This deposition was delivered to C.A.T.A. with the following pages missing

Pages 34 to 39

Pages _____ to _____

Pages _____ to _____

IN THE COURT OF COMMON PLEAS

OF LORAIN COUNTY, OHIO

- - - - - - - - - - - - - - X

JASMINE MERRIWEATHER by and :
through her next Friend and :
Parent RHONDA MERRIWEATHER :
and RHONDA MERRIWEATHER, :
Individually and ORLANDO :
MERRIWEATHER, Individually, :
Plaintiffs, :
vs. : Case No. 98CV120349
ELYRIA MEMORIAL HOSPITAL :
and LIENGKONG SIEW, M.D., :
Defendants. :

- - - - - - - - - - - - - - X

Baltimore, Maryland

Saturday, September 18, 1999

Deposition of MICHAEL V. JOHNSTON, M.D., a witness herein, called for examination by counsel for Plaintiffs, in the above-entitled matter, pursuant to notice, the witness being duly sworn by ANN L. BLAZEJEWSKI, a Notary Public in and for the State of Maryland, taken at the offices of Salomon Reporting Service, 200 East Lexington, Baltimore, Maryland at 1:10 p.m., Saturday, September 18, 1999, and the

proceedings being taken down by Stenotype by ANN L. BLAZEJEWSKI and transcribed under her direction.

APPEARANCES:

On behalf of the Plaintiffs:

WILLIAM J. NOVAK, ESQ.
Rubenstein Novak, Einbund & Pavlik
1660 West Second
Cleveland, Ohio 44113
(216) 781-8700

On behalf of the Defendant Elyria Memorial Hospital:

JOHN W. JEFFERS, ESQ.
Weston Hurd Fallon Paisley & Howley
2500 Terminal Tower
50 Public Square
Cleveland, Ohio 44113-2241
(216) 687-3214

APPEARANCES (Continued):

On behalf of the Defendant Dr. Siew:
LYNNE K. SCHOENLING, ESQ.
Mazanec, Raskin & Ryder Co., L.P.A.
250 Civic Center Drive, Suite 400
Columbus, Ohio 43215
(614) 228-5931

CONTENTS

EXHIBITS

PROCEEDINGS

Whereupon,

MICHAEL V. JOHNSTON, M.D.,

business address at 707 N. Broadway, Baltimore, Maryland, was called as a witness by counsel for Plaintiffs, and having been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR PLAINTIFFS

BY MR. NOVAK:

Q. For the record, Doctor, can we have your name, please.

A. It's Dr. Michael V. Johnston.

Q. Dr. Johnston, before I start, could I see materials that you received from Ms. Schoenling regarding this case. This way it will be a little quicker, save a lot of time.

MS. SCHOENLING: Just to interrupt briefly, on the bottom of those records you will see University Hospital records. Those are my copies of the University Hospital records. The doctor does have UH records. He didn't bring them today, but he has them in his file and he has seen them prior to today.

MR. JEFFERS: Is this the 18th?

MS. SCHOENLING: Yes.

THE WITNESS: Time flies.

(Johnston Exhibit Nos. 1 and 2 were marked for identification.)

BY MR. NOVAK:

Q. Doctor, we received your CV before today, so I'm not going to waste any time going over any of your credentials. You do have a letter in your file which we've marked as Exhibit 1, and it's a letter dated which I believe is May 18, 1999?

A. Yeah.

Q. From Lynn Schoenling. In the first paragraph she indicates that you had worked with Beverly Harris who is a partner of hers in the law firm of Mazanec, Raskin & Ryder. Could you tell me what kinds of cases you've worked on with Beverly Harris in the past?

A. I don't remember.

Q. Do you have a recollection as to how many cases?

A. No.

Q. Would it be more than one?

A. I have no memory.

Q. Do you remember who Beverly Harris is?

A. No.

Q. Have you ever testified in the Cleveland,

Ohio -- I'm going to call it the greater Cleveland area?

A. I've given a couple depositions, yeah.

Q. Have you actually ever gone to court in the greater Cleveland area?

A. No.

Q. On the cases that you've given depositions on in the greater Cleveland area, do you have a recollection as to what kinds of cases those were?

A. I think they were infants, cerebral palsy. I think I worked with a firm, Remington.

Q. Reminger & Reminger?

A. Yeah, Reminger.

Q. Gary Goldwasser, does that ring a bell?

A. Could be, yeah.

Q. Do you remember the other firm that you worked with there?

A. No. I remember the guy I worked with, his wife worked for -- she may have worked at the Cleveland Clinic or something. There was some connection with somebody I knew at Hopkins with I guess the dean of Ohio State used to -- is married to the guy --

Q. Bernadine Healey is married to --

A. Yeah, so she knew Bernadine.

Q. Floyd Lupe.
A. That's the only way I remember.
Q. Have you ever testified for the plaintiff in any cases?
A. In Cleveland?
Q. Anywhere.
A. Yeah. I think overall it's 10 to 15 percent of the cases.
Q. 10 to 15 percent plaintiff versus about 90 to 85 percent defense?
A. Yeah, around 80 to 90 percent defense.
Q. And I also noticed you're buddies with Dr. Bonn; is that right?
A. Well, we were on the faculty at Michigan for eight years.
Q. You've written some articles with him?
A. Yeah.
Q. As you sit here today, do you have any patients in the hospital right now?
A. Yeah, we have about -- I forgot to check the census, but I think we have about 45.
Q. Did you make rounds this morning?
A. No.
Q. Did you make rounds yesterday?
A. No.

