State of Ohio,)
) ss:
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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Steven Maksym, a Minor, etc., et al.,	)	
Plaintiffs,	)	Case No. 243093
vs.	)	Judge Michael Corrigan
Joseph A. Jamhour, M.D., et al.,	)	
Defendants.	)	

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DEPOSITION OF JOSEPH A. JAMHOUR, M.D.

MONDAY, AUGUST 16, 1993

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The deposition of Joseph A. Jamhour, M.D., a Defendant herein, called by the Plaintiffs for examination under the Ohio Rules of Civil Procedure, taken before me, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at the offices of Jacobson, Maynard, Tuschman & Kalur, 1001 Lakeside Avenue - Suite 1600, Cleveland, Ohio, commencing at 10:05 a.m., on the day and date above set forth

APPEARANCES:

On behalf of the Plaintiffs:

Michael F. Becker, Esq.
Joanne Sysack, Legal Assistant
Michael F. Becker Company
134 Middle Avenue
Elyria, Ohio 44035

and

Stephen J. Charms, Esq.
Standard Building - Suite 600
Cleveland, Ohio 44113

On behalf of Defendants Joseph A. Jamhour, M.D.; Murty S. Vuppala, M.D. and Pediatric Health Center:

William D. Bonezzi, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue - Suite 1600
Cleveland, Ohio 44114

On behalf of Defendant Deaconess Hospital of Cleveland:

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JOSEPH A. JAMHOUR, M.D.

a defendant herein, called by the plaintiffs for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS EXAMINATION

BY MR. BECKER:

Q. Doctor, would you state your full name for us, please?

A. It is Joseph A. Jamhour, J-a-m-h-o-u-r.

Q. What is your home address, sir?

A. 3379 Fairhill Drive, Rocky River.

Q. And you are in partnership with Dr. Vuppala?

A. Yes.

Q. We have obtained the business addresses Friday.

Have you ever had your deposition taken before?

A. I have had a deposition taken before.

(Thereupon, Mr. Charms left the room.)

Q. Just to review things, this is a question and answer session under oath. It is important that you understand the question that I ask you.

If you don't understand the question or if it

is inartfully phrased, or whatever, tell me so and I will attempt to rephrase or restate the question.

However, unless you indicate otherwise to me, I am going to assume that you fully understood the question that has been posed; fair enough?

A. Yes.

Q. And it is also important that you answer verbally, because it is difficult for Ivy here to pick up a head nod, okay?

A. Okay.

Q. Do you have a vitae, Doctor, that is handy?

A. I did not bring one with me, no.

Q. Tell me something about your medical education?

A. My medical school was in American University of Beirut, Lebanon. I did my residency here at Case Western Reserve and Metro General Hospital. In '76, I graduated, and from '76 until 1980, I was doing my residency and my chief residency.

Q. So you went to medical school in Lebanon?

A. Right.

Q. You did no residency in pediatrics there?

A. The last year of medical school there is an internship year.

Q. Okay.

And what year did you finish medical school there?

A. In 1976.

Q. And then you came to the States?

A. Right.

Q. And you started your residency in pediatrics at Case?

A. Right, and Metro General Hospital, it was a combined program.

Q. And you stayed -- it took you four years, '76 to '80?

A. Right. My last year was a chief resident.

Q. Are you an American citizen?

A. No, I am not.

Q. When you finished your residency in 1980, you began working or practicing pediatrics?

A. Right.

Q. Tell me your work history up until today?

A. I have been in private practice with Dr. Vuppala until today; from 1980 until today.

Q. Are you Board certified in pediatrics?

A. I am Board certified.

Q. And did you pass your examinations the first time you took them?

A. Right.

One addendum to that. I think the oral -- the written, yes. The oral, I did it the second time.

Q. Have you ever had your license to practice medicine called into question?

A. No.

Q. Have you ever authored or coauthored any medical journal article?

A. No.

Q. Do you have any association with Case Western Reserve?

A. I am a clinical instructor.

Q. And would you explain that to me?

A. That is a title that we get. We obviously have privileges if we desire, but at this point in time -- I mean, I don't have an active teaching participation with Case Western, but it is a title that we -- that is given.

Q. Have you had active teaching in the past, or have you had teaching in the past, where residents would follow you around, or you would lecture to them?

A. As a chief resident.

Q. And have you ever lectured to your residents on the field, on the subject matter of sepsis,

jaundice, things like that?
A. I don't remember it specifically, but certainly as a chief resident, we are constantly exposed to that.
(Thereupon, Mr. Charms re-entered the room.)
Q. Would your lectures be reduced to writing or outline form?
A. Again, I don't remember specifically, but a lot of teaching does occur as a chief resident.
Q. Do you think it may have been reduced to outline form?
A. Possibly.
Q. Would you still have that in existence?
A. I will have to look.
Q. Would you look for us, and see if you have any of your outlines or lectures while you were a chief resident?
A. I would be happy to.
Q. And let Mr. Bonezzi know what you find, all right?
A. Sure.
Q. Would you define a few terms for me. First of all, what is hyperbilirubinemia?
A. Hyperbilirubinemia is a bilirubin level above

the normal range.
Q. What is a normal range for a newborn, full term?
A. Well, it is usually above a level of 2 to 2.5, is designated as an elevated level, for anybody.
Q. And what does the term, kernicterus, mean?
A. It is when you have symptoms from elevated unconjugated bilirubin.
Q. And what may those symptoms be?
A. The symptoms could be seizures, could be lethargy, vomiting.
Q. And what is septicemia?
A. Septicemia is a -- it is a difficult term to define. It is usually associated with an infection, either due to the actual organism, or due to the products, the exogenous products that this organism may tend to produce. Also it may be associated with endogenous structures. It is a symptom complex.
Q. Now, you were the pediatrician that took care of Steven Maksym?
A. Right.
Q. Can you tell me what days, while he was in Deaconess, that you actually had hands-on care?
A. I believe I saw him on the 15th of August,

'89, and on the 16th.

