the Coombs

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[1] at 6:00 o'clock, approximately 6:00 o'clock.

[2] Q: Do you know who the nurse was?
[3] Was it indicated to you?

[4] A: No. And I may be misstating that,
[5] but that's my recollection.

[6] Q: From the testimony that you read
[7] and from the chart itself, there doesn't
[8] appear to be any indication of abdominal
[9] distension up to 2100; is that correct?

[10] A: Correct.

[11] Q: Also you mentioned spitting up.
[12] Is there any indication of spitting up in
[13] this time frame?

[14] A: Yes. Well, suctioned mouthful of
[15] formula and mucous and then DeLee is also a
[16] suction. It's not actually spitting up, that
[17] is out of the mouth onto the bed, but
[18] basically what you're saying is food that had
[19] been in the stomach has now come up, refluxed
[20] up, into the mouth. I use those fairly
[21] synonymously but technically you are right.
[22] It's not spitting it all the way out. It's
[23] only spitting it up to the mouth.

[24] Q: Anything else in terms of
[25] observation that you would expect either the

[1] and phototherapy.

[2] Q: For example, "Bilirubin 7.0 last
[3] night," do you know one way or the other
[4] whether that was from reviewing the earlier
[5] chart or from discussion with the nurse?

[6] A: I don't know.

[7] Q: Do you know whether or not there
[8] was any discussion between the nurse and Dr.
[9] Buganski as to the child's temperature?

[10] A: I do not know. And then he went
[11] on to do a circumcision. 0855 is when the
[12] mother signs the consent, and I assume that
[13] he does it shortly thereafter. Most
[14] pediatricians don't spend all morning in the
[15] hospital. They want to get to their office.
[16] So sometime between 9:00 and 10:00 he has
[17] done the circumcision and has observed the
[18] child during that procedure.

[19] Q: Now knowing the end of the story,
[20] would you have expected that in the course of
[21] that hour or two with the child that there
[22] would have been any sign or symptom that Dr.
[23] Buganski would have or should have picked up
[24] on?

[25] A: Potentially not, especially if

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[1] most of the exam occurred while the child was
[2] being circumcized on an infant restraint
[3] board, crying and appearing — when you are
[4] doing that much stress, the baby is going to
[5] generate cries and an adrenaline response
[6] which is not his usual state, so you may be
[7] fooled by that.

[8] Q: Can you tell from the chart as to
[9] when exactly the circumcision was done?

[10] A: No. As I said, the consent is
[11] signed at 0855. This is labeled at 0800.
[12] The pediatrician is not going to spend the
[13] day in the hospital. He wants to get back to
[14] his office because he has got patients to
[15] see. He does the circumcision because he
[16] signs it. In my opinion it has got to be
[17] done after 0855, after the consent is signed,
[18] and probably before 10:00 o'clock because he
[19] wants to be in his office seeing patients.
[20] That is an educated guess.

[21] Q: Is this the consent form that you
[22] have seen in the chart?

[23] A: Yes.

[24] Q: It is your understanding that this
[25] is Dr. Buganski's signature? And I'm not

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[1] trying to trick you by the question, but I
[2] have had this same question in my mind.

[3] A: Yes. I think it is. Do you see
[4] it is signed by the mom and it's dated and
[5] timed at 0855?

[6] Q: Yes.

[7] A: Okay.

[8] Q: Shortly after Joey's birth, a
[9] neonatologist by the name of Dr. Kripke saw
[10] Joey. Do you have any criticisms with any of
[11] his assessment or care?

[12] A: No.

[13] Q: Any criticisms of any of the
[14] neonatologists who were consulted at roughly
[15] 2:15 in the morning on the 24th?

[16] A: No.

[17] Q: By that I mean from that time
[18] forward?

[19] A: None.

[20] Q: Any criticisms of how this child
[21] was worked up for sepsis once he was sent
[22] over to the neonatal unit?

[23] A: No. There is some controversy of
[24] whether they should have done the LP
[25] immediately. It makes no difference as far

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[1] as I'm concerned. They waited because of the
[2] child's abdominal distension and did it that
[3] afternoon. I think that meets the standard.

[4] Q: Do you think that the antibiotic
[5] coverage that was initially begun was
[6] appropriate?

[7] A: Well, they were considering more
[8] of an intestinal problem and they started
[9] different antibiotics. I think it was
[10] appropriate.