Q. Did you make rounds Thursday?
A. Thursday? I think I made rounds Wednesday.
Q. Now, when you make rounds, would it be fair to state that your conduct during rounds is as a teaching neurologist; is that right?
A. Well, I'm the chief medical officer, so I'm in charge of everything and hopefully there are no crises.
Q. But I guess what I'm saying is that your practice doesn't require you to be there on a daily basis, but you're there more in the position of a teacher for residents under you; is that right?
A. Well, it's sort of 24 hour responsibility, so sometimes I'm actually there, sometimes I sleep there, but usually that's confined to several months a year.
Q. Out of the course of a year, how much of your time is spent actively treating patients, percentage wise?
A. Percentage wise, about 60 percent.
Q. And the other percentage, 40 percent, would be what?
A. 5 percent classroom teaching, 15 percent pushing papers, and 20 percent research.

10

Q. And you've come up with 100 percent. Out of the 100 percent, is there any percentage attributable to doing any medical/legal consultation?

A. No. That's sort of off time, nights.

Q. How much of your income on an average from a percentage basis is based on medical/legal consultation?

A. Probably 15 percent.

Q. And the Kennedy Krieger Institute, could you tell me what that is?

A. It's a children's hospital. We also have a school and a research institute focused on brain disorders in children.

Q. And by the way, the cases that you had in the Cleveland area, were you ever deposed by a lawyer named Chuck Kampinski, a plaintiff's lawyer?

A. I don't remember, but my memory is terrible for lawyers' names.

MR. JEFFERS: Nobody remembers plaintiffs lawyers.

BY MR. **NOVAK:**

Q. In looking at the May 18, 1999 letter, in addition to your prior relationship with Beverly Harris, there's also a paragraph outlining what materials Lynn Schoenling sent you, and could you

tell me what materials were sent.

MS. SCHOENLING: Note my objection. I'm not sure that there was a prior relationship with Beverly Harris, but go ahead.

THE WITNESS: Sent me the Elyria Memorial Hospital records on the infant, the records from Elyria on the mother, fetal monitoring strips, deposition transcript of Dr. Siew, S-i-e-w, Dr. Howard Tucker, and Dr. John Engel.

BY MR. NOVAK:

Q. At the time that letter was sent, would it be fair to state that you did not have available to you the University Hospital records?

A. Yeah.

Q. Is that a fair statement?

A. Right.

Q. And at the time you wrote your report, which is dated June 23, 1999, in the first paragraph of your report there is no mention of the University Hospital records. Would it be fair to state, then, that you did not have those available at that time?

A. I'm not sure. I don't -- I mean, the key part of the University records are, you know, the MR scans, and so I didn't include that in the letter.

Q. So you're telling me, then, that the

clinical picture that this newborn presented at University Hospital commencing on November 12th was not important to you?

A. No -- well, I think the letter speaks for itself. The neonatal picture is incompatible with asphyxia.

Q. But my question for you is, do you feel as you sit here today that the clinical picture of November 12th and thereafter while this newborn was at University Hospital was totally irrelevant as far as you were concerned in terms of your evaluation of the cause in this case?

MS. SCHOENLING: Objection. He's answered that. Go ahead.

THE WITNESS: No. I think -- well, I'm not sure how to answer that. You say totally irrelevant. Obviously -- I mean, I think the later records, the January '93 and the August '93 records are of more importance than the 11-92 records because they give a better idea of what was actually going on.

BY MR. NOVAK:

Q. Let me ask you a couple of -- well, just so I understand, though, when you wrote this report, the first paragraph, there's no mention of the MRI,

no mention of the CT scan, fair statement?
A. Right.
Q. Would it be fair to state, then, that you didn't even have those when you wrote this report?
A. You mean the reports?
Q. Yes.
A. I'm not sure. I mean, I had -- Dr. Tucker, I think, recited a lot of this in his report, but I don't think at that point I actually had seen the MR reports from January; from November, January. I knew the MR and CT from 11-92 were normal, but I didn't know that the one in August of '93 was very abnormal because I would have probably put that in because that's, you know, absolutely critical to showing that this obviously had nothing to do with asphyxia, so I think I probably would have put that in if I had it.
Q. You don't have any opinion that there's a congenital microcephaly in this case, do you?
A. You mean the -- well, I saw the plot that Dr. Reiley did, and I think that -- I mean, the head was on the small side. I'm not sure if I would call it microcephaly, but to me the most telling part of that was that the head growth grew normally for a while and then fell off after about six months.