Q. Incidentally, Doctor, during the course of this deposition, if you would rather refer to the chart before responding, I want you to know that you are more than free to do so.

A. Okay.

Q. You saw him two days; you didn't see him on the last day he was there, the 17th?

A. Right, two days.

Q. And did you detect any abnormalities in Steven, during the course of your hands-on care?

A. Well, my physical exam was apparently normal, and on the second exam, he did show some facial and truncal jaundice.

a. Can you tell by the chart at what -- excuse me.

A. I have to come to my exam. Can I just refer to that?

Q. Sure.

A. Okay, your question is?

Q. My question is, can you tell me at what hour of life you first made the assessment?

A. Generally we will tend to examine our patients in the evening, after office hours, or after we finish from our office. Usually in the

time between like about 6:00 and 7:00 in the evening.

Q. Okay.

A. So probably -- he was born 1:00 o'clock in the morning; is that right?

MR. BONEZZI: You were contacted at 5:25 a.m., which would have been subsequently to when his birth occurred.

A. (Continuing) At 5:25, generally what they do is they contact our answering service, and the answering service, if the baby has no apparent problems, they would wait until the office opens and transfer the information to our receptionist at that time. And we would be told that there is a new baby.

Q. And you did not detect any abnormality in his eyes; is that correct?

A. No. His eyes were normal.

You mean on the first physical?

Q. Right.

A. On the first physical exam?

Q. Right.

A. There was no evidence of any problems at that time, on this exam.

Q. What does the physical assessment consist of;

can you give me an idea what you may be doing to complete that physical assessment?

A. Yes. Basically the entire assessment -- of the patient, or you want the physical exam, per se?

Q. Of the patient.

A. Of the patient.

We would ask the nurses if there are any problems, any perinatal problems, any maternal fever, any prolonged ruptured membranes, any difficulty during delivery.

There is a sheet -- a delivery room sheet, we would go over that to see what his Apgar scores were, the time of ruptured membranes, and the type of delivery, and if the mother received any form of medications.

Also, it would briefly tend to assess the mother's course during pregnancy, whether there were any problems at that period of time.

Q. This would all be before you do the hands-on physical exam?

A. That is right.

Q. All right.

A. Then we would assess his chart, his vital signs, and how the baby has been behaving during that time, and we would even ask the nurses if they

have any concerns.

Then we would examine the baby.

Q. Now, what would that examination consist of?

A. Well, it will be a compete exam. The baby would be undressed, and the baby would -- basically when I examine the baby, I examine their hearts first, because they are usually quiet, and I undress the babies, rather than have them undressed, slowly, and make sure that there are no murmurs. It is difficult sometimes, because the baby is crying. And if the baby is crying, it is difficult to hear if there are any murmurs.

So I would do the cardiovascular exam first.

Q. Okay.

A. Then the second exam would be the abdomen.

Q. What would your examination of the abdomen consist of?

A. I would look at the baby, check if the baby's abdomen is soft, if there are any enlarged liver, enlarged spleen, if there are any masses, if the bowel sounds were normal.

Q. Okay.

A. And if there are any hernias.

Q. So that would complete the abdomen workup?

A. Yes.

Q. What then would you do?
A. Well, as part of the cardiovascular, you also check the pulses.
And then I would check the neck, the eyes, the oropharynx, the ears, the fontanel, the muscle tone, and his reflexes, and check his extremities.
Basically we would go through this routine -- the lungs.
Would you like me to go over these one by one?
Q. Well, what I want to understand is, you would normally complete your physical exam first in the way that you just described it, and then you would --
A. In great detail.
Q. And then you would go ahead at a later date, or later time, maybe that day, and then complete that form?
A. We would complete that form immediately after we finish examining the baby.
Q. But the examination would be complete before you begin that form?
A. Definitely.
Q. Now, what time do your office hours begin?
A. What time --

Q. In the day.
A. -- does my secretary come, is that what you mean?
Q. What time do you begin seeing patients in your office?
A. It did vary. We may begin at 1:00 o'clock, or we may begin at 10:00 o'clock in the morning, depending on the day.
Is there any particular day you would like?
Q. I just want to know how you and your partner work it. You take one day and your partner takes the other day, and you alternate between the office and hospital?
A. We have two office locations. Basically he would be in one and I would be in the other.
Q. Okay.
A. Wednesdays one person works, and weekends, one person works.
Q. So when do you normally do your hospital visits, or rounds?
A. At Deaconess, it is usually -- usually in the evening, most of the time, or in the afternoons. Occasionally we may do it in the morning, if we don't have our office hours at that time.
Q. Now, you were the on call pediatrician at the

time this baby was born; is that how -- is that your understanding as to how you were deemed to take coverage of this child?

A. I believe so. I am really -- I didn't go into details to check that, but it is a possibility, yes.

Q. What other pediatricians besides you and your partner had on call privileges at Deaconess, could you name a few?

A. Probably Dr. Liang, Dr. Ayala, Dr. Kepler, Dr. Shah.

Would you like more?

Q. No, that is fine, Doctor.

Doctor, what medical journals articles do you subscribe to in pediatrics?

A. Pediatrics.

Q. That is the name of it, Pediatrics?

A. Yes.

Q. Any others?

A. We also read the Journal of Pediatrics, Lancet, but I don't subscribe to those.

Q. Which journal articles would you consider the best?

MR. BONEZZI: Objection. On what subject matter?

You are asking for articles. What subject matter?

Q. (Continuing) Strike that question.

Which journals would you consider the most reliable in pediatrics?