[11] Q: Does it appear, though, that once
[12] there was some laboratory studies back on
[13] this child, that the antibiotics were then
[14] changed?

[15] A: They were changed to Ampicillin
[16] and Genomicin and then they were changed
[17] again to a higher dose when two days later
[18] they were still seeing some strep in the
[19] spinal tap that was done on the 26th. So
[20] they went I think from 200 milligrams per
[21] kilogram to 400 milligrams per kilogram per
[22] day which is the appropriate meningeal dose.

[23] Q: Have you formulated opinions with
[24] regard to the appropriateness of the nursing
[25] care in this case?

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[1] A: The only problem I have with the
[2] nursing care is from approximately noon or
[3] 2:00 o'clock on the 23rd until the
[4] notification to the physician at 2:00 o'clock
[5] in the morning on the 24th.

[6] Q: I assume that in your opinion
[7] contact should have been made by the nurses
[8] to the physician at some point in time?

[9] A: Yes.

[10] Q: When is it that you feel that
[11] contact should have been made?

[12] A: Between 3:00 and 6:00 p.m., and
[13] the contact at 2100 hours should have in one
[14] way or another — and I don't know who to lay
[15] this responsibility on — in one way or
[16] another should have conveyed the fact that
[17] this baby was not doing well from multiple
[18] points of view, you know, whether it be
[19] feeding or temperature control or
[20] observational state or having cyanotic
[21] episodes or abdominal distension. There was
[22] enough there to raise the flag that something
[23] is wrong with this baby, and again, I can't
[24] lay responsibility at that point because I
[25] don't know what went on in the conversation.

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[1] Q: Fair enough. To make sure that I
[2] understand your criticisms, between 3:00 and
[3] 6:00 p.m. tell me anything in the chart that
[4] is a finding or something to you of
[5] significance that you feel that the physician
[6] should have been contacted about?
[7] A: All the temperatures and the
[8] things that we just talked about. In other
[9] words, the doctor gave an order at 2:30 to
[10] undress the baby and to retake the
[11] temperature in an hour. There should have
[12] been some communication back to him that the
[13] temperature did not fall below 99 and at the
[14] same time to indicate to him the other
[15] problems that were going on with the baby.
[16] Q: That's what I want to make sure
[17] I'm clear. By other problems, we have talked
[18] already about the episode at 1835.
[19] A: Feeding, cyanosis, potentially
[20] abdominal distension — we will have to check
[21] that out in the nurse's deposition — and
[22] behavioral state. And, again, I'm not asking
[23] the nurse to give a McCarthy scale. What I'm
[24] saying is "this baby doesn't look right."
[25] That's all she has to say.

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[1] Q: 1835 is 6:35?
[2] A: Yes, ma'am.
[3] Q: That's when this episode occurs.
[4] We have talked about this time frame of
[5] between 3:00 and 6:00 p.m. That episode
[6] occurs after that point in time.
[7] A: Well, then I will amend my thing
[8] to say 3:00 and 6:35 p.m.
[9] Q: If there is an elevated
[10] temperature sustained over a half hour period
[11] of time, is it appropriate for the nurse to
[12] contact either the attending pediatrician or
[13] the neonatologist?
[14] A: Yes.
[15] Q: Let's assume at 1430, when there
[16] is now a temperature of 99.9, assuming that a
[17] phone call had been made to Dr. Buganski, or
[18] to anyone for that matter, how in your
[19] opinion would that have changed the outcome
[20] of this case?
[21] A: I think that should have brought
[22] the pediatrician or the neonatologist to the
[23] bedside for an exam, and that given the other
[24] things that were going on concurrently and
[25] what I believe to be the behavioral state of

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[1] that child that at this point is not
[2] undergoing a circumcision, that someone would
[3] have said "This baby doesn't look right, we
[4] need to do a septic workup, stop the feeding
[5] and start an IV" and do the appropriate
[6] things. I think that diagnosis was capable
[7] of being made any time after 1430 in the
[8] afternoon is what I'm saying by a reasonably
[9] prudent physician/neonatologist and that
[10] something should have been seen wrong by a
[11] reasonably prudent nurse saying "This baby
[12] doesn't look right."
[13] Q: In terms of what is documented in
[14] the chart by way of findings or red herrings
[15] or red flags, I guess I should call them —
[16] let's not confuse the two, red flags. At
[17] 1400 we have a temperature of 100.6, correct?
[18] A: Correct.
[19] Q: At 1430 we have a temperature of
[20] 99.9, correct?
[21] A: Correct.
[22] Q: If your time is cut off, let me
[23] show you. At 11:00 o'clock the child fed one
[24] and one half ounce.
[25] A: Yes.