Q. Did you have a chance to read Dr. Reiley's deposition?

A. Yeah.

Q. Did you see where he said that his plotting was out of whack?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

MR. NOVAK: Are you going to start again?

MR. JEFFERS: Absolutely, Bill, when you keep mischaracterizing testimony, which is your norm, of course.

MR. NOVAK: Do you want a piece of me, old man?

MR. JEFFERS: Right now.

MR. NOVAK: Do you want to go out there? I've just about had it.

MR. JEFFERS: I'm here. Stand up, and we'll go. Okay.

MR. NOVAK: Let's go.

THE WITNESS: Come on, guys, I haven't got all day. I'm a pediatric neurologist.

MR. NOVAK: You're going to have to examine his head injury.

MR. JEFFERS: I've had a lot of head injuries.

THE WITNESS: We can deal with facts.

BY MR. NOVAK:

Q. Would it be fair to state that you do not share the opinion of Dr. Reiley in this case, that this is a case of congenital microcephaly?

A. Well, I thought his statements were pretty reasonable. It's just a question of -- I think he was quite right in pointing out that the head was on the small side at birth.

Q. But my question for you is, was this a case of congenital microcephaly?

A. I guess I would not quite have used that word, but I thought the growth was -- the growth pattern was certainly consistent with what the MRI showed, that the brain was really moving along pretty well until about six months, and then fell off, indicating that it's probably genetic metabolic disorder of brain growth.

Q. Dr. Reiley based his notion of congenital microcephaly based on the head circumference being in the third percentile or lower at the time of birth. You didn't see that, did you?

A. Well, I thought it was around the third percentile. I thought he had a good point. I think it's maybe just a terminology issue.

16

Q. Well, did you have a chance to look at the Elyria Memorial Hospital records and note that as a matter of fact the head circumference was noted to be appropriate for gestational age?

A. You mean that they put that down?

Q. Yes, they did.

MR. JEFFERS: Someone wrote it.

MR. NOVAK: One of your employees, John.

MR. JEFFERS: It doesn't matter. You already said they were nincompoops two depositions ago.

MR. NOVAK: Which is an accurate statement.

THE WITNESS: But the measurements he put down were around the third percentile. I thought that was --

BY MR. NOVAK:

Q. The ones he put down were around the third percentile, but would it be fair to state that based on your review of the Elyria Memorial Hospital records there is no indication of congenital microcephaly, is there?

A. You mean the measurements he put down were wrong? I mean, there is sort of two different things. I guess one is appropriate for gestational

age.

Q. Do you know what the measurement was at Elyria Memorial Hospital?

A. No.

MR. JEFFERS: I think there were multiple measurements.

MR. NOVAK: At Elyria Memorial Hospital.

MR. JEFFERS: Go ahead.

MR. NOVAK: The measurement is 32.5 centimeters, and according to that chart, that places it in the 25th percentile. That would be an appropriate for gestational age head circumference, wouldn't it?

THE WITNESS: Yeah, if that's what it was.

BY MR. NOVAK:

Q. Do you have a recollection as to what the charts at University Hospital had this head circumference at?

A. No, I didn't go into that.

Q. Now, if I told you that the head circumference measured at 4:15 p.m. on November 12th, was 33.2 centimeters, you would agree with me that that measurement is not consistent with congenital microcephaly, is it?

MR. JEFFERS: I want to object.

18

MS. SCHOENLING: I'll object, too.
MR. JEFFERS: You're not telling him that there were two others at 32.
MR. NOVAK: John, you can ask him what you want. I'm asking him my questions.
MS. SCHOENLING: I'm objecting to the question;
MR. JEFFERS: It's going to give an improper inference.
MR. NOVAK: Whatever.
THE WITNESS: I think my position is that the head size was on the small side, and that it's been characterized as microcephaly, which is probably not a word that I would use, but I think it's a semantic issue in terms of whether you call the head size -- my point is that it looked like the head was accelerating pretty normally for the first four to six months, and then kind of plateaued after that, which would be inconsistent with perinatal asphyxia as the cause.
BY MR. NOVAK:
Q. But would you agree with me that -- I want you to assume 33.2 centimeters is recorded on a chart at University Hospital at the time that this infant is there during the first admission. Would you agree

with me that that is not consistent with congenital microcephaly?

MR. JEFFERS: Same objection.

MS. SCHOENLING: Same objection here as well.

THE WITNESS: Yeah, but I didn't say it was consistent in the first place, so --

BY MR. NOVAK:

Q. And there is also a chart for the infant in January of 1993 at University Hospital, and that chart has the recording at the 50th percentile. Would that be consistent with congenital microcephaly?

A. No, not that measurement.

Q. Then there is a recording at --

MR. JEFFERS: Objection to the consistency. I'm not sure that's what that says.