A. Pediatrics, and the Journal of Pediatrics.

Q. And would you consider them authoritative?

MR. BONEZZI: Objection to that term. Go ahead and answer.

A. They are guidelines.

Q. You would not consider them authoritative, or would you consider them authoritative?

MR. BONEZZI: Objection.

A. They are usually done with a great deal of research. Many opinions that they have, later on goes to show to the contrary, or to difference. So I mean, they are good guidelines, very good guidelines.

Q. You have indicated that you have had your deposition taken before. Under what circumstances?

A. We were taking care of a newborn, I think it was in '84, '85. We were not directly involved in the action that was done, it was a deposition to -- I think it was a premature baby -- no, it was a C-section, and the baby turned out to be early,

premature, and the mother at that time was unhappy with the obstetrician.

Q. So you weren't a named party?

A. We were not a named party.

Q. I understand.

Now, as the attending for Steven Maksym, what did you feel your duties and responsibilities to be during his stay at Deaconess?

A. I didn't understand.

Q. Because you were on call, you became Steven Maksym's attending pediatrician --

A. Right.

Q. -- during the course of his hospital stay at Deaconess, correct?

A. Yes.

Q. What, in your mind, were your duties and responsibilities because of that?

A. His complete health care.

Q. Okay.

A. We don't even ask whether we got the patient as an on call physician, or if it was referred to us, or even if we are continuing the care of the patient.

Do you have any independent recollection of Steven Maksym, aside from the chart?

A. Vaguely.
Q. What is your vague recollection?
A. He is among one of the many infants that I took care of.
Q. Do you remember anything more than that about him?
A. Specifically, no.
Q. Do you remember anything about Steven Maksym's parents?
A. No, I don't.
I mean, specifically?
Q. Do you recall any conversations you may have had with Steven Maksym's parents?
A. We always discuss the baby after I examine the baby.
Q. Okay.
A. Probably on two occasions, it would have taken place.
Q. So what you are telling me is you don't have any specific recollection of conversations with the parents, but you generally have a conversation with the parents of the child?
A. We always do. I always do.
Q. But you don't have any specific recollection of any conversations with them?

A. No.
Q. Do you agree that increasing jaundice can be a sign of increasing bilirubin?
A. Jaundice, yes, it could be a sign of increasing bilirubin.
Q. And do you agree that increasing bilirubin level may be a sign of sepsis?
A. Could be.
Q. Do you agree that increasing jaundice may be the only sign of a bacterial infection in a newborn?
A. No.
Q. What other signs must you see for there to be, within your differential, bacterial infection or sepsis within a newborn?
MR. BONEZZI: Objection to the form of the question.
Go ahead and answer.
A. Could you repeat that?
Q. I am gathering by way of your previous answer that you feel that for there to be within your consideration of sepsis or a bacterial infection in a newborn, signs in addition, signs or symptoms in addition to jaundice.
And my question is, what are those other ones that you feel must be present?

A. Well, if the baby is lethargic, if the baby has a poor suck, if there is a temperature instability. In the context, if the mother had prolonged ruptured membranes, if there was maternal fever, if there was any form of instrumentation, like intubation, catheters installed, inserted.

Q. When you use the term, temperature instability, what do you mean?

A. Well, the temperature may go up or it may go down beyond the normal range.

Q. You are saying those could be other signs of sepsis, that you have just outlined; lethargy, poor suck, temperature instability?

A. If the baby has a breathing problem, if it is tachypnic, very rapid heart rate or very slow heart rate.

Do you want the physical signs, as well?

Q. Sure.

A. If the fontanel is tense, bulging. If the muscle tone is poor. And most importantly, also, if he has a poor suck. All these.

Q. What about distended abdomen, could that be a sign of sepsis?

MR. BONEZZI: By itself?

Q. (Continuing) Let's start, by itself.

A. I am sorry?
Q. Distended abdomen.
MR. BONEZZI: How long?
A. A distended abdomen could be a sign of necrotizing enterocolitis, it could be a sign of intestinal obstruction, it could be a sign of meconium ileus, and infection could be secondary to those problems, yes.
Q. Okay.
A. See, a sepsis -- sepsis is usually when you have -- when you have certain organ tissues involved, whether there is a pneumonia and there is a sepsis, or whether there is an invasion of the intestinal mucosa and there is a sepsis. It is a constellation -- it is not a one -- it is a constellation of symptoms.
Q. If a newborn had a distended abdomen, was jaundiced, lethargic, would sepsis be within your differential?
A. Definitely.
Q. And if a sepsis is within your differential, I trust you would agree that it would be your responsibility to take steps to rule out sepsis?
A. Right.
Whenever we think of the possibility of an

infection, whether -- we always have to rule out infection.

Q. How do you rule it out?

A. Well, if the baby appears to be sick, then we would completely do a complete septic workup, which would include a blood culture, a urine culture, CSF studies, a chest x-ray, and a CBC and differential.

And any other areas that are involved, if the joints appear to be swollen, then you will tap the joint and make sure that there is no fluid there, any other areas, and you go from there.

And we would then put the baby on antibiotics and wait to see if the cultures tend to show any infection.

Q. Is it your opinion that jaundice did not appear within the first twenty-four hours of life?

A. When --

Q. With Steven Maksym.

A. Right.

When I saw him, he did not appear to be jaundiced, on the first physical exam --

Q. And did we establish that was 6:00 a.m. or 6:00 p.m.?

A. Probably in the evening.

Q. Okay.

A. -- significantly jaundiced.

Usually almost -- the majority of full term babies do get jaundiced, I mean, that is an extremely common problem, or common occurrence that we see.

Q. Doctor, on the pediatric record, Newborn Service Sheet, I wonder if you could find that.

A. Find what?

Q. Find that sheet.

You have got it?