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[1] Q: Which is the only documented
[2] feeding that we have before 1430, correct?
[3] A: I think that's the last time you
[4] can say that this baby meets some reasonable
[5] criteria of doing adequately.
[6] Q: Is it fair then that what we have
[7] in the chart by 1430 are two elevated
[8] temperatures in terms of any signs or
[9] symptoms that there's something brewing here
[10] or something going on?
[11] MR. KULWICKI:
[12] Let me have the court reporter
[13] read that back.
[14] MS. BAER:
[15] I can repeat it.
[16] BY MS. BAER:
[17] Q: Is it fair then that by 1430 what
[18] we have in the chart that evidences from your
[19] testimony any red flag or potential sign of a
[20] problem are two temperatures above 99 degrees?
[21] A: Yes. And I can't read the time on
[22] when the feeding starts to decrease.
[23] Q: Let me show you here. At 11:00
[24] o'clock we have the child —
[25] A: That's 1515. I'm sorry. What you

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[1] would expect in a baby is for feedings to get
[2] better with time generally, but we go from
[3] one and a half ounce to one ounce to
[4] three-quarter ounce to one ounce to one
[5] ounce. The feeding is getting less, and they
[6] are doing more to get the baby to feed by
[7] changing to a premie nipple.
[8] Q: But sticking to the 1430 time
[9] frame.
[10] A: 1430 I would agree with you.
[11] Q: In light of that fact, if a
[12] pediatrician had come in to see the child and
[13] decided to just have some continued
[14] observation of the child, would that be
[15] appropriate?
[16] A: If he examined the child and he
[17] felt that the child did not look sick,
[18] whether that's because of his experience or
[19] whatever, but to come to the bedside and see
[20] the child himself would have met the standard.
[21] Q: Assuming that someone did come to
[22] the bedside at roughly 1430, felt that the
[23] child looked okay. Now looking at what is
[24] documented in the chart, at what point in
[25] time at the outside do you feel that a septic

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[1] workup should have been done on this child?
[2] A: Well, then from 1430 to 2100 we
[3] have many more things happening, so I think
[4] certainly by 2100. That would be 9:00
[5] o'clock at night that a septic workup should
[6] have been done.
[7] Q: Would the first step in a septic
[8] workup be to get a cbc and differential?
[9] A: It's not the first step. They are
[10] all done concurrently. It's part of the
[11] workup.
[12] Q: Would you simultaneously draw for
[13] cultures?
[14] A: Yes.
[15] Q: And at what point in time would
[16] you start the child on antibiotics?
[17] A: As soon as you drew the culture.
[18] Q: In this case what would you have
[19] started this child on at the time cultures
[20] were drawn?
[21] A: Personally I would have used
[22] Ampicillin and Genomicin, which are the
[23] standard penicillin and aminoglycoside
[24] therapy for neonatal sepsis. I don't think I
[25] would have been as oriented towards a GI

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[1] cause and, therefore, using more antibiotic
[2] coverage for GI organisms, but that's an area
[3] I wouldn't have a strong opinion on.
[4] Q: Assuming that a septic workup had
[5] been begun at 2100 — and by that I mean cbc
[6] and differential drawn, cultures drawn and
[7] the child started on antibiotics. Do you
[8] have an opinion, to a reasonable degree of
[9] medical probability, as to how this child's
[10] course would have been altered?
[11] A: Well, the closer you get to the
[12] time that it was actually done, the less
[13] comfortable I feel in saying there would have
[14] been a difference.
[15] Q: Can you say to a medical
[16] probability that if it was started at 2100,
[17] it would have changed this child's outcome?
[18] A: In general, we have used — and I
[19] don't think with a lot of evidence. There's
[20] some evidence, but it's derived from a lot of
[21] different sources, but in general, we say
[22] that greater than a six-hour delay makes a
[23] difference in these kinds of cases, and at
[24] 2100 hours we are at seven hours. We are at
[25] the cusp of what would be considered a

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[1] significant delay. There are neonatologists
[2] and there are infectious disease people who
[3] would say it would be a longer period of
[4] time, but it depends on the organism and on
[5] the person. An older child probably has a
[6] better defense mechanism than a younger
[7] child, and certain organisms are more
[8] aggressive than other organisms. So delays
[9] mean different things depending on the case.
[10] But, in general, we have used a
[11] six-hour delay. So possibly 2100 hours a
[12] septic workup would have made a difference,
[13] possibly not. I can't say more likely than
[14] not. You are right at that six to seven hour
[15] period.
[16] Q: Is it fair to say then that you
[17] can't quantify in any way in terms of saying
[18] "Joey Stalma would have this impairment or
[19] wouldn't have that impairment"?
[20] A: No. I can't quantify. I can not
[21] quantify.
[22] Q: Ultimately Joey was diagnosed with
[23] Group B strep meningitis, correct?
[24] A: Septicemia and meningitis, correct.
[25] Q: In your opinion, was that probably

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[1] transmitted through the genital tract at
[2] birth?
[3] A: Most likely, yes. It's a little
[4] late in terms of three days, but we consider
[5] early onset strep anything in the first week
[6] of life, and in general, the vast majority of
[7] those cases are transmitted from the genital
[8] tract, although there may be interventions
[9] which increase the risk. In other words, the
[10] baby can be colonized, that is the germ on
[11] the skin or in the GI tract, and not cause
[12] any problems, but certain things which invade
[13] the baby may cause the organism that is
[14] sitting on the skin to invade, and there were
[15] two procedures that were done that were
[16] invasive; one was the fetal scalp electrode
[17] that was done during monitoring, which may
[18] have been the point of invasion, and the
[19] second is the circumcision.
[20] Now, many of these babies inhale
[21] their fluid at birth into their lungs and
[22] start off with a pneumonia. Since Joey did
[23] not start off with a pneumonia, I think it's
[24] unlikely that that was the point of entry.
[25] It is much more likely that the point of

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[1] entry was either through the scalp electrode
[2] site or the circumcision site.
[3] Q: Can you say to a probability which
[4] that was?
[5] A: No.
[6] Q: In any event, from your review of
[7] the mother's labor and delivery records, were
[8] there any contraindications to placing a
[9] fetal scalp electrode?
[10] A: No. It was an induction and it's
[11] standard in that hospital for inductions to
[12] have fetal scalp electrodes or certainly
[13] fetal monitoring. Let me just say the mother
[14] had received, starting early on, because of
[15] her Rh problem she started receiving
[16] Celestone injections weekly, and I could not
[17] determine when they stopped, but they started
[18] in early February, and we know that steroids
[19] potentially increase the risk of infection to
[20] both the mother and the baby. So I don't
[21] think that was thought about after this baby
[22] was born but, you know, 20/20 hindsight is
[23] great vision. You look back and say "Why did
[24] this baby get beta strep and not another
[25] baby?" Twenty-five percent or so of moms are

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[1] colonized with beta strep. Why this one?
[2] The mom had a number of amniocenteses, she
[3] was given Celestone on a weekly basis, we had
[4] a fetal scalp electrode. There are a number
[5] of issues here that placed this baby at a
[6] slightly high risk, but now I'm looking at
[7] that with a 20/20 hindsight.
[8] Q: Is it fair to say that based on
[9] what was known at the time of Joey's birth
[10] the mom didn't have the risk factors or
[11] predisposing factors that would have put Joey
[12] at increased risk; for example, prolonged
[13] ruptured membranes? She didn't have any
[14] evidence of that, did she?
[15] A: No. The risk factors that are
[16] named or used in the CDC 1996 treatise, she
[17] would not qualify under any of those. No
[18] beta strep bacteruria during pregnancy, no
[19] history of previous baby with beta strep, no
[20] prolonged rupture of membranes, the baby was
[21] not less than 37 weeks gestation. She
[22] doesn't meet any of those criteria.
[23] Q: No evidence of chorioamnionitis?
[24] A: No evidence of chorio. She never
[25] developed a fever after the delivery or

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[1] before the delivery. She doesn't meet any of
[2] those criteria.
[3] Q: Do you have an opinion to a
[4] medical probability as to when this infection
[5] became colonized?
[6] A: Colonized probably at birth, in
[7] utero or at birth.
[8] Q: Is it fair then that at whatever
[9] point antibiotic coverage was started on this
[10] child, it would have been for treatment, not
[11] for prevention?
[12] A: Correct.
[13] Q: Let's assume a septic workup had
[14] been begun and antibiotic treatment started
[15] at 1835, which was the time of this reported
[16] event with mom. Can you state to a medical
[17] probability as to whether or not, with those
[18] events occurring at that time, it would have
[19] made any difference in Joey's outcome?
[20] A: I think it would have. At that
[21] point we are getting far enough away from the
[22] actual time that I think it begins to have
[23] some validity that there would have been a
[24] difference.
[25] Q: Can you quantify that for me in

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[1] any way?
[2] A: No, ma'am, I can't.
[3] Q: Maybe that was a poor question.
[4] By that I mean in terms of either percentages
[5] or particular deficits that Joey would or
[6] would not have sustained?
[7] A: No, I can't.
[8] Q: What is an average respiratory
[9] rate in a newborn?
[10] A: Forty to 60.
[11] Q: How about average pulse rate?
[12] A: 120 to 160. In post mature babies
[13] it may get down as low as 100. As long as
[14] the blood pressure is maintained, it's not a
[15] problem.
[16] Q: Do you have any criticisms of the
[17] fact that there weren't in the first couple
[18] of days any blood pressures taken on Joey?
[19] A: There should be an initial blood
[20] pressure. It's standard to take an initial
[21] blood pressure. Once the initial blood
[22] pressure is found to be normal, it doesn't
[23] have to be taken again.
[24] Q: Do you know if there was an
[25] initial blood pressure taken on him at the

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[1] time of birth?
[2] A: I didn't check, but I don't have a
[3] criticism.
[4] Q: Okay. That's fair enough. We can
[5] curtail that. What is normal blood pressure
[6] for a term newborn?
[7] A: It depends on gestational age.
[8] Q: Thirty-eight to 40 weeks.
[9] A: The graph by Versmold, which is
[10] published 1991, is going to give you
[11] somewhere between 60 systolic, 40 diastolic.
[12] I have a copy of that as an appendix to my
[13] textbook. I don't see that many normal blood
[14] pressures in term infants, but somewhere in
[15] that range.
[16] Q: Can an increased serum bilirubin
[17] cause poor suck, cause the baby to have poor
[18] suck?
[19] A: If it's quite high.
[20] Q: Would you have a cut-off level at
[21] which you would expect to see that?
[22] A: Above 15. Not at the levels that
[23] he had.
[24] Q: How about irritability? Same
[25] question.

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[1] A: No. In fact, again, above 15 they
[2] may be a little somnolent, a little more
[3] hypotonic than to normally expect.
[4] Q: What are the signs and symptoms
[5] of sepsis in a newborn?
[6] A: That's the problem. They can
[7] manifest to almost anything. Signs are very
[8] diffuse. They can be hyperthermic,
[9] normothermic or hypothermic. They can be
[10] irritable, they can be somnolent. High
[11] bilirubin, jaundice can be a sign,
[12] respiratory distress, grunting, poor feeding.
[13] Basically any time a baby doesn't
[14] look stone cold normal, sepsis has to be in
[15] the differential of why not, because sepsis
[16] is something that we can treat, and so we
[17] teach the residents always look for sepsis in
[18] every differential in a newborn that is not
[19] acting right, consider it.
[20] Q: Do I understand that you feel
[21] probably that jaundice in this case wasn't
[22] related to the child's sepsis?
[23] A: It was not. It was not a direct
[24] type of bilirubinemia and it wasn't that
[25] high.

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[1] Q: This was primarily an indirect
[2] that he had, correct?
[3] A: Primarily an indirect which the
[4] liver was processing well. In general, when
[5] you have sepsis, one of the early signs of
[6] sepsis is a direct bilirubin greater than
[7] two.
[8] Q: Do you have an opinion as to a
[9] medical probability as to what point in time
[10] central nervous system damage began on Joey?
[11] A: I think it began when he began
[12] having some irritability.
[13] Q: Can you time that for me?
[14] A: Let me go back to the nurse's
[15] notes. I will just state that he had central
[16] nervous system irritability at 1835 on the
[17] 23rd; therefore, I think that the process was
[18] beginning at that time.
[19] Q: In your experience, is there any
[20] difference in the presentation of sepsis from
[21] Group B strep in an early onset as opposed to
[22] a late onset?
[23] A: Well, the late onset most commonly
[24] are Type 3's and they often come in with only
[25] fever or fever and minimal other symptoms.

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[1] The early onset most commonly starts out with
[2] respiratory problems, and although can go to
[3] meningitis, as it did here, most commonly
[4] does not. There really is a different
[5] presentation based on the type, and the type
[6] is related to how it's acquired and also we
[7] differentiate early onset from late onset.

[8] Q: Other than the possibility that
[9] there was grunting at 1835 with this episode
[10] that was described with Joey, did you see any
[11] other evidence of respiratory distress in
[12] Joey up to 2100 on the evening of the 23rd?

[13] A: No. I did not. His lungs were
[14] clear, and I don't think he had the
[15] pneumonitis form of Type 1 Group B strep, the
[16] way it usually presents. It usually presents
[17] initially with pneumonitis.

[18] The grunting is a very important
[19] sign. It's not a sign necessarily of
[20] respiratory problems. It's a sign of a child
[21] who is not well and using accessory muscles,
[22] plus closing his glottis to help him maintain
[23] his normal ventilation status.

[24] Q: Do you have any information on
[25] Joey's current condition?

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[1] A: Just verbally from counsel today.

[2] Q: I assume then that you have not
[3] formulated any opinions in terms of the
[4] permanency of Joey's current condition?

[5] A: I think it's permanent because
[6] it's a static encephalopathy and it was
[7] permanent — I have records up to about two
[8] years of age. I don't think it's going to
[9] get better or go away. I think there's some
[10] treatments which may prevent it from
[11] worsening, and some treatments in
[12] occupational and other things which may help
[13] him function better, but in general, these
[14] neonatal encephalopathies are static and
[15] permanent. I have no opinions on life
[16] expectancy. I have no opinions on the type
[17] of care he will need later in life. Those
[18] are all handled by other people other than
[19] myself.

[20] Q: Just to make sure that I am
[21] clear. In your opinion, a septic workup and
[22] antibiotic treatment should have been started
[23] by 2100 on this child?

[24] A: I said between 1430 and 1835 it
[25] should have been initially, somebody should

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[1] have been called and it should have been
[2] started. If we miss that opportunity, then
[3] certainly by 2100. Obviously the closer that
[4] you get to the time antibiotics were actually
[5] started, the less strong is my opinion that
[6] it would have made a difference.

[7] Q: Assuming that a physician was
[8] made aware of the episode at 1835, the amount
[9] of feeding or how Joey fed at 1515, at 1830
[10] and the temperatures between that time
[11] change, would it have been reasonable to
[12] start a septic workup by 2100?

[13] A: The physician should have come to
[14] the bedside within 30 minutes and examined
[15] the child, and I believe that he would have
[16] seen at that time by 1900 that this child was
[17] not doing well and then another 30 minutes to
[18] start antibiotics. We are now to 1930.
[19] You're still an hour and a half away from
[20] 2100. I don't think it takes two and a half
[21] to three hours to get to the bedside and
[22] start treatment. In general, our response
[23] time from a call from the nursery needs to be
[24] 30 minutes or less, very similar to the ACOG
[25] Emergency Cesarean Section Rule of 1985.

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[1] Q: What we are looking at is 1935 to
[2] have antibiotics started?

[3] A: Correct.

[4] Q: With a septic workup to have been
[5] started by 1900?

[6] A: Correct. Or you could have
[7] started that over the phone and come to the
[8] bedside and examined him and cut that time
[9] down a little bit, but you understand we are
[10] dealing with hypothesis here.

[11] Q: Sure. I think that's all the
[12] questions that I have. The only other thing,
[13] is there any other particular literature cite
[14] that I ought to be aware of that would relate
[15] to this case other than what is in your
[16] folder, which we will have her put on the
[17] record quickly so you know I get what I need?

[18] A: Not that I'm aware of.

[19] Q: Okay. Thank you very much.

[20] MR. KULWICKI:

[21] Doctor, you have the right to
[22] review this transcript in the event it is
[23] transcribed or you can waive that right?

[24] THE WITNESS:

[25] I would like to review it if we

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[1] think we are going to go to trial.
[2] MR. KULWICKI:
[3] That's a good idea.
[4] THE WITNESS:
[5] Because I'm going to be asked
[6] about it I'm sure at trial.
[7] MR. KULWICKI:
[8] Lisa, could we have a waiver of
[9] the seven-day rule?
[10] MS. BAER:
[11] Sure. Do you want 30 days?
[12] MR. KULWICKI:
[13] That would be great.
[14] MS. BAER:
[15] Are you comfortable with that,
[16] Doctor, a 30-day time frame to have a chance
[17] to look through the transcript?
[18] THE WITNESS:
[19] Sure. When is the trial set for?
[20] MS. BAER:
[21] April.
[22] MR. KULWICKI:
[23] Are you going to order this?
[24] MS. BAER:
[25] Yes.

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[1] MR. KULWICKI:
[2] I will order a copy.
[3] (Off the record.)
[4] THE WITNESS:
[5] Practice Guideline for the
[6] Management of Infants and Children, 0 to 36
[7] Months of Age, With Fever, Without Source. I
[8] will give you only the first author. Baraff,
[9] Pediatrics, Page 1, July 1993.
[10] Hot Babies, Managing the Very
[11] Young Febrile Infant, Roberts, Contemporary
[12] Pediatrics, September 1987.
[13] Managing the Febrile Infant, No
[14] Rules are Golden, Prober, Contemporary
[15] Pediatrics, June 1999.
[16] The Febrile Infant and the
[17] Assumption of Risk, Radetsky. This actually
[18] is probably not published. This is probably
[19] something I got at a conference.
[20] Evaluation and Management of
[21] Febrile Infants Younger Than 60 Days of Age,
[22] Powell, Pediatric Infectious Disease Journal,
[23] 1990, Page 153.
[24] This is a drug throwaway on
[25] Claforan by the pharmaceutical company called

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[1] Hoechst. It's called Challenge to Pediatric
[2] Medicine: Is it Sepsis in this Febrile
[3] Infant?
[4] Evaluation of the Necessity For
[5] Hospitalization of the Febrile Infant Less
[6] Than Three Months of Age, Wasserman,
[7] Pediatric Infectious Disease Journal, March
[8] 1990.
[9] Six Criteria: Obviate
[10] Hospitalizing Febrile Infants, by Yasgur,
[11] Pediatric News, August 2000. That's a
[12] throwaway.
[13] Another throwaway, Clues Offered
[14] in Diagnosing a Child with Fever of Unknown
[15] Origin by Rosenthal, Infectious Diseases in
[16] Children. Unfortunately I don't have a
[17] date.
[18] Determining Which Child With Fever
[19] Is At Risk, Infectious Diseases in Children
[20] by Rosenthal, March 1998.
[21] MS. BAER:
[22] That's it. Thank you very much.
[23] (End of Deposition.)
[24]
[25]

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[1] WITNESS CERTIFICATE
[2]
[3]
[4] I have read or have had the
[5] foregoing testimony read to me and hereby
[6] certify that it is a true and correct
[7] transcription of my testimony with the
[8] exception of any attached corrections or
[9] changes.
[10]
[11]
[12]
[13]
[14] JAY P. GOLDSMITH, M.D.
[15]
[16]
[17]
[18]
[19] (Check One)
[20]
[21] () NO CORRECTIONS
[22] () CORRECTIONS; ERRATA SHEET(S) E
[23]
[24]
[25]

CERTIFICATE

[1]
[2]
[3]
[4] I, DIANA S. EZELL, RPR-RMR,
[5] Certified Court Reporter, do hereby certify
[6] that the witness, after having been first
[7] duly sworn to testify to the truth, the whole
[8] truth, and nothing but the truth, did
[9] testify as hereinabove set forth;
[10] That the testimony was reported by
[11] me in shorthand and transcribed under my
[12] personal direction and supervision, and is a
[13] true and correct transcript, to the best of
[14] my ability and understanding;
[15] That I am not of counsel, not
[16] related to counsel or the parties hereto, and
[17] in no way interested in the outcome of this
[18] event.

[19] That my certificate is in good
[20] standing.
[21]
[22]
[23]

[24] DIANA S. EZELL, RPR-RMR #85142
[25] CERTIFIED COURT REPORTER

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