BY MR. NOVAK:

Q. At nine months there is a 44 centimeter recording which places it just below the 50th percentile. Would that be consistent with congenital microcephaly'?

A. No.

Q. Okay. Now, you have some basic knowledge, do you not, even though you're not an ob/gyn, of

fetal heart monitoring, don't you?

A. A little bit, yeah.

Q. Would you agree with me that an elevated fetal heart baseline is consistent with tachycardia of the fetus?

A. Oh, okay, sure.

Q. IS that a fair statement?

A. Sure.

MS. SCHOENLING: You're asking him generally?

BY MR. NOVAK:

Q. Would you agree with the concept that cord compression can manifest itself as elevated fetal heart rate?

MS. SCHOENLING: Generally?

MR. NOVAK: Generally.

MS. SCHOENLING: Let me just interject an objection as to this line of questioning, only on the basis that Dr. Johnston was not retained as an oblgyn expert, he does not hold himself out to be an ob/gyn expert, and for that we will maintain an objection to any OB type questions.

MR. NOVAK: Right. Right. And the reason I'm asking these questions is much of Dr. Johnston's writing does contain references to Apgar scores, pH

levels, and also fetal heart monitoring, which is within the realm of ob/gyn, so I'm assuming you have some general knowledge of fetal heart monitoring.

MS. SCHOENLING: He has already told you that.

BY MR. NOVAK:

Q. Based on fetal heart monitoring, my question to you is, can tachycardia as manifested in a fetal heart strip be consistent with cord compression?

A. Yeah, sure.

Q. And if you have a true knot in a nuchal cord and when the contractions cause the knot to tighten and loosen, can that cause the fetal heart rate to elevate?

A. Well, there are a huge number of things. Most of the changes in fetal heart rate are false positives, so there must be -- so that must be one of probably 50 different things.

Q. But I guess my question to you is, would you agree with me that a nuchal cord that has a knot in it that compresses on and off can cause the fetal heart rate to elevate?

A. It might, sure.

Q. Do you have an impression as you sit here

today, having reviewed Dr. Siew's deposition and defending his position in this case, as to his skill level, just based on the review of his deposition?

MR. JEFFERS: Skill levels, you mean in speech or practice?

MR. NOVAK: No, skill as a practitioner.

MR. JEFFERS: Objection.

MS. SCHOENLING: I'm going to object as well, not only on the basis that this witness is not an OB, but you're asking him to base it only on a review of a deposition transcript?

MR. NOVAK: Right.

MS. SCHOENLING: Objection.

BY MR. NOVAK:

Q. Do you have any opinion of Dr. Siew as a practitioner, just based on the deposition?

A. No, I couldn't get any idea about that.

Q. By the way, having practiced in a hospital setting, you're aware that hospitals have various guidelines for nurseries; isn't that right?

A. Yeah.

Q. Have you seen the guidelines for the Elyria Memorial Hospital with respect to the nursery?

A. No, I didn't do anything related to standard of care.

Q. But with respect to the standard of care, did Miss Schoenling show you any guidelines that Elyria Memorial Hospital has for its nurses?

A. I would just be talking about causation, not standard of care.

Q. In reviewing the Elyria Memorial chart, were you aware of the standing orders that were in place for the nurses who were taking care of this newborn on the nursery floor?

A. No. And it's really irrelevant to my opinion, which is really about what happened to the baby. It has nothing to do with the environment of standard of care.

Q. Would you agree with me that if a nursing care plan requires a nurse to record and report significant findings as respects breathing patterns and a nurse doesn't do that, that that would be a violation of the standard of care?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

MR. JEFFERS: This is outside the realm he said the scope of what his testimony was, which is causation. It has nothing whatsoever to do with it, and he has not been presented as an expert in that realm and should not be offering testimony in that.

I object to your asking about it, and I would object to any answer. Let me have a continuing objection, and then I will attempt not to interrupt you on this same subject.

MR. NOVAK: Uh-huh.

MR. JEFFERS: Say yes.

MR. NOVAK: I'm going to be a perfect gentleman.

THE WITNESS: That's good.

BY MR. NOVAK:

Q. Once again, I'll ask you, if the standing orders require the nursing staff to report significant findings with respect to breathing pattern and it is not done, would that be a violation of the standard of care as far as you're concerned?

A. I don't have any opinion on that.

Q. If a nurse doesn't follow your standing orders at Johns Hopkins University Medical Center, you wouldn't be a happy camper, would you?

MR. JEFFERS: Objection.

THE WITNESS: It would depend on the Circumstances.

BY MR. NOVAK:

Q. So if the circumstances would be that a newborn that's under your care stops breathing and

there's a standing order to report any findings relating to breathing patterns and the nurse doesn't tell you that the newborn stops breathing, you wouldn't be real happy about it, would you?

MS. SCHOENLING: Objection.

MR. JEFFERS: Objection.

THE WITNESS: First I would gather data to find out what actually happened.

BY MR. NOVAK:

Q. Now, do you know how long the infant stopped breathing in this case?

A. I couldn't really be precise about it, no.

Q. Doctor, the fact of the matter is, that as we sit here today, we really don't know how long this infant stopped breathing, do we?

A. Yeah, I think that's what I said.

Q. Let me ask you, there was testimony from Dr. Reiley, and he said that if this infant had an apneac episode for three hours, it could result in cerebral palsy. Is that a fair statement?

MR. JEFFERS: Objection. That's out of context.

MS. SCHOENLING: I'm going to object as well.

MR. JEFFERS: It is not dealing with HIE

versus metabolic injuries.

MS. SCHOENLING: Same objection.

MR. JEFFERS: I object to you questioning, him anyway, since you've already defined what his realm is in this.

MR. NOVAK: All right, can we go back to that.

MR. JEFFERS: Sure. I'm sure you'll find something.

BY MR. NOVAK:

Q. If you have a situation, Doctor, where this infant stopped breathing for three hours, would you agree with me and agree with Dr. Reiley that that could result in cerebral palsy?

A. Well, usually a lot of -- yeah, they are really prevented from having cerebral palsy because they don't survive. I think that would be sort of a nonsurvivable question.

MS. SCHOENLING: Was the question three hours?

MR. JEFFERS: Yeah. Obviously the baby is dead.

MS. SCHOENLING: He would be dead by that time.

BY MR. NOVAK:

Q. Let me ask you how many hours of an apneac episode could you have that could result in a living infant that had cerebral palsy?

MR. JEFFERS: Would you read that back to me, please.

THE REPORTER: "Question: Let me ask you how many hours of an apneac episode could you have that could result in a living infant that had cerebral palsy?"

THE WITNESS: The Perinatal Collaborative Study published data on that and found that an Apgar score of 3 or less that was prolonged for 15 minutes, was where you began to get the inflection in the curve, and that I think about 15 percent of babies who had Apgars of 3 for 20 minutes ended up with cerebral palsy, so it was a risk, although the majority still survive without impairment.

BY MR. NOVAK:

Q. If this episode of apnea at 1:30 lasted for more than 20 minutes, could it result in cerebral palsy?

MR. JEFFERS: Objection.

THE WITNESS: The intermediary would have to be significant metabolic acidosis. In other words, you would have to have some evidence that

there was a large base excess, usually in the minus 20s, very low bicarbonates, that sort of thing. So I think really that's the critical issue is how much metabolic acidosis was there.

BY MR. NOVAK:

Q. But we're talking about the newborn being on the nursery floor at 1:30 in the morning, 12 hours post-delivery, and the infant has this apneac episode which we don't know how long it lasted because the nurse's notes don't reflect how long it lasted. Would it be fair to state that if the episode lasted 20 minutes, it could result in cerebral palsy?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

THE WITNESS: Well, you really have to have other signs of systemic illness. That's why the Apgar is so relevant. You're really talking about not just apnea, you're talking about poor perfusion, you're talking about low blood pressure and slow heart rate.

BY MR. NOVAK:

Q. Doctor, I'm not on the Apgar score delivery, I'm talking 12 hours post-delivery. The question I have is, in the period of time 12 hours post-delivery, we have an infant that has an apneac

episode at 1:30 in the morning, we don't know how long it lasts, and I want you to assume that it lasts 20 minutes. Can that result in cerebral palsy?

MR. JEFFERS: Objection.

MS. SCHOENLING: He has already answered the question, now, Bill, twice.

MR. NOVAK: No, I'm assuming that up to that time everything is fine. Let's assume that there were no prior problems at the time of labor and delivery with this child, but we have an apneac episode that occurs at 1:30 in the morning and lasts for 20 minutes.

MS. SCHOENLING: Are you also assuming 6 and 8 Apgars in your scenario?

MR. NOVAK: Yeah, yeah, everything else. Let's assume the following. You have a normal labor and delivery, infant goes to the nursery, and at 1:30 in the morning, approximately 12 hours post-delivery, the infant has an apneac episode that lasts 20 minutes.

MR. JEFFERS: In this baby or in general?

MR. NOVAK: In general. Can that result in cerebral palsy?

MR. JEFFERS: Objection.

THE WITNESS: I think you're saying just

apnea, though, not other --

MR. NOVAK: Right, just apnea, just stops breathing for 20 minutes, can it result in cerebral palsy?

THE WITNESS: I think that's where the Apgar -- or data from the Perinatal Collaborative Study is important because whether it was at birth or whether it was at 12 hours, you would have to get into a cardiac arrest situation.

BY MR. NOVAK:

Q. And we don't know if there was a cardiac arrest because the nurses never called anybody, did they?

MR. JEFFERS: Oh, objection. The record's clear there is no cardiac arrest in this.