A. Yes.

Q. On the bottom it says, description of abnormal findings. Would you read that for us?

A. It says, facial and truncal jaundice.

Q. So at the time of your examination, there was jaundice?

A. On the discharge.

Q. Oh, I am sorry, I am misreading that.

The top section is the initial history, or initial physical?

A. Right.

Q. And the bottom section is the discharge findings.

A. Right.

Q. Was that completed by you?

A. Right.

See, because jaundice is such a common finding in newborns, I mean, when I wrote the discharge diagnosis, I wrote, full term -- I didn't include the word, jaundice, because it is such a common finding. As I said, almost all babies are jaundiced to some degree or another.

Q. Okay.

A. The majority of them are.

But at the time of the discharge exam, when I saw him, on the 16th, he did have facial and truncal jaundice.

Q. Now, you would agree with me that at the time of discharge his bilirubin level was on its way up?

MR. BONEZZI: Objection.

A. Well, usually when there is truncal jaundice, it is probably within the range of like eight to ten, that is an association. Usually as a jaundice tends to increase -- as the bilirubin tends to increase, the level increases, the jaundice, the yellow discoloration of the skin tends to descend.

In other words, it starts off usually of the eyes and face, and then goes to the trunk, and then goes to the legs, and then goes to the feet.

And with levels that are usually involving

the trunk, up to the umbilical level, for example, it is usually in the range of eight to ten, and when it goes down to involve the feet, it is usually like in the range of twelve or so.

Q. Do you think that is a reliable marker for determining a baby's bilirubin level?

A. Alone, no, but when we see jaundice levels, or when we see the skin to be jaundiced to those levels, then we have a ballpark figure of where the levels might be. But alone, it is not a reliable marker to designate a particular level.

Q. Do you agree that early treatment of sepsis with appropriate antibiotics will prevent sepsis from developing into meningitis?

A. Again, it depends upon what is the underlying cause of the sepsis, and where is the sepsis initiated.

If there is a tremendous amount of endogenous elements involved, then it may not, but if the sepsis originates in an infection in the meninges, then it probably won't prevent the meningitis.

In other words, you can have a bacteriemia without having a sepsis, and it depends on where that bacteria goes and deposits.

Q. Would you distinguish bacteriemia and sepsis

for me?

A. Bacteriemia is having bacteria from your -- from the blood, growing in the blood, or being in the blood, or being present there. You can be bacteremic, without being septic.

In other words, you can be totally asymptomatic, and a blood culture which showed bacteria in the blood, but you may not be septic from it.

Sepsis is when you have a reaction or an organ reaction to that particular infection, whether it is to the bacteria itself, or to the products of that bacteria.

Q. When I asked you whether early intervention would prevent it from developing, would prevent sepsis from developing into meningitis, you said, depending on where it is from.

A. Right.

Q. Do you also mean depending on which organism we are dealing with, as to the cause?

A. Probably different organisms have a different tendency to affect the CSF fluid.

Q. Have you diagnosed E. coli bacteriemia or E. coli sepsis in newborns?

A. I didn't understand that question. Have I --

Q. Have you ever diagnosed, in a newborn, E. coli sepsis or E. coli bacteriemia?
A. You mean, have I ever had a patient with E. coli sepsis?
Q. Yes, that you diagnosed as having E. coli sepsis.
A. Not to my recollection.
Q. Have you ever had a patient where you diagnosed sepsis in the newborn period?
A. Yes.
Q. What was the organism?
A. Group B Strep.
Q. Did you --
A. Bacteriemia -- I am sorry.
See, again, the definition of sepsis. What we diagnosed was an infection where Group B Strep grew out of the blood and the patient showed evidence of being ill. And we assume it was a sepsis at that time.
Q. I am gathering it would be extremely difficult to diagnose bacteriemia because you wouldn't have the suspicions because there wouldn't be signs or symptoms?
A. No, that is not true. You can pick up a bacteriemia by going to the history. If the mother

had prolonged ruptured membranes, if she had a maternal fever, if she had a chorioamnionitis, if she had a potential problem, okay, then all babies would get a blood culture, and that blood culture, before the baby is symptomatic, could grow the Group B Strep.

Q. While Joanne is looking for something, on this case where you had Group B Strep sepsis, did you intervene via appropriate antibiotics?

A. Right.

Q. So as to avoid meningitis?

A. Right.

Well, it is to avoid propagation of the infection, not specifically just meningitis.

Q. But you prevented the situation, the clinical situation from reaching the stage of meningitis in that case?

A. When we do a blood culture, the blood culture result takes twenty-four to forty-eight to seventy-two hours to come back.

Q. Okay.

A. So by the time we get the result of the blood culture, okay, the baby most likely would be on antibiotics.

So the baby would be treated long before --

Q. I understand.
A. -- we get the result of the blood culture.
Q. I understand.
A. So at that time -- so the purpose is to prevent any propagation of infection, yes.
Q. When you are gaining the history of the mom, before you begin your hands-on initial newborn physical, do you rely upon the nurses to bring things to your attention, or do you actually go through the mother's chart?
A. No, we generally do not go through the mother's chart. There is a delivery room sheet that is filled out, and we tend to go over that. And we ask the obstetrician.
Q. You apparently ordered a second bilirubin --
A. Right.
Q. -- measurement for Steven. Why did you do that?
A. Well, when I saw him the second time, he was jaundiced to his -- no, sorry, can I rephrase that?
Q. Sure.
A. When I saw his blood level earlier, they had done one in the morning, apparently he looked jaundiced to the nurses, and the nurses felt that he should have a bilirubin done.

And we do give that privilege to the nurses, if they feel that the baby is jaundiced, then to go ahead and do a level on him.

It was a level of 6.5.

And then when I saw him in the afternoon on the 16th, I saw that he was jaundiced to his truncal area, and I wanted to determine what the rate of rise and what his level is. That is why I ordered a bilirubin to be done the second day. And to be done the second day, because I would like to know what it was at the time before discharge. I did not feel that it was high enough to be done that particular evening.

Q. So you ordered it to be done the next day?

A. Right.

Q. How long does it take for the results to come back?

A. Usually like one to two hours.

Q. And is it something that the lab calls up to the floor, or do they actually send a sheet up to the floor?

A. For what?

Q. When a bilirubin is run, how does that information get back to the nursery, at this hospital?

A. I think usually the nurses call down and check what the level is. If it is very high, then the lab would automatically call up.

Q. And is it the responsibility of the nurses to chart what they were told from the lab, as to what the values were?

A. Well, they would pass it on to us, yes.

Q. And should that be within the chart?

A. They usually put it on our sheet, we have a sheet with the list of the babies, and their weights, and so on, and the time of birth, and so on, and there is an area that says, comment, and they would write that down for us to see, because when we come in, we just look at that sheet to see the babies we have, and so on.

So they would put that down on the time that the baby is discharged, they would verbalize that to us over the phone, yes.

In other words, whether they go and put it in the chart themselves, I really don't know.

Q. But you mentioned that there is a sheet, something aside from the chart that the nurses relay messages to you or your partner on?

A. Right.

Q. What is that sheet called?

A. I don't know if it has a name, but basically it is a list of the patients that we have, their room numbers, and the baby's weight today, and the baby's weight the day before, and if the baby needs to be examined, like first physical, or a discharge physical, and there would be an area for comments.

Q. As to any problems?

A. As to, yes, any problems.

Q. What happens to those sheets, to your knowledge? Are they ever incorporated into the actual chart of the baby?

A. No.

Q. Are they simply thrown away?

MR. BONEZZI: If you know, Doctor.

A. I really don't know what happens to them. I mean, we don't keep them. I do not keep them, personally.

Q. It is something the nurses keep?

A. I don't know if they keep them.

Q. Well, it is something the nurses generate, it is a form that they use, and they complete; is that correct?

A. Right.

Q. For relaying information to you, in addition to the chart?

A. Well, basically it is primarily designed so we know the babies that we have, and in which rooms they are, right.

Q. You told me that you are not certain that that form has a name, but if you were referring to a nurse as to that form, what would you call it?

A. Basically I would say -- well, I usually don't refer to that particular sheet, but when I go in, I just tell -- I think it is a doctors' sheet or something, I don't know what you call it, basically. There is no specific name for it.

Q. Doctor, I am looking at the physician progress notes. Do you have those?

MR. BONEZZI: Those are the orders. This is the only progress note (indicating).

Q. (Continuing) Doctor, are there any progress notes by you on this baby?

A. No, apparently not.

Q. Why not?

A. I think I just simply forgot to write a progress note.

The baby appeared to be normal at that time, within a normal range, and I guess I didn't write a progress note. But I did examine him that

particular day.

See, usually what we -- things that we tend to fill out on the day prior to discharge or on the day of discharge is the physical exam, which we do, and the front sheet, which I don't know if it is here.

But sometimes we even forget to do that, the front sheet where it says, diagnosis, and things like that.

So I guess I did not write one.

(Thereupon, Mr. Chamrs left the room.)

Q. Doctor, you would agree that the hospital expects physicians to complete progress notes when they are taking care of a patient?

MR. BONEZZI: Objection.

A. I usually write progress notes.

Q. That is part of your duties, is to write progress notes?

A. Is to write a progress note.

Q. That is part of the standard of care when you are taking care of a patient in the hospital?

MR. BONEZZI: Objection.

A. Right.

Q. Doctor, you did not have any role in the actual discharge of this infant; is that correct?

A. Right.
Q. Were there any discussions between you and your partner as to --
A. Yes, usually we sign out about 9:30 in the morning, and I tell him of the patients that we have in the hospital, and if there are any problems.
Q. Your partner, Dr. Vuppala, has told us that it is his responsibility, when he discharges a patient, to give certain instructions to the patient's parents as to what to look for.
A. Right.
Q. And that is particularly so when these new parents aren't going to be followed by you out of the hospital?
A. Frankly, I didn't even know that. But anyway, we always discuss with the parents, whether the mother, or the father, or both, as to what to look for.
And I don't remember specifically, but what I do is if the patient is jaundiced, I tell the parents, the patient is jaundiced, and I discuss that with them.
Q. Would you have -- I know you don't have any specific independent recollection, but would you have -- since you weren't the discharging physician

here -- would you have still had that discussion with the parents, as to what to look for, even though you --

A. Most definitely. Most definitely.

Q. Okay.

A. I would tell them that the baby is jaundiced.

Q. Tell me generally what you would tell the parents?

A. As to --

Q. What to look for.

A. What to look for.

Q. Even though you are not the discharging pediatrician.

A. Basically, on the day of my last exam, I will go in and tell them that generally if the baby is sucking good, and wants to eat, it is a sign that he is a pretty healthy baby.

And with respect to the jaundice, what they should look for is if the jaundice tends to progress, and if it starts to involve the lower extremities and the feet, we definitely would like to know about it. Because then it would warrant us to repeat a level.

And then we would like to see him within a two week period.

MR. BECKER: Could I have that back, Ivy.

(Record read.)

BY MR. BECKER:

Q. I will take those one at a time, Doctor. The first one is that if the baby has a good suck and has a good appetite, that is a good sign?

A. Right.

Q. And you would tell the parents that?

A. Right.

Q. And the corollary to that obviously is, if the baby is not feeding well, that is a bad sign?

A. Well, it does warrant attention.

Q. And would you tell the parents that?

A. Definitely.

Q. And that would be part and parcel of your responsibility as an attending pediatrician in the nursery, to tell the new parents that?

A. That is what I tell all my mothers.

Q. And that is part of your responsibility and duty?

A. That is what I tell them.

MR. BONEZZI: Objection to your characterization of responsibilities and duties.

Q. Doctor, do you feel that those instructions to your mothers comports with the appropriate standard of care of a pediatrician taking care of a newborn within the nursery?

MR. BONEZZI: Objection.

A. Well, we also go -- I mean, we tend to go into a little more detail, if you like.

Q. Just answer this last question.

Can I have the question -- listen to the question.

(Record read.)

A. Yes.

Q. You said that you generally go into a little bit more detail. Since you don't have any independent recollection, what type of detail do you generally go into?

A. Well, we ask them if they have any questions, if they have any concerns, okay?

Q. Okay.

A. And if they have any concerns of taking care of the circumcision, if they have any concerns taking care of the umbilical cord. We actually spend like about ten to fifteen minutes.

Q. If a mother voiced a concern to you about the baby's eyes, the baby not opening his eyes, would

that cause you to take a harder look or take a closer look at the baby's ability to open his eyes?

A. Yes, it does. I always check the baby's eyes, I mean, at the time of discharge.

Q. Doctor, I don't know if you have looked at any other records in advance of this deposition, and I probably forgot to ask you what you did look at in advance of this deposition. Maybe I should start by asking you that.

What did you look at prior to this deposition?

A. I reviewed the chart.

Q. Did you see any of the records from Metro on this child?

A. I saw the first forty-eight hours, very briefly.

Q. Are you aware that this child had a congenital eye problem at birth?

A. No, I am not. I am not.

But at that time, any child who is jaundiced, we always check his eyes for good red reflex

Q. You also said, and generally what you would be telling the parents is, that if the jaundice looks like it is increasing or going down to his feet, that should tell the parents that the child

should be seen within two weeks?

MR. BONEZZI: Objection, that is not what he said.

A. No.

Q. Let's get it clarified then. What did you say?

A. I said, if the jaundice appears to be descending to involve the lower extremities and the feet, we would like to know about this so we could repeat a level --

Q. Okay.

A. -- and check the baby, because we are a little more concerned.

Q. Is that something that you would want to know about immediately?

A. Yes, we would like to know. If the jaundice involves the feet, usually it is in the range of like twelve, at least, a minimum. That is a ballpark figure. And this is why we would like to do a level and see what the level is, whether it is twelve, or fifteen, or sixteen, or greater.

But it is important that we do know about it.

Q. But your general instructions would be that if the jaundice extended down to his feet, then the parents should immediately contact you or their

attending pediatrician outside the hospital?
A. We usually tell them to call us, yes.
Q. And if a parent called you, and told you that in their mind, the jaundice was descending, what action would you normally take?
A. Well, we generally would like to see the baby -- what we ask them, is the baby eating well? Because usually if the baby is feeding well and wants to eat, that means that the jaundice will probably not go much higher, okay?
So it is good for us to know whether the baby is feeding well or not.
Q. Okay.
A. And if the baby is having any abnormalities, like temperature changes, and primarily if the baby is sucking good or not, and we would definitely repeat a level, yes, and we would like to see the baby the following day.
Q. So you would want to repeat a level immediately, within twenty-four hours after the phone call?
A. I think if the baby wasn't feeding well, then we would do it right away.
Q. Because what would that tell you, Doctor, if the baby wasn't feeding well, and the jaundice level

was increasing?

A. Well, either he is -- usually when the baby's jaundice tends to go up, they are sluggish eaters. And when they start to pick up in their feeding habits, and when they start to -- their weight tends to gain, then the jaundice is probably peaked, and it is going to start to come down.

Basically we are concerned whether the baby is feeding well, and we make sure that the level is going up or there is another problem involved.

Q. Doctor, just because a family is not going to utilize you as --

A. I didn't even know that, to tell you the truth

Q. Listen to my question.

You would agree with me, Doctor, that the standard of care that you render should be the same whether or not --

A. Absolutely.

Q. Let me finish my question, first of all.

You would agree with me, Doctor, that the standard of care for you should be the same whether or not you will be the subsequent treating pediatrician, or someone else would be?

A. Yes.

(Thereupon, Mr. Charms re-entered the room.)

Q. Now, there was some discussion last Friday about a booklet that was normally given to the mother at the time of discharge.

Are you familiar with a booklet given at Deaconess at or about the time of this birth?

A. There is an instruction booklet -- it is sort of a generalized booklet that is given to the mother, yes.

Q. Are you familiar with that booklet?

A. In great detail, no.

Q. Can you just tell me what the substance of that booklet is; what does it speak to?

A. It was a long time since I read it, but it would basically cover --

MR. BONEZZI: Don't guess. If you don't remember, tell him what you remember, but I don't want you to guess as to what may be in there.

Q. I don't want you to guess. Tell me your basic recollection of what generally is in there?

A. In the care of the umbilical -- umbilicus, umbilical cord. I mean, that is as far as -- I mean, specifically, I don't know specifically. I

haven't looked at it for a long time.
Q. Dr. Vuppala made some reference to a booklet that spoke to signs or symptoms that the new parents should look for in a newborn. Are you familiar with any booklet like that?
A. I believe that will address that, too.
Q. You think that is the same booklet?
A. I think it is the same booklet.
And at that time, I think there was a sheet -- I mean, that I have actually seen -- about jaundice, that it is given to all mothers, it is a separate sheet. Whether they stopped it at that time or not, but I know that they did have a separate sheet discussing jaundice in the newborn.
Q. You think that that sheet, the distribution of that sheet, ceased?
A. I don't know. I mean, I have to ask about that.
But I definitely do remember seeing a sheet on jaundice that is usually distributed to all mothers.
Q. Is it your opinion, Doctor, that it is the responsibility of the nurses to distribute a sheet on jaundice to mothers at the time of their discharge?

MR. BONEZZI: Objection.

MR. MARKWORTH: Objection.

A. We basically try to educate the mother as much as possible.

Q. Can you answer my question directly?

A. It is the responsibility of the nurse, you mean?

Q. Yes.

A. I don't think it is specifically the responsibility of the nurse.

Q. Is it either your responsibility or the nurses' responsibility to ensure that the new parents receive this sheet on jaundice in the newborn?

MR. MARKWORTH: Objection.

A. I really don't think it is the responsibility of anybody. I think the important thing is to try to educate the parents as much as possible.

Q. So it is not so much that they get a specific sheet, the bottom line is if they get fully educated prior to their discharge?

A. Right.

Q. And would you agree with me, Doctor, that the nurses have some -- bear some responsibility in the education of the parents relative to jaundice?

MR. MARKWORTH: Objection.

A. Relative to all elements, I guess, yes.

Q. Doctor, you have told me that you had an opportunity to look at this chart prior to this deposition.

A. Right.

Q. May I ask how recently have you looked at this chart?

A. Well, I looked at it yesterday. That is probably the most recent.

Q. Did you detect any problems in this newborn in feeding during his stay at Deaconess?

MR. BONEZZI: You are going to review the chart.

THE WITNESS: I beg your pardon?

MR. BONEZZI: I said, you are going to review the chart before you answer.

A. I did not. And usually, with my discharge physical, I always check the baby's suck. I do it -- if there is a bottle in the crib, I offer it to the baby and see how vigorously the baby sucks.

Q. You actually observe the suck?

A. Yes.

Q. Go ahead.

A. And if there is no bottle in the crib, I

usually use my finger, and see how vigorously that baby tends to suck, and how active that baby is.

And in the presence of jaundice, we always check the spleen, the liver, the abdomen, and we always look at the skin to see if there is any rash, and we always check the eyes for a good red reflex. It is always done that way.

Q. If there were problems in feeding, whether not having a good suck, or vomiting the feeding, would you expect the nurses to bring that to your attention --

A. Yes.

Q. -- to comport with the standard of care of pediatric nurses?

MR. MARKWORTH: Objection.

A. Well --

MR. BONEZZI: I am going to object as it relates to this physician knowing what the standard of care is relative to nurses.

MR. BECKER: Okay.

A. (Continuing) I think if the nurse has experienced a problem with a baby, I would expect her to tell me that there was a problem.

Q. Doctor, you mentioned the term, red reflex?

A. Right.

Q. What does that mean?
A. It usually means it is sort of a reflection of the retina. For example, if there is any form of increased intracranial pressure, or if there is cataract, or if there is any inflammation involving the retina, we may tend to pick it up, or if there is clouding of the cornea.
Q. Doctor, with Steven apparently there was a yellow discharge from his eyes --
A. Right.
Q. -- that was swabbed and cultured.
A. Right.
Q. Any significance to that finding and the results of that culture?
A. I am sorry, the finding of what?
Q. Finding, actually the finding of that process, that is the discharge, yellow discharge from his eye, is there any significance to that?
A. Well, when we have a discharge from a baby's eye, we always culture it to make sure whether there is an infection there or not.
Q. And was there any evidence of infection as a result of the culture?
A. The culture was basically normal flora there.
Q. Doctor, the results of the pathology results

reflect slight growth viridans streptococcus group; is that normal?

A. It is a normal skin flora.

Q. Moderate WBCs; is that normal?

A. It is within -- probably -- if there is a lot of white pus cells there, then you worry about a possible infection. If there is a moderate amount, and the culture is negative, then it could be secondary to an irritation.

Q. Well, when it describes it in this form as moderate WBCs, does that tell you the number of the WBCs?

A. No, but if the bacteria is normal skin flora, then alone it doesn't mean -- it may not be significant.

Q. Can you explain to me why the preliminary result shows slight growth gram positive cocci and the final result shows slight growth viridans streptococcus group?

A. Because the viridans streptococcus is a gram positive cocci.

Q. Okay.

Doctor, Steven Maksym, I believe he was brought back to Deaconess Hospital through the emergency room before he was ultimately transferred

to Metro. Were you contacted the day that he came back?
A. No. I was off that weekend. It was a weekend, and it was my weekend off.
Q. I forgot to ask you prior, do you have any knowledge whether your partner was contacted?
A. I believe the emergency room called him.
Q. So between you and Dr. Vuppala, it was like a joint management of this newborn?
A. That is how we manage our patients, yes.
Q. If there is a projectile type of vomiting in a newborn, is that more significant to you than simply spitting up?
A. Right.
Q. Would you explain to me why?
A. Well, if it is projectile, we worry about if there is an intestinal obstruction, one. That is probably the main concern. There are other things that can cause it, obviously.
Q. But that is more concerning than normal spit up?
A. Most definitely. Especially if it is associated with any color changes, like bile involved in the vomitus. If there is bilious material in the vomitus, it is of great concern.

Q. Do you agree with me, Doctor, that there are different types of E. coli meningitis, some that come on rapid onset, and some that are more of a chronic nature, if you have an opinion?

MR. BONEZZI: Objection to the form of the question.

E. coli meningitis is E. coli meningitis. You are asking about the rapidity of the onset of the symptoms, as opposed to whether or not there are different types of E. coli meningitis.

Q. (Continuing) Let's just start with meningitis in general. Are there differences in rapidity of onset, depending on the bug?

A. Once you have a meningitis, it will generally show.

In other words, it is very unlikely to have a meningitis, and linger on for a long period of time without having signs or symptoms.

Q. Do you have an opinion, or will you have an opinion, that meningitis that is fulminating has a worse prognosis than slow onset meningitis?

A. I don't understand what you mean, slow onset meningitis. There is no -- I don't believe there is a slow onset meningitis. You either have a

meningitis, or you don't have a meningitis.

Q. Okay.

After your review of this chart, do you have any problems or criticisms of the nursing care given to Steven Maksym?

MR. BONEZZI: Objection.

MR. MARKWORTH: Objection.

A. Do I answer that?

Q. Yes.

A. No.

MR. BECKER: Okay, we will take a short break.

(Short recess had.)

BY MR. BECKER:

Q. Doctor, what are the congenital conditions that would prohibit a baby from opening its eyes; can you name a few of them?

A. Basically if there is an abnormality in the palpebral fissures, if the palpebral fissure is too small, or if there is a stricture, or if they are fused, if there is a muscle problem like either a paralysis on the levator muscles of the eyelid, if there is a nerve palsy.

Q. Doctor, all of those things you have outlined should be obvious to a prudent pediatrician in his

examination of a newborn?

A. Usually if it is significant -- I think if the palpebral fissures are fused, that is pretty obvious If there is a nerve palsy, like a cranial nerve palsy, it may be subtle It really depends upon how --

Q. It depends on what is actually causing it?

A. Right, and how many muscles are involved

MR BECKER: Why don't you mark that

(Thereupon, Plaintiffs' Exhibit 1 (Jamhour) was marked for identification.)

BY MR BECKER:

Q. Doctor, going back through these conditions on the eyes, congenital problems can you give me the medical terms for those?

A. For what?

Q. For these eye conditions, potential eye conditions, congenital eye conditions?

A. Basically if there is fusion of the palpebral fissures --

Q. Yes.

A. -- or there is stenosis of the palpebral fissures that is basically what I remember to be -- I mean, if there is a cranial nerve palsy, a Bell's palsy.

Q. Doctor, I am going to hand you what has been marked as Plaintiffs' Deposition Exhibit 1, and I am going to show it to your counsel first, then I am going to ask you some questions about it.

(Thereupon, the document was handed to counsel and then handed to the witness.)

Q. (Continuing) Doctor, can you tell by that photograph, in your mind, whether or not the abdomen is distended in that child?

MR. BONEZZI: Objection.

You may answer.

A. It appears to be full. Probably. It is not a two dimensional -- it is not three dimensional.

Q. I appreciate that.

Does it not look like that abdomen is distended?

MR. BONEZZI: Objection.

A. It really depends upon his state of respirations. If he was in an expiratory phase of breathing, the abdomen may look distended in that picture. It appears to be full.

MR. BONEZZI: Is that a picture taken from the hospital, or is that a picture taken by Mr. Maksym? Because if it is the latter, I want a copy of it, please.

MR. BECKER: Would you say that again, please?

MR. BONEZZI: Yes.

Who took the picture, the hospital, or Mr. Maksym?

MR. BECKER: It is a family photo.

MR. BONEZZI: I would like a copy of it, please.

MR. BECKER: Sure.

MR. MARKWORTH: The same.

MR. BECKER: Sure.

Just for the record, this is a photograph taken just prior to his discharge.

MR. BONEZZI: Would you make sure that the writing that appears on the back also is put onto --

MR. BECKER: Why don't I read it now.

MR. BONEZZI: That is fine.

MR. BECKER: This shows his date of birth. On the back it says, Steven Lee Maksym, eight pounds four ounces, August 15, 1989, 1:10 a.m., which is his time of birth.

A. (Continuing) If that picture was taken after the baby was fed, I mean, it could look similar to that, too, or in an expiration phase of his

breathing.

Q. Would jaundice impact a child's feeding?

A. Generally what we find, if the tendency of the jaundice is to go up, the baby may not have as good of an appetite. And in babies who tend to gain weight, the jaundice probably has peaked and will tend to descend. That is a clinical finding.

Q. Are you talking about in the newborn nursery?

A. I am talking about -- I am talking about in the newborn period, whether it is in the first -- usually babies don't gain weight --

Q. Right.

A. -- in the first few days of life.

Q. In fact, generally they lose a little bit?

A. When we talk to them over the phone, if they say the baby is feeding well and doing well, over the phone, then we are a little more relaxed in caring for that -- we are a little more relaxed in the sense that the baby is less likely to have a severe problem.

It is a reassuring factor.

Q. Doctor, do you measure the jaundice level, or the bili level, in all jaundiced infants?

A. Not on all jaundiced infants. Again, it depends to what level they appear to be.

Q. You only measure bili levels on infants that you feel the jaundice is significant?
A. Right. For example, if it appears to be involving the trunk, then we would like to know what that level is, and beyond.
Q. Doctor, would you agree or disagree with this concept, that it would be extremely difficult if not impossible to correlate serum bilirubin levels with clinical appearance?
A. Right. You cannot say --

MR. BONEZZI: You answered the question, Doctor. You answered the question.

MR. BECKER: Doctor, what I have remaining are a few questions off the discovery deposition of your partner, Dr. Vuppala.

And Bill, you told me that I am not going to be permitted to ask him any questions along those lines, so we will suspend the depo and reconvene at a later date after the depo has been read and signed.

Is that fair?

MR. BONEZZI: Yes.

MR. BECKER: Thank you, Doctor.

Any questions from the hospital at

that end?

MR. MARKWORTH: I will wait until your exam is done.

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(DEPOSITION CONCLUDED)

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Joseph A. Jamhour, M.D.

CERTIFICATE

State of Ohio,)
) *ss:*
County of Cuyahoga.)

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named JOSEPH A. JAMHOUR, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 3rd day of September, 1993.

_____
Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.
My commission expires September 13, 1993.