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STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

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IN THE COURT OF COMMON PLEAS

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JOHN R. CACARO, JR., ETC., ET AL.,

Plaintiffs,

Case No. 88275

-vs-

SOUTHWEST GENERAL HOSPITAL, ET AL.,

Defendants.

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Transcript of the deposition of SAMUEL J. HORWITZ, M.D., called as a Witness by the Plaintiffs, pursuant to the Ohio Rules of Civil Procedure, taken before me, Suzanne Vadnal, a Registered Professional Reporter and Notary Public within and for the State of Ohio, pursuant to notice of counsel, at Rainbow Babies' and Children's Hospital, 2103 Adelbert Road, Cleveland, Ohio, on Wednesday, the 12th day of November, 1986, commencing at 9:35 o'clock a.m.

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APPEARANCES:

On behalf of the Plaintiffs:

Jeffries & Monteleone Co., L.P.A.:
J. Michael Monteleone, Esq.

On behalf of the Defendants:

Jacobson, Maynard, Tuschman & Kalur Co., L.P.A.:
Jerome S. Kalur, Esq.

Weston, Hurd, Fallon, Paisley & Howley:
Donald H. Switzer, Esq.

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SAMUEL J. HORWITZ, M.D.,

called as a Witness by the Plaintiffs, pursuant to the Ohio Rules of Civil me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. MONTELEONE:

Q. Doctor, let's have your full name, please.

A. My name is Samuel J. Horwitz.

Q. I'm sure Mr. Kalur told you that I'm Mike Monteleone and I represent the Cacaro family for the injuries that their child suffered in November, 1982 and I want to ask you some questions here today.

I know you have written a report. It's dated March 21, 1986.

A Yes.

Q. Do you have that report in front of you?

A Right.

Q. I presume that's the only report that you've written, Doctor, in this case.

A Yes.

Q. Is this a current copy of your curriculum v tae?

A Yes.

Q. Since it's my responsibility to ay you for your

time while you're being deposed, and I will gladly do that, why don't you be kind enough to tell me what your hourly charge is, Doctor?

A. My hourly charges for deposition are $200.

Q. How about trial testimony?

A. Usually around $250 an hour.

Q. I know that you have worked with Mr. Kalur in the past. How many times is that that you've worked with Mr. Kalur?

MR. KALUR: You mean in a courtroom or reviewing cases or what?

Q. Everything.

A. As far as I can recall, cases in Court I have a recollection of one, and other cases I have reviewed for Mr. Kalur, I'm going to guess about four, and then I've been in cases where Mr. Kalur was the attorney but I was not involved with Mr. Kalur. I was giving evidence for the Plaintiff's attorney or for my patient where I was treating physician.

Q. Did you testify in a Columbus case for Mr. Kalur?

A. Yes.

Q. Did you go down to Columbus and testify in that case?

A. Yes.

Q. That was the Tsitouris case.
A. Yes.
Q. How about in Cleveland last year, did you testify in a case for him?
A. I remember testifying in deposition. If you can give me a name, it could be I just don't recall it.
Q. Frank, does that ring a bell?
A. Frank?
MR. KALUR: No. On the Frank case he was a treating doctor.
A. I think Melissa Frank, I believe that was Mr. -- I'm trying to think of Plaintiff's --
MR. KALUR: It was Lancione.
A. Lancione. I was treating physician and Mr. Lancione called me on that case.
Q. All told then you've worked with Mr. Kalur what, on about five cases?
A. Five, six. I'm giving you a rough thing. It could be four. It could be seven. I don't know.
Q. You know his firm represents doctors in malpractice cases. You know that.
A. Yes.
Q. I presume each of those cases involved that

topic and you were giving evidence on behalf of the defendant.

A. I would have to be sure they were all malpractice because some could have been some other injury. I just don't remember them all. I would have to look at each one but most were probably malpractice.

Q. How about other members of his firm, have you worked with other members of his firm? Jacobson?

A No, not Mr. Jacobson.

Q. He's got about, what have you got, about 30 lawyers there, Jerry, 35 lawyers there?

MR. KALUR: Here in the Cleveland office, I think 22.

Q. Okay. I don't know all of their names. I don't know all of them personally.

A. I have been involved with the other attorneys but I think Mr. Kalur has always been involved as well. I don't recall any case where he was not involved.

Q. Did I understand you to say earlier that you also were involved in a case in which he was on the other side?

A. Yes.

Q. Did you give testimony in that case on behalf of the plaintiff?
A. Yes.
Q. Did you give testimony in that case that a doctor was negligent or had departed from acceptable standards of medical care?
A. If memory serves me correctly, in one case, yes.
Q. Do you happen to recall the name of that case?
A. I recall the first name was Erin but I can't remember the last name. I know who the attorney was.
Q. That would help.
A. It was Fred Weisman. It was a case with jaundice, I believe. No, that was not that. Now I've got to remember. It was Mr. Weisman but I think it was a case against Booth Memorial Hospital and I don't remember the name of the patient.
Q. Just in the last five years, just approximately, Doctor, I realize that you may not be able to give me an exact number, how many times have you testified that a doctor has been negligent?
A. To give you a rough guess, I mean it's almost an impossible question. I'm just going to say 10.

Q. You've testified 10 times in the last five years?
A. That a doctor has been negligent?
Q. Yes.
A. I would say that's a fair estimate.
MR. KALUR: Off the record.
(A discussion was had off the record.)
Q. This has been in Court testimony or deposition testimony?
A. Yes.
Q. Have you been asked to give opinions whether or not defendant doctors have complied with acceptable standards of medical care; in other words, not been negligent in their treatment of a patient?
A. Yes.
Q. In the last five years how many times have you done that?
A. Testified?
Q. Or given reports or given depositions.
A. I really have a hard time with the numbers. I'm going to give you something that is a pure guess and say that probably by report and by testimony, it will probably go 15, 20.
Q. Any idea, Dr. Horwitz, how much of your time is

concerned with legal matters such as this?

A. Very little because the time I put in is usually at night. I do take very little of this. Most of the time that I spend on this involves my own patients where a Court case comes up. So, I see more of those where I'm the treating physician and called rather than accepting de novo cases.

Q. Are you able to give me any kind of a ballpark, whether it's time spent at home or on the weekends or here in the office, as to what percentage of your professional time involves legal cases, be it testimony, reviewing records for lawyers, whatever?

A. Can't be more than one percent of my time.

Q. One percent.

A. Yes. You must remember I work about a 65 to 70 hour week.

Q. So, about seven-tenths of an hour a week is what you --

A. Seven-tenths of an hour a week. I'm sure that I don't put in more time there because many, many weeks go by where I never have anything like this to deal with.

Q. How many hours have you spent on this case,

Dr. Horwitz?

A. Probably, I'd say, five, six hours at the most.

Q. Does your report of March 21, 1986, does that include all the information that forms the basis of your opinion, Doctor? You make reference to seven enumerated items in the first paragraph.

A. Well, when I wrote this report these were the seven items.

Q. Since that time have you reviewed other material?

A. I was going to say I'd seen the CAT scan but looking at my report I'd already seen it at the time, so the only other thing I have seen since this came up was this morning I looked for five minutes literally at a few paragraphs of Dr. Jacobs' deposition but that was the first time I'd seen it.

Q. Did you, in fact, actually review the actual CAT scan of this child?

A. Yes.

Q. Whom did you get that from?

A. Mr. Kalur supplied that to me.

MR. MONTELEONE: Where is that, by the way, Jerry?

MR. KALUR: It's right here.

Q. Dr. Irwin Jacobs, do you know him, sir?
A. Very well.
Q. Is he a qualified and competent neurologist?
A. Definitely.
Q. Is he a qualified and competent pediatric neurologist?
A. Yes.
Q. Dr. Horwitz, would you tell me, please, from the information that you have, sir, what the diagnosis of this child is?
A. There is one primary diagnosis from what I can glean from it and that is mental retardation. Also at various times Dr. Jacobs has used the term atonic diplegia.
Q. Any other diagnoses?
A. Seizures.
Q. Does this child have cerebral palsy, Doctor?
A. Cerebral palsy is such a broad term that almost any child who is handicapped you can throw into that wastebasket term, so in the widest sense, yes.
Q. How do you define the term cerebral palsy as a professional? What parameters do you place on it?
A. First of all let me say that I only use that

term for convenience. I do not believe it's a medical diagnosis. So, I use it for communication purposes and for billing purposes but it does not exist to me in scientific terms. I'll define the way I use it, if you wish.

Q. I'd like you to do that.

A. Cerebral palsy is a term used to describe children who have nonprogressive motor disorders of the nervous system acquired prior to, at or shortly after birth.

Q. Now, when you use the term for billing purposes, what does that mean? It is recognized by some group of people, a recognized medical diagnosis; is it not?

A. Yes.

Q. You just don't happen to like the term cerebral palsy or you don't recognize it as a medical diagnosis; is that what you are saying?

A. I don't recognize it as a medical diagnosis.

Q. Are you able to tell us what degree of mental retardation this child has?

A. From the reports that I've seen I would have to say that it is probably in the moderate range of mental retardation.

Q. If you were to recognize cerebral palsy as a medical diagnosis, would you agree that this child also has cerebral palsy?

A. Yes, I would say that it has very mild features of cerebral palsy.

Q. In your opinion, Dr. Horwitz, what is the cause of this child's mental retardation?

A. What is the cause?

Q. Yes, sir.

A. Not substantiated.

Q. I'm sorry?

A. The cause is not substantiated. It's unknown if you want to use that term.

Q. Your opinion is that you don't know what the cause of this child's mental retardation is.

A. It's my opinion that the cause is not known, including my own not knowing.

Q. Forgive me, I don't mean to be argumentative. You don't presume to say what another physician knows or does not know about the cause of this child's mental retardation.

A. Not at all, no. The medical records speak for themselves that the physicians have not established a cause. That is my interpretation of their records.

Q. You make that conclusion then based upon the records alone.

A. Based upon the records of Dr. Jacobs basically.

Q. What records of Dr. Jacobs have you seen?

A I have seen written records of his care of the child and the letters he has sent to the referring physician, to the child's primary physician.

Q. I presume since you don't recognize the term cerebral palsy, it would not be a good idea to even ask you what the cause of the child's cerebral palsy is since you don't believe that he has cerebral palsy.

A. Let me clarify that. I don't use the term because I think there are better terms for physician to physician communication. But the term is an acceptable term and I do use it to parents because it is a used term. So, I don't want to imply that I never say cerebral palsy; that I don't use it.

What I'm trying to say, as a scientific term which a physician would use to another physician, cerebral palsy is a poor term but I am forced to use it because it is in use. I can't not use it, so that I don't want to

mislead you on my answer.

Q. Well, then let me ask you what the cause of this child's cerebral palsy is? Do you have an opinion of that?

A. I have an opinion.

Q. Would you tell us what it is, please?

A. The cause of the child's cerebral palsy is due to a dysfunction, malfunction of the motor system of the brain.

Q. What agent or agents are responsible for the dysfunction of the central nervous system of this child?

A. No agent or agents have, in my opinion, been demonstrated in this child to be responsible.

Q. Looking at the hospital records of both the mother and the child, and you've seen both of those, haven't you?

A. Yes.

Q. Is there anything in those hospital records, Doctor, to suggest to you what the cause of the baby's mental retardation is?

A. No, sir, there is not.

Q. How about the cerebral palsy?

A. There is nothing in the records to suggest the cause of the cerebral palsy.

Q. You do a lot of work in this area. I know you do some consulting. I know that you are authored in this area. Would you be kind enough to identify for me some of the causes of cerebral palsy?

A. Certainly. Malformation of the brain.

Q. Is there any evidence of that in this child?

A. No.

Q. What else?

A. Damage from infection.

Q. Any evidence of that in this child?

A. No. Chemical abnormalities.

Q. Such as?

A. Various biochemical disorders such as amino-acidurias.

Q. Any evidence of that in this child4

A. To my knowledge I can't see that it's ever been identified.

Q. What kind of test would you propose to perform, Doctor?

A. You would do blood and urine screening.

Q. A specific kind of screening, I take it?

A. Yes, it's called metabolic screening.

Q. If that testing were done today would that give you an indication, Doctor, whether or not that's

the etiologic factor?

A. If the test showed abnormal chemicals it would be the etiologic factor. If the test did not show it, it would not be the etiologic factor.

Q. What other factors?

A. Trauma.

Q. Any evidence of trauma in this child?

A. No. Birth asphyxia.

Q. That certainly is a cause of mental retardation, isn't it?

A. Yes.

Q. It is a recognized cause also of cerebral palsy; is it not?

A. That is correct.

Q. Does that cover the major categories?

A. No.

Q. It does not, I'm sorry.

A. No.

Q. Go ahead.

A. It doesn't cover it because the biggest category, well, let me just back off. There are intra-uterine events that happen to the fetus. For example, infarcts of the brain that can just happen in utero. That accounts for a substantial number.

Q. Any evidence of that in this child?
A. No.
Q. Continue, please.
A. There is postnatal hypoxia, afterbirth complications that occur to the infant.
Q Any evidence of that in this case?
A. No.
Q. Okay.
A. Then there is the biggest category of all which accounts probably for 80 percent of retarded children.
Q. And that is?
A. Unknown.
Q. Does that cover all of the major categories?
A I think it covers the major categories.
Q. Are you able to tell from Dr. Jacobs' reports or testimony or records what the prognosis for this child is in the future?
A. I think you can draw an assumption from the reports.
Q. One that you are comfortable with professionally?
A. Yes.
Q. Would you tell us what that is, please?
It would be my opinion from what Dr. Jacobs has written that this child is retarded and

will be retarded and will be always retarded.

Q. Will he be able to live independently, Doctor?

A. I've never seen this child so I'm taking it from the reports, but judging on the level of retardation described I would have to say probably not.

Q. Will he ever be able to in his lifetime engage in any kind of employment?

A. I wouldn't want to answer that because I think the tests that I have are of a very young child and the word employment is very broad. There are retarded children who do some very, very menial repetitive tasks. Even the severely retarded can be taught to do that, or a significant number of severely retarded, and they do earn nickels and dimes. So, in that sense he might be able to earn something. I just don't know. I think it's too early to pass that opinion.

Q. But before we leave it, from what you are telling me, although it is too early, are you able to say to any kind of reasonable degree of medical certainty that this child will ever do more than minimum wage kind of work?

A. In all probability he will not.

Q. He is on a prescribed course now of -- I use the term broadly -- occupational therapy, physical therapy, speech therapy. Do you agree that he needs those kinds of things?

A. I would agree that it's a good idea to give it to him.

Q. Are you aware, Doctor, of anything during the course of this mother's pregnancy that you can pinpoint as a causative factor in the mental retardation or cerebral palsy of this child?

A. No.

Q. Do you feel that the Bendectin that she took for a couple of days, maybe as long as a week, has any relationship whatsoever?

A. No.

Q. You know that when the child was born, there is a report at least in the hospital records that the cord was wrapped around the child's legs.

A. Yes.

Q. Does that play any factor in this case at all, Doctor?

A. No.

Q. Are you planning in either the arbitration of this case or the trial of this case to express any opinions on the standard of care exercised

by the obstetrician, Dr. Hughes?

A. No.

Q. Are you planning in this case either in trial or arbitration to express any opinion on the standard of care utilized by the hospital or the nurses or any other employees of the hospital?

A. I have difficulty with that. I wasn't asked specifically to address that issue.

Q. I understand.

A. So, I don't know if it came up if I was asked how I would answer.

Q. Let me ask you now then, okay?

A. Yes.

Q. I want to be fair with you, of course.

A. Yes.

Q. I just want to cover the bases to make sure if you are going to be expressing any opinions other than on the causation aspects of this case, I'd like to know what they are.

A. Sure, no problem.

Q. In looking at the labor room records you can see that towards the very end of this mother's first stage of labor, there was a period of 45 minutes in which the fetal heart rate was not

monitored or checked or recorded.

A. Yes.

Q. Does that comply, Doctor, with acceptable standards of medical care?

MR. SWITZER: Objection.

Q. You may answer the question.

A. Again I'm not an expert, but it's my understanding that usually the fetal heart towards the end of the first stage is listened to more often.

Q. That's important, isn't it?

A. It should be done.

Q. Are you also aware that towards the end of the first stage of labor in this case the mother did not have a vaginal examination for an hour and 15 minutes?

A. I'm not aware. I really didn't look at that particular issue.

Q. Will you accept my word for that?

A. I will accept your word for that.

Q. Does that, Doctor, comply with acceptable standards of medical care?

MR. KALUR: Objection.

MR. SWITZER: Objection.

A. I would offer no opinion on that.

Q You have no opinion on that.

A I have absolutely no opinion. I wouldn't offer an opinion.

Q. What does the term or the generic category TORCH titers mean?

A. It refers to the measurement of antibodies basically against a variety of congenital infections so that the letters stand for toxoplasmosis, rubella, cytomegalovirus, herpes.

Q Those were not done in this case.

A I haven't seen them done in this case.

Q. In your opinion should they have been done, Doctor? Was there any reason to have them done?

A. Yes.

Q. There was?

A. Yes.

Q. What was the reason to have these done?

A. The reason to have them done is when you have a case of retardation and/or cerebral palsy and you can't establish the cause by history or physical examination, establish the cause to your own satisfaction, then there are some basic tests you do to try and find out if any cause is demonstrable, for example, the TORCH infections. So, I would have done them.

Q. Are you telling us, Dr. Horwitz, that had they been done in this case they would have changed your opinion in any way?

A. They could have but not necessarily. Let me just make it clear. If they are negative, they are helpful to say that those were not the causes. If they are positive, you have got to be careful when you did them. If you do them shortly after birth they are valid.

Q. If you do them now?

A. If you do them later you have problems because of acquired infection. There are ways to try and get around this. If they were positive, you may or may not have established the cause of the child's retardation.

Q. How valid would those tests be if they were done now, Doctor?

A. I would say they basically would be close to worthless probably.

Q. Who then, if anyone, should have done these TORCH titers?

A. The only answer I can say is that I don't know from my own knowledge when and who first started suspecting that this child was not normal, so I really can't answer the question.

If the family doctor at two months was concerned, he should have done them. If nobody got concerned for the first year or 18 months, then probably it's hardly worth doing them at that point so no one would have done them. It would have depended on the circumstances.

Q. Let's go to your report, if we can, for a little bit, okay?

A. Sure.

Q. I want to talk about the second paragraph on the first page. The last sentence or the second last sentence discusses the Apgar scores of this child.

A. Yes.

Q. All right? Does the fact that this child was given an eight and a nine at one and five minutes respectively have something to do with your opinion in this case?

A. It's just one factor to do with my opinion.

Q. You don't mean to imply by that statement or mean to say that just because a baby has a normal Apgar that that baby is not going to go on to have cerebral palsy or mental retardation.

A. I agree with that statement.

Q. Does the fact that a child has an eight or nine

Apgar mean, Doctor, also that the child did not have some asphyxia or anoxia3

A. That does not mean that.

Q. From the little reading I've done in this area, there is some wide debate about the value of Apgar scores anymore, isn't there, Doctor?

A. I think there is debate about the use of Apgar scores for purposes for which they were not intended, but that doesn't mean that Apgar scores don't have a use.

Q. They do have some use.

A. Yes, they have some use.

Q. As I understand, Virginia Apgar, she was an anesthesiologist, wasn't she?

A. Yes.

Q. She developed this handy little test to determine whether the child needed to be resuscitated in any way once the child was born.

A. That's the basic reason, and I think also a score is something that becomes a physician to physician communication system so you don't use vague generalities.

Q. Certainly it is not meant to determine whether or not there was some anoxia or asphyxia

intra-uterine, does it?

A. I don't think that that statement is quite correct. It wasn't developed for that purpose maybe and yet it was. In its own way, it can be used to determine that.

Q. But, Doctor, a normal Apgar score does not rule out that there may have been some anoxia or asphyxia.

A. Absolutely, that's correct.

Q. Your report indicates in the last sentence of the second paragraph, "The neonatal course was essentially unremarkable except for some mottling of the skin."

I was looking through the baby's chart and it appeared that the child was mottled consistently.

A. Yes.

Q. Some nurses described it as very mottled. Some described it as partially. But in any event, throughout the child's stay at the hospital he was mottled.

A. Yes.

Q. Is that of some importance or significance to you, Doctor?

A. Per se, no.

Q. What can be the cause of that kind of mottling?

A. The commonest cause of mottling is just a physiologic cause that the infant's circulation to the extremities particularly is not as well developed as to the central organs, so infants will mottle very readily and many of them who were perfectly healthy looked pretty mottled. It can be part of a more global thing.

Q. Meaning?

A. You can see mottling as part of an overall sick baby syndrome but then the mottling is just one feature of a sick baby with a number of other parameters. But as an isolated finding, mottling is just an isolated finding.

Q. Can it be an indication, Doctor, that there has been some damage to the central nervous system?

A. I would have to say that mottling may be part of a whole syndrome that indicates a problem with the nervous system. But in my opinion mottling per se as an isolated incident is not indicative of involvement of the nervous system.

Q. So that in and of itself what you are saying in this case is the fact that you see mottling by

itself does not give you any strong suspicion that there was some damage to the central nervous

A.

Q. If you saw it in conjunction with other symptoms or signs then you might become more concerned.

A. That's fine.

Q. Did you look at Mrs. Cacaro's testimony at all?

A.

Q.

in

the word taxed, t-a-x-e-d?

MR. MONTELEONE: I don't know that she did. That's my term.

MR. KALUR: No, no. I'm just asking if that's what you said. I didn't hear what you said.

Q. Taxed, t-a-x-e-d, yes. She noticed the child having some difficulty breathing, respiratory difficulties.

A. I think that the problem there is that there are variations in the respiratory rate and the respiratory path in newborns. I'm not

questioning her abilities. It's very difficult to know what somebody means by that because I'll see this reported up here and we look at it and it's just a normal variation of breathing. So, I don't know what she meant by it.

Q. I can appreciate that. What do you consider to be the normal range of respirations per minute for a newborn?

A. On a newborn it's going around 60 and there are irregularities in there.

Q. Sixty?

A. Usually 40 to 60.

Q. Per minute?

A. Yes.

Q. Did you take into consideration in your opinion here that the mother did, however, say that the child appeared to be having some respiratory difficulties?

A. Yes.

Q. Did you also see her comment that the child had a low body temperature?

A. Yes.

Q. Or hypothermia?

A. Yes.

Q. Is that at all important or significant, Doctor?

A. Low body temperature is something that you obviously try and avoid in infants because infants are required to have normal body temperature.

Q. Like all of us.

A. Like all of us. I took into account what she said but in my opinion it was not compatible with other aspects of this child's let's say overall performance in the newborn period.

Q. Hypothermia or a low body temperature, can that be caused by injury to the central nervous system?

A. There are a wide variety of causes including injury to the nervous system.

Q. How about the fact that the child, according to the mother, had a very poor suck when it was nursing? Was that of any significance to you, Doctor?

A. You would have to look at the facts of whether the child had a poor suck or not because the poor suck involves feeding.

Q. Certainly.

A. If the child has a poor suck it will not get its adequate amount of nutrition. If it doesn't get its adequate amount of nutrition it will

lose weight very rapidly and will have to be artifically fed in quick time if it's not to become dehydrated. There are no indications to me from the record that such occurred.

Q. What, that the child had --

A. Had a profound weight loss and required to be supplemented. Children who can't suck can't feed.

Q. Well, the mother having had one other child before this and having nursed that child for a good period of time, you would certainly place some credence in her decision or her statement as to whether the child had a poor suck or not, wouldn't you?

A. Well, I put credence that she noticed the difference between the sucking of one child and another and often on the first day or so infants don't suck very well. But if this child had a significant sucking abnormality, then the baby would have to have had supplementary feeding. It would have difficulty. It would be noticed by whoever gives it a bottle or breast fed it and the baby's weight would drop. That's a common problem. It's nothing unusual for us.

Q. Did this baby's weight drop, Doctor?
A. All babies' weight drops some but my recollection is, and I haven't looked at it for months, there was no significant weight drop, not out of the ordinary.
Q. It's not uncommon for a normal healthy baby to lose six or eight or 10 ounces during the first three days after birth, right?
A. That is correct.
Q. Assuming that the mother were correct, for the moment, that this child did have a poor suck, is that an indication of early neurologic difficulties, Doctor?
A. A poor suck may be an indication of neurologic difficulties.
Q. Did you notice anything else in the mother's testimony that you felt could be caused by some early neurological problems the child was having?
A. I don't recall any others.
Q. She said the baby was limp. Does that make any difference to you? Is that a sign of a neurological abnormality?

MR. KALUR: Show an objection. I don't remember her saying

that but show my objection.

A. Again the word limp would have to be defined carefully. I don't recall seeing it but limp is something that you really have to identify by careful examination.

Q. Lay people I guess don't go around defining those things very good. They just make a one word description.

A. I'm not criticizing them. They notice something and I think all their notations always are worthy of consideration, but often the term is used very loosely.

Q. Assuming just for the moment, if you will, that what the mother says is correct in this regard, that the child's breathing was taxed, that the baby was mottled, that there was a low body temperature and that the child had a poor suck, are any of these, Doctor, suggestive of oxygen deprivation at the time of birth?

A. No.

Q. Either individually or together.

A. I don't want to be contentious but the way the question is put, obviously you have to look at a whole picture, not at a single symptom or a couple of symptoms. You have to look at

severity in the whole behavior of the baby. So, I'm going to answer the question by saying as presented it is not consistent in my opinion with significant oxygen deprivation at the time of birth, during birth.

Q. Well, how much oxygen deprivation does a fetus need to become mentally retarded, Doctor? Can you quantify it?

A. Yes.

Q. Please do.

A. I'll quantify it by saying in order to become retarded an infant requires to be a near miss death.

Q. Would you explain that, please?

A. Yes.

Q. Because I'm having some trouble following you.

A. In order to do sufficient damage to cause mental retardation by a process of hypoxia, the hypoxia has to be of such severity that the infant very close to dies, so that the outcome is either death or just surviving with retardation. Any lesser degree of hypoxia will not cause mental retardation.

Q. Will it cause cerebral palsy?

A. No.

Q. Will it cause any abnormality?

A. No.

Q. How does one account for the difference between a child then who is mildly retarded or moderately retarded or severely retarded? How does one account for those differences, Doctor?

A. Let me state right away that the majority of cases of retardation have nothing to do with the birth process and are not engineered by any anoxia or ischemia in birth period. So that if you took 100 retarded children, just go to a school for the retarded, the relationship of those to the birth process will be a very small minority. That's the first thing.

Q. Eight to 10 or something like that out of those 100?

A. I think that's an excessive estimate. I think you'd have to come down to more than likely two to three. It's tough to get the figures because populations are different, but I'm just going to say two, three, four percent may relate to birth. I think even that might be high. You're talking about retardation rather than cerebral palsy?

Q. We can talk about both but right now you are

talking about mental retardation.

A. Right. It's a very small minority, two, three, four, five percent that relate in any way to birth. If we confine it to that let's say five percent in whom it is related to birth, the statement stands that those are cases of near miss deaths. They very nearly died.

Now, the recovery of the brain from a near miss death can have a spectrum from total recovery, which is the majority of infants who survive, to mild retardation to severe retardation. Am I making that clear?

Q. I think I follow what you are saying. You are telling me that the degree of lack of oxygen is not necessarily correlated with the degree of mental retardation.

A. I'm only saying it in the sense that the degree of lack of oxygen has to be severe. That's the first premise. It has to be profound. Go beyond the word severe. It has to be profound and in the survivors thereof, it does not correlate with a little more or a little less. It just is sort of the luck of the draw if you survive.

You can hit a point of no return. That's

the point. If you hit the point of absolutely no return, you die. If you are this side of the point of no return and you don't die, depending on how profoundly severe, that severity will determine whether you come out as a normal citizen, as a mildly affected citizen or as a profoundly affected citizen. So, it's in very narrow confines. You've got a little room to maneuver in that narrow spectrum.

Q. Are you able to cite me to any authorities that support that opinion for my own edification?

A. Sure.

Q. Would you, please?

A. I'll cite you to John Freeman.

Q. John Freeman? Where is Dr. Freeman at?

A. Johns Hopkins.

Q. Okay.

A. Referable more to the cerebral palsy side, I will cite you to Karen Nelson.

Q. John Allenberg?

A. Yes, and I will cite you in the general sense to the outcome of severe asphyxia and the clinical manifestations, etc. as shown by Vopi.

Q. John Vopi, is it?

A. Joe Vopi.

Q. Those are all authorities that support your opinion?

A. Yes.

Q. Was Freeman the lead author or the editor of that book put out by the Department of Health and Human Services? I think it's called Prenatal and Perinatal Disorders.

A. I think he was the editor, yes.

Q. You know which book I'm talking about. It's that black book.

A. Yes, published by the NIH, I think, yes.

Q. You are aware, from what Mr. Kalur has told you, I'm sure, that Pat Cacaro and John Cacaro say that when she was brought into the delivery suite to deliver John, Jr., that she was placed in a kneeling position on the table with her buttocks on her heels, if you will, and told to stay in that position. This is her allegation. It's her statement. You also know that that's not reported in the records.

A. Yes.

Q. What I want to know from you is can such a position cause deprivation of oxygen to the fetus?

A. Depends how you do it. I mean that position is

adopted by women in countries -- where I come from that's how they deliver their babies.

Q. Where is that?

A. In Africa. They get in the crouched position on their buttocks and crouch and deliver their babies that way.

Q. They stay in that position for 40 minutes.

A. I have never watched that. That's what they did in the tribal areas. I didn't go there. Being the white man I delived them in the conventional western way. We never allowed them that privilege but many people who have written about it -- I haven't looked at this for 30 years -- will comment how easily they deliver and that they seem to be able to do it in that position without difficulty. I remember at medical school there was a raging argument whether we should allow some women to deliver that way.

Q. What was the outcome of that? Did you decide to let her deliver that way or not?

A. Of course, we didn't because western ways demanded lying comfortably in the bed with your legs up and getting some morphine and the other stuff.

Q. There were also some safety considerations,

weren't there?

A. I don't think that was an issue at all. You had to go against all of the established God and country, so I don't know about that. I was a student then and I was just being taught. Maybe they did it. I really don't know. I never followed up on it. It's not an area of interest.

Q. In any event, can the position that Pat Cacaro says she was placed in prior to delivery cause asphyxia, anoxia or oxygen deprivation to the fetus?

A. Can I make an assumption in that regard?

Q. Surely, go ahead.

A. I'm going to make an assumption because I can't personally visualize the position accurately. But I'm going to make an assumption if you put somebody in a position where the baby is trying to get out and you by some manner totally obstruct that baby, that you prevent the baby coming out totally and you therefore obstruct the labor, that you would have the potential for causing injury to the baby if you did this for long enough. I'm assuming that that is so.

Q. That's based upon, of course, your expertise,

your training as a doctor, isn't it?

A. My training as a doctor is fundamental.

Q. It's not a good idea to obstruct delivery. When the baby is ready to come out the baby is supposed to be delivered, true?

A. That's fine.

Q. To obstruct a delivery can be harmful to the baby.

A. I think that you would have to say it can be depending upon the severity and duration of obstruction.

Q. Well, using the position that she says she was in, how long would she have to be in that position before there could be such damage to the fetus?

MR. KALUR: I'm going to object. You are assuming that we really obstructed delivery and it's contrary to any assumption he just made. He told you he couldn't envision that situation.

MR. MONTELEONE: No, I don't think he said that. Read the question back to the Doctor.

(The question was read by the Reporter.)

A. I think that question is not really answerable.
Q. You can't answer it?
A. I think there are too many variables in that question to make a straight answer to that.
Q. If you can't give me an answer that's all right. I'm not trying to pressure you on this.
A. I'm also not trying to be difficult. If you obstructed the labor, making that assumption, you would have to know how severe the contractions are, how frequently they are coming. It's an issue of obstructed labor. If contractions die down a little bit that baby can probably tolerate that position perfectly well with no harm whatever. If you did it for four hours with active contractions every two minutes, you would either harm the baby or rupture the uterus.

I think you are raising a lot of variables in terms of how many contractions. I don't want to not answer the question but I don't think I can in the way you've asked it.

Q. At the end of the first page on your report, your final sentence regards the position that we just talked about and the temperatures of the child and you say, "Neither assertion is

documented in the medical records."

A. Yes.

Q. Is that important to you, Dr. Horwitz, that it's not documented in the medical records?

A. Not particularly.

Q. We can agree, I think, that there have been situations and unfortunately there are situations where certain items just are not put into medical records; isn't that true?

A. That's fine.

Q. Sometimes that's because there is information there that would be harmful or suggest negligence on the part of either the doctor or the hospital.

A. Well, I don't know all that. I mean most times things are not put in the records. They are just acts of good recordkeeping. That's the general reason things are not put in.

Q. There are other reasons, aren't there?

A. I'm not aware personally of those things so I assume they occur.

Q. I wouldn't mean to suggest, of course, that you would have any part in that. I'm just saying we all know, we are all adults, that there are times when harmful information which may suggest

negligence on the part of a doctor is just not put into a medical record.

A. All right. I'll assume that that happens.

Q. Onto the second page of your report, under the category of in the neonatal period.

A. Yes.

Q. What do you define as the neonatal period?

A. The neonatal period is actually the first 28 days, but what I was referring to here, the word should probably have been immediate, the immediate neonatal period, so take it that's what I'm referring to.

Q. Five to seven days, is that what you are talking about?

A. Even shorter than that.

Q. Even shorter. We already talked about the Apgar.

Part of your opinion is based upon the fact that there were no documented seizures distress occurring. You know that at some later time the child did have seizures. Don't you know that?

A Oh, yes, that's later. I'm talking about day one, two.

Q. Doesn't it make any difference that the child

had seizures later on3

A. Absolutely not.

Q. It doesn't suggest to you an oxygen deprivation?

A. Absolutely not. On that I'll be 100 percent categoric.

Q. Are you telling us that every child who has oxygen deprivation at birth is going to go on to seize or have a seizure within the neonatal period?

A. No.

Q. The statistics say otherwise, don't they?

A. Depends what you are talking about, lack of oxygen.

MR. KALUR: You mean sufficient to cause brain damage?

MR. MONTELEONE: That's what I'm talking about.

MR. KALUR: That wasn't the question.

A. All right. That's a big difference. In children with deprivation of oxygen sufficient to cause brain damage, seizures will occur in the vast majority in the immediate neonatal period.

Q. And that's defined again as?

A. Well, let's just stick with the first 72 hours.

I'm making that term as mine for immediate. I don't know that that's the term. I'm just saying in the first 72 hours, the vast majority will have seizures.

Q. I just want to be clear. Not all of these babies seize, though, do they?

A. Minority don't.

Q. Can seizures occur without there being documentation of them, Doctor?

A. It's possible.

Q. I'm sorry?

A. It's possible, if the nurse doesn't notice it or the mother doesn't notice it.

Q. You, as a neurologist, I'm sure you have occasion to treat many, many children who have seizures, true?

A. Yes.

Q. You prescribe medications for such.

A. Yes.

Q. Doctor, you haven't seen all of your patients have seizures, have you?

A. No, I don't see them all have seizures.

Q. But if the mother tells you that they do seize and describes to you a set of signs that indicate that there has been a seizure, you

take her word for it, don't you?

A. Yes, most times.

Q. Especially if they have an abnormal EEG.

A. Not necessarily.

Q. It's helpful if they have an abnormal EEG, true?

A. Under certain circumstances, not always.

Q. This baby had an abnormal EEG; did he not?

A. Not in the neonatal period.

Q. Not in the neonatal period. He had one in May of 1985. He had a markedly abnormal EEG.

A. Yes, he had it then.

Q. What then would be the cause of the seizures, Doctor, if it weren't oxygen deprivation?

MR. KALUR: You mean the seizures he had much later in life than at the time of birth, is that what you mean, or seizures in general?

Q. I'm talking about the seizures he had beginning, according to the mother, in January of 1984.

A. His retardation and the cause of his retardation.

Q. You also indicate under Item 3 that there was no period of impaired consciousness. How are we to know whether this occurred or not?

A. It is so obvious when the baby has impaired consciousness. That baby does not wake up, does

not suck. I mean that mother notices. The nurses notice. It's fundamental. It's right there. It doesn't have to be seen. It's there for the seeing.

Q. May be difficult to arouse?

A. It's more than difficult to arouse.

Q. Can't wake the baby up?

A. The baby is profoundly stuporous or comatose.

Q. Does this happen in all cases, Doctor?

A. In all cases of significant asphyxia?

Q. Yes.

A. Yes.

Q. What are you speaking of when you talk about there not being any focal or generalized neurological abnormality being documented?

A. The neonatal period. Nobody documented by examination any focal, one-sided focal abnormality of function.

Q. Give me an example.

A. A paralyzed arm, a leg that's not kicking, a face that's skewed. It's not moving. That's what I meant by focal.

Q. This again is in that 72 hour period that you are talking about, right?

A. Yes.

Q. Did you notice in the chart, Dr. Horwitz, that there were no physician progress notes for the first 72 hours of this child's birth? Did you notice that?

A. I just don't remember looking. If you say there weren't I'm willing to accept that.

Q. How do we know then what the pediatrician was finding or not finding if there are no notes in the hospital record?

A. Well, it's not only the pediatrician. There are nurses' notes in the record. If there is a nonmovement of one side or the baby is severely hypotonic or not moving, the nurses' notes reflect that. The nurses write that.

Q. Is it your opinion that all babies who have significant oxygen deprivation that go on to become mentally retarded will have some paralysis of some kind in the immediate neonatal period?

A. Well, the word paralysis, I wouldn't use that. But if I can just say that they would have motor abnormalities? Yes, all.

Q. All of them would.

A. All.

Q. These motor abnormalities would manifest themselves in what way?

A. Either focal paralysis or more common generalized movement and severe hypotonia, profound, unmistakable.

Q. Let's go on to the subsequent development of this child after the first 72 hours. You say that there has been substantiated normal head growth?

A. Yes.

Q. Is that significant to you?

A. Yes.

Q. According to Dr. Jacobs, the baby's head size was in the 30th percentile when the baby was born.

A. Yes.

Q. Is that normal or abnormal?

A. That's normal.

Q. To be in the 30th percentile?

A. Yes.

Q. And to remain that way up until now?

A. Yes.

Q. I never was very strong in statistics, but doesn't 50th percentile indicate the mean or the normal range?

A. 50th is mean but theoretically in the population sample 50 children will have heads above the

50th and 50 will have them below the 50th. So, 30th just means that if you take 100 children of the normal range, 70 will be larger than this given child and 30 will be lower than this given child.

Q. You say that's normal.

A. Sure.

Q. You looked at the CT scan that was done at Metro General.

A. I did.

Are you qualified, Doctor, to read those CT scans?

A. I'm qualified to look at them and express opinion, but it depends what you call read.

Q. Is this something you feel competent to say that you are expert in, reading CT scans?

A. I'm expert at looking at them. I'm being careful about the word reading because reading usually implies the person who issues the final written report on interpretation in a hospital. I don't want to say that I do it because I don't. This hospital doesn't permit me to do that.

Q. You are not qualified to do that.

A. I didn't say that. They don't permit me to.

But technically, no, you are correct, because somebody who is going to read that report is somebody who has had extended training. I have not. But I am qualified to look at that x-ray and render an interpretation of that x-ray.

Q. You say that you don't see any atrophy.

A. That's correct.

Q. The person who read it --

A. Yes.

Q. -- found there to be atrophy; did he not?

MR. KALUR: I'm going to object to that. That's not what it says.

A. The person who read it saw some changes in the sylvian fissure in one thing up top but I'm not sure. Even if they read it as atrophy I would beg to differ with them.

Q. The person who is qualified to read these at Metro General and who reported it as such said there was "mild atrophic process in these areas," referring to the ones above.

A. Right.

Q. You are telling me you disagree with that interpretation.

A. I do.

Q. Would you give me the reason for your

disagreement, please?

A The reason for the disagreement is, firstly, I've looked at these scans and the one part where they talk about the sylvian fissure being larger on one side than the other, both sylvian fissures are really big and they are normally big in small children and this film is slightly rotated which makes interpretation questionable. As soon as you get rotation of the films, the way the baby's head is turned, you are going to get differences on the two sides, so you can overinterpret them, and the little thingy they sew at the very top, it's so high up, you are right to the very top of the skin, and if you just cut tangentially into one of the groups, the psalis of the brain, you will have that appearance.

In my opinion that is not significant at all so I would disagree with that.

Q. A child can have a perfectly normal CAT scan and still be retarded, isn't that true, Doctor?

A. Sure.

Q. So, Your conclusion here in No. 2 under subsequent course really doesn't tell us whether there was oxygen deprivation or not, does

it?

MR. KALUR: Show an objection.

A. A CAT scan can't tell you if there was oxygen deprivation to an individual. That's not what it's designed to do.

A CAT scan can show you whether there is a physical structural abnormality of the brain or not. That's all it tells you.

Q. I understand your opinion is that the cause of the child's mental retardation and cerebral palsy is not due to any oxygen deprivation. I understand that's your opinion.

A. Yes.

Q. What would you expect to see on the CAT scan, Doctor, if that were, in fact, the case?

A. As I understand the question, if a child had mental retardation and/or cerebral palsy from anoxia intrapartum, is that the question?

Q. Yes.

A. I just don't want to give you a misleading answer.

Q. Yes, that's the question.

A. If you have sufficient damage from anoxia to cause retardation, you must have generalized

atrophy of the gray matter or at least profound atrophy of most of the gray matter, not a little here or a little there, but the whole gray matter basically being significantly atrophic.

Q. So, you would expect the CT scan to say what then?

A. The CT scan would show generalized atrophy of the gray matter.

Q. Is that true in every case?

A. Where --

Q. There is significant oxygen deprivation sufficient to cause mental retardation.

A. Let me just say that where sufficient oxygen deprivation occurred and was the cause of the mental retardation, it will show that. I'm not trying to be cagey but there are cases where there's been severe oxygen deprivation and there is mental retardation but that the oxygen deprivation didn't cause the mental retardation. Other factors caused it. That took place too.

Q. Your final point under the subsequent development of this child is that because there was not significant motor abnormality, that being no spasticity or athetosis, you felt this supports your opinion that oxygen deprivation

did not cause this child's condition.

A. Yes.

Q. Dr. Jacobs, in his deposition, says that there was spasticity, I believe, in his last examination.

MR. KALUR: I'm going to object to that. I don't think that's accurate. I don't think that is accurate. I'm going to object to that.

In fact, he said specifically he didn't write it down in his last exam and he went back, way back in his exams and found something he thought might be some spastic movement.

Q. Whatever, all right? If I am wrong I apologize, okay? I'm assuming he did find some spasticity.

A. It wouldn't alter because the word some is a wide word. But I've read Dr. Jacobs' notes and specifically if you read them carefully he says, "When I hold the child up there may be a little alteration in tone," and he describes the hypotonia. That's minimal tone difference.

I'm talking about real, honest to God, anybody can see it spasticity. Mother, father, you, me or anybody else. When you get hypoxic

brain damage causing severe retardation, you get that and I'm sticking with that.

Q. Do you feel that this child has a significant motor abnormality?

A. No. It has some, I think, from Dr. Jacobs' description, but the word significant, again I'm using as being an honest to God, major problem in this. No, the answer is no.

Q. He can't really do anything at all for himself.

A. That doesn't mean that there is significant motor problem in spasticity or cerebral palsy. I mean look at just retarded children. There are many retarded children who never ever walk without spasticity, without gross hypotonia. They are just so retarded that they never walk. So, the degree of motor abnormality is often a reflex just of the retardation as such.

Q. Does the fact that this baby needs braces to walk around, you don't consider that significant?

A Absolutely not. Can I answer why?

Q. Sure, please.

A. The decision to use bracing or not in mild cases is very controversial. There are some people who are bracophiles and there are some who are

bracophobes, if I may use the term, and there is a huge spectrum in between. I know the particular people who prescribe the braces and they are very hot on braces so that many times they are put on in one hospital and we end up taking them off and vice versa.

Q. You don't think this baby needs braces is what you are telling me.

A. I don't know that he does or doesn't need braces but most hypotonic children in mild cases are often prescribed braces because it may aid them in walking a little earlier.

I take the view often that nature may take a little longer but it's better and a lot cheaper, so I'm not sure that this is a cut and dried case. I'm not going to say it isn't either. I haven't examined him. It may turn out that I would also recommend braces in this case. But bracing per se is a very controversial issue in these children.

Q. Let me check my notes, Doctor. Just let me be sure I understand a couple of points here.

Are you telling me that it requires a significant degree of hypoxia to cause mental retardation?

A. Yes.
Q. Almost near death is what you are saying.
A. Yes.
Q. And that a child who is mildly retarded does not mean that the child had mild asphyxia or anoxia.
A. That's correct.
Q. A child who is severely retarded, I guess it would necessarily mean that the child had significant deprivation of oxygen.
A. Yes. If that is the cause of the retardation, yes.
Q. Is this your complete file over here, Doctor, on this case, this and this?
A. No, this is not mine. This is Mr. Kalur's, and this book.
Q. May I see that for a moment, please?
A. Sure.
Q. You saw the evaluation of Dr. Wilson in this case, the psychologist.
A. Yes.
Q. Do you know Dr. Wilson?
A. Sure. She works here.
Q. I presume that she is a capable and qualified psychologist.
A. I think she's very good.

Q. Do you agree with the conclusions that she makes in her report?

A. I haven't looked at the conclusion for some time. I agree that she verifies Dr. Jacobs' diagnosis that the child is retarded. I think that that's in there. I don't know if there is anything else she put in and I don't remember.

Q. Doctor, I have a few more questions. I'm almost through over here.

Who is your malpractice insurance carrier?

MR. KALUR: Show an objection.

Q. Who is it; do you know?

A. At the present time?

Q. Yes, sir.

A. I think it is PIE.

Q. The same group that insures the Defendant, Dr. Hughes.

MR. KALUR: Same objection.

A. I don't know who is defending Dr. Hughes. I assume it is. I really don't pay attention to that.

Q. Doctor, I don't think I have anything else. I'd like to thank you for your time here today.

A. You're welcome.

Q. Be kind enough, if you will, please, if you

change any of your opinions or if you come up with some new opinions that I've asked you about, be kind enough to let Mr. Kalur know prior to the trial or arbitration so I might be able to ask you about them. Would you do that?

A. I will do that.

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CROSS-EXAMINATION

BY MR. SWITZER:

Q. I have a couple questions here.

You've reviewed the labor room and delivery notes from the hospital, Southwest General Hospital.

A. Yes.

Q. The fetal heart readings which were taken during the period from 4:00 p.m. through 4:53 p.m. which was approximately 15 minutes before the birth. Did you notice any abnormal readings?

A. I haven't looked at those for a while but I don't recall seeing anything abnormal.

MR. SWITZER: Thank you very much, Doctor.

(Deposition concluded.)

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STATE OF OHIO,)
) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Suzanne Vadnal, a Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, SAMUEL J. HORWITZ, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a typewriter; and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 18th day of November, 1986.

Suzanne Vadnal, RPR, Notary Public
In and for the State of Ohio

My commission expires October 4, 1988.