MR. NOVAK: Doctor, is there any indication in this chart as to the time, the length of time that this apneac episode lasted?

MR. JEFFERS: Other than inferential?

BY MR. NOVAK:

Q. Is there anything in the chart? Nothing, is there?

A. No, I couldn't see exact -- but it would have to be severe enough to get to the point of needing resuscitation, full resuscitation. It has to

be in that 3 or less Apgars.

Q. But I'm assuming, for instance, that we have a normal child, Apgar scores are normal, no fetal distress, we have a child who suddenly has an apneac episode that lasts for 20 minutes. Can that result in cerebral palsy?

MR. JEFFERS: Objection. He has just responded to that.

THE WITNESS: Not absent the kind of physiologic depression that would be represented by an Apgar of 3.

BY MR. NOVAK:

Q. Have you ever seen a child who is being fed begin to choke and stop breathing?

MR. JEFFERS: Begin to what? Choke?

MS. SCHOENLING: Being fed and begins to choke?

MR. NOVAK: And stop breathing. Have you ever seen that?

THE WITNESS: Yeah.

BY MR. NOVAK:

Q. Is it possible that an infant can begin to choke while being fed the first time and suffer an apneac episode?

A. Sure.

Q. Depending on the skill of the nurse available, can that apneac episode take some time before the infant recovers?

A. Yeah.

Q. And I guess my question for you, just this question, can you have an apneac episode that lasts 20 minutes that can result in cerebral palsy?

MS. SCHOENLING: Objection. He's answered it four or five times now.

MR. JEFFERS: Objection.

THE WITNESS: Not absent the kind of physiologic depression that would be represented by an Apgar of 3.

BY MR. NOVAK:

Q. But if the infant is being fed, begins to choke, and stops breathing, apart from the Apgar scores, we're talking about someone who is normal on the nursery floor, being fed, starts choking on the formula, and stops breathing, and it lasts for 20 minutes. Can that result in cerebral palsy?

MR. JEFFERS: Objection.

THE WITNESS: No, because, see, there's kind of a blur where you stop using the Apgar and you start using the advanced cardiac life support, but basically the same guidelines in terms of heart rate,

breathing, tissue perfusion, and blood pressure, and what we're saying is that you can be apneac for long periods of time, but as long as it doesn't get to the point where your heart rate is very low, you're not perfusing your tissues, the kind of thing that would trigger a resuscitation, then there is really no risk that your brain is going to be injured.

BY MR. NOVAK:

Q. Did you find it somewhat interesting that both times when they attempted to feed this newborn, on both occasions the apneac episode followed an attempt to feed it? Did you find that interesting at all?

A. Yeah, I was interested in that.

Q. And did you notice that the newborn was gagging during both of those episodes?

A. Yeah.

Q. Are you aware that nurse Polly Kapronica was a relatively new registered nurse who was on an orientation program on the floor at that time? Were you aware of that?

A. No.

Q. Were you aware that the nurse who fed this newborn the first time was an LPN, and the RN wasn't even around? Did you know that?

MR. JEFFERS: Not his total opinion.
MR. NOVAK: I understand. But one of them was written by John Freeman and Karen Nelson, who work under you at Johns Hopkins, don't they?
THE WITNESS: No, Freeman was -- Freeman's still there. He was one of my teachers.
BY MR. NOVAK:
Q. How about Karen Nelson?
A. She's a colleague down at NIH. They're both --
Q. You know both of them?
A. Yeah.
Q. Let me ask you if you agree or disagree with this statement.
MS. SCHOENLING: Referring to the interim part of asphyxia and cerebral palsy article of Freeman and Nelson?
MR. NOVAK: Yes.
MS. SCHOENLING: What page?
MR. NOVAK: Page 244 at the bottom. Although nonpreventable factors can cause neonatal seizures, such seizures during the first 48 hours of life are now suggested as possible indicators in groups of patients of a quality of intrapartum obstetrical care and evidence of intrapartum

asphyxia.

MR. JEFFERS: This is the 1988 article, right?

MR. NOVAK: '87.

MR. JEFFERS: '88.

BY MR. NOVAK:

Q. Do you agree with that statement?

A. Yeah, I agree with that, sure.

Q. And would you agree with this statement on the same page, it says infants who have suffered sufficient intrapartum asphyxia to result in irreversible brain damage and subsequent cerebral palsy often have seizures during the first 48 hours of life?

THE WITNESS: Yes.

MS. SCHOENLING: This is the paragraph on 245?

MR. NOVAK: The second full paragraph. Would you agree with that statement?

THE WITNESS: Right.

BY MR. NOVAK:

Q. Okay.

A. Of course the next sentence says, however, it does not follow that all infants who have such seizures and later neurologic deficit had these

seizures because of asphyxia.

MR. NOVAK: Right, right.

BY MR. NOVAK:

Q. And then on page --

MR. JEFFERS: This is the article about asphyxia?

MR. NOVAK: Right.

BY MR. NOVAK:

Q. Page 247, second column, second -- I'm sorry, first column, second full paragraph, second sentence from the end, it says however, if a child has cerebral palsy and had evidence of perinatal encephalopathy, then the encephalopathy may have been due to intrapartum asphyxia. Do you agree with that statement?

MS. SCHOENLING: Where are you, Bill?

MR. NOVAK: First column, second full paragraph, second sentence from the bottom.

MS. SCHOENLING: Starting with the word, "however?"

THE WITNESS: Yeah, okay. However, if a child has cerebral palsy and had evidence of perinatal encephalopathy, then the encephalopathy may have been due to intrapartum asphyxia.

BY MR. NOVAK:

Q. Do you agree with that statement?
A. Yeah, if that infant had sufficient asphyxia to result in permanent deficit, then signs and symptoms are likely to have been present in the delivery room as well.
Q. Okay.
A. Which they weren't here.
Q. Let's kind of hold on to that thought for a minute. Then in the very top of the second column on that same page it says, acidosis (cord or scalp pH of less than 7.1), is probably the best evidence of intrauterine asphyxia and of its duration/severity, but unfortunately in this case we don't have the cord or scalp pH; am I right?
A. Right.
MR. JEFFERS: Wait, wait. There's two questions there.
BY MR. NOVAK:
Q. You're not going to render an opinion in this case as to what you think the cord or scalp pH would have been had it been analyzed?
A. I think your earlier question was exactly what it was. I mean, I think an hour later there really was no metabolic acidosis. I think the bicarb was 26, the base excess was minus 4.

Q. But the pH was 7.21?
A. Right, which is normal for the average. It would certainly be normal for a cord pH, but you couldn't have had a pH in the asphyxia range in the cord when an hour later you have a bicarb of 26.
Q. Except an hour later this infant was on oxygen, was it not?
A. Yeah, but oxygen doesn't affect the bicarb.
Q. Now, are you aware that Dr. Reiley testified that at 1359 that blood study was acidotic?
A. Oh, yeah, it was acidotic, but the key thing for the hypoxia is not the pH, it's the base excess and the bicarb because it's sort of like the old baking soda and vinegar experiment that you add the vinegar, and then the baking soda gets turned into CO 2, and once that happens to a point where the baby is asphyxiated, there's no way to replenish that bicarb unless somebody infuses it.
Q. Except the HCO 3 is never mentioned in any of these articles. They always talk about the cord or scalp pH, don't they?
A. Well, it's not mentioned in this article. Now, I think the publication that supersedes this is the NIH consensus meeting on the definition of acute

intrapartum asphyxia that was published in 1997, I think, and there they talk about base excess, and that's what -- I think a lot of articles talk about base excess and sort of link pH to a severe metabolic acidosis.

Q. In your article on hypoxic and ischemic nervous system disorders, you make reference to the NIH consensus group on perinatal asphyxia, and you make no mention, do you, of the bicarb, but in fact speak in terms of a pH of less than 7 at five minutes; isn't that correct?

A. I don't know. It's been a while since I've read that. Yeah, I guess I didn't put it in. But that's what the NIH consensus group on perinatal asphyxia indicated.

Q. Would you agree with me there's nothing in your article about the HCO 3; your article limits the blood study to a pH of less than 7 at five minutes; is that right?

MS. SCHOENLING: In this article that we're referring to, hypoxic and ischemic nervous system disorders.

THE WITNESS: Let me read that again.

MR. NOVAK: Right. Right.

MS. SCHOENLING: And the year of that

publication?

MR. NOVAK: 1995, and it makes reference to the NIH consensus, which he made reference to before I asked him about this question.

THE WITNESS: That's interesting, that sentence should read Apgar score of 3 or less at five minutes combined -- it doesn't really change it, but it just got switched around, combined metabolic and acidosis. It says pH of less than 7.

MS. SCHOENLING: What page is that, Bill?

MR. NOVAK: Page 14.

MS. SCHOENLING: Thank you.

BY MR. NOVAK:

Q. I have a question for you, Doctor. In that same article you make the following comment: You say the term HIE, and we're talking about hypoxic ischemic encephalopathy, describes the syndrome of brain dysfunction that can follow a substantial period of severe hypoxemia combined with brain ischemia. The neonatal neurologic manifestations of HIE include coma, severe lethargy, hypotonia, poor feeding, seizures, and respiratory distress.

Let me ask you, in this case on November the 12th when this infant was taken into the SAR admit note at University Hospital, there is mention

of the following: Lethargy, hypotonia, and you would agree with me that up until that time there was seizure activity, was there not?

A. Right.

Q. There was also poor feeding, wasn't there?

A. Yeah.

Q. And there was also some respiratory depression, was there not?

A. Well, just during the seizures.

Q. And as I followed reading that article it says, these clinical features typically develop over a period of 12 to 24 hours after an asphyxial insult, probably corresponding to the time needed for the neurotoxic cascade to produce neuronal dysfunction.

Would you agree with me that the seizure activity in this case developed between 12 and 24 hours after labor and delivery?

A. Yeah.

Q. Would you agree with me that the note that's recorded here on November the 13th was somewhere in a period of 24 hours after labor and delivery?

A. Say that again.

Q. The note that demonstrates the hypotonia is sometime at around 12 to 24 hours after labor and

delivery?

A. Yeah.

Q. Would you agree with me that the episode of poor feeding occurred sometime between 12 and 24 hours after labor and delivery?

A. Sure.

Q. Would you -- are you going to offer any testimony on issues relating to the necessity for multi-organ compromise as being a necessity in a case of hypoxic ischemic encephalopathy?

A. Well, generally you like to see a pretty good bump in the creatinine.

Q. But would you agree with me that you don't have to have multi-organ failure in all cases of hypoxic ischemic encephalopathy, do you?

A. Well, that's a different question. I think the question is more what, you know, what makes a diagnosis that you can be comfortable with, and I think that to really be comfortable with that -- well, asphyxia -- as you know, in order to say that asphyxia caused it, number one, you've got to have evidence of asphyxia, which you don't in this case, so that's a problem. Then you've got to have encephalopathy, which you do have, but we know that most of the time encephalopathy and seizures are not

produced by asphyxia. In fact, the Australian study, the western Australian study showed that two-thirds of the time it was not due to hypoxia, and then I think the proper place of the creatinine is once you've documented asphyxia and once you've documented that the encephalopathy probably is related to asphyxia, then I think the creatinine is kind of the icing on the cake, that you really want to nail it, and I think you've got to see a pretty good bump, a rise in the creatinine.

Q. Let me ask you this: Are you familiar with Pearlman's studies that indicated that in 67 percent of cases that he studied of HIE, 60 percent of those had multi-organ dysfunction, 33 percent did not? Are you familiar with that study?

A. Well, it's the old chicken and egg problem. In other words, what were the criteria that this was really HIE. I think if you take a careful look at HIE, this was the British Medical Journal study that was published in December of '98, you know, intrauterine growth, retardation, congenital anomalies, maternal thyroid disorders or infection were far more common causes than hypoxia. Without the imaging, how do you really know that this actually damaged the brain?

Q. Well, you mentioned about the bump in the serum creatinine. In this particular case, the serum creatinine was elevated at .9 at University Hospital; isn't that correct?

A. That's not really elevated for a baby, though. The baby generally reflects the mother, which usually -- often babies are born with 1.5, 1.6, and then --

MS. SCHOENLING: Serum creatinine, Doctor, the 1.5?

THE WITNESS: Yes, the serum creatinine.

BY MR. NOVAK:

Q. According to the University Hospital laboratory ranges, .9 for that hospital, for that children's hospital, is an elevated serum creatinine. Do you agree or disagree with .9 as being elevated?

A. No, it's not elevated.

Q. Are you aware that this newborn had grossly bloody stools on the 14th of November?

A. Yeah, I think they were.

Q. Would you agree with me that grossly bloody stools can be a result of enteritis?

A. Yeah, sure.

Q. And would you agree with me that an enteritis can be the -- what's the matter, John? Is

something wrong?

MR. JEFFERS: I'm just watching your inference on an inference on an inference ad nauseam.

MR. NOVAK: You don't like this?

MR. JEFFERS: You asked me what I was thinking about.

THE WITNESS: Maybe I'll save you some time. As far as multi-organ dysfunction to me, it means congestive heart failure and renal failure, and the rest of it doesn't mean a whole lot to me. It probably should, but it doesn't.

BY MR. NOVAK:

Q. Now, I asked Dr. Reiley, who's a neonatologist, the question, and I asked him the following: I asked him, now, to have multi organ injury doesn't mean permanent injury to each of the organs necessarily, but it can mean some compromise to those organs; isn't that right? And he answered yes. Do you agree with that question and the answer?

A. Yeah, I agree.

Q. Okay.

A. But just so it's clear, there was no kidney dysfunction, no heart dysfunction in this case. To me that means it's case closed.

Q. Well, I asked him this question: I asked

him, a child who has had an hypoxic ischemic event can have enteritis manifested by grossly bloody stools; isn't that correct? And his answer is, that's correct. Do you agree with that?

A. Not really. I mean, I don't --

MR. JEFFERS: What page is this, Bill?

MR. NOVAK: Page 63.

THE WITNESS: I don't really see bloody stools as evidence of anything. I guess in my experience it's more related to some bleeding disorder or something like that rather than --

BY MR. NOVAK:

Q. Now, Dr. Reiley with respect to the Pearlman question on the 67 percent indicated that that's correct, the kidney with or without involvement of the lung.

MS. SCHOENLING: What page?

MR. NOVAK: Page 60. Would you agree with that?

THE WITNESS: No, my opinion is, which I'm not going to change, that it's kidney failure, heart failure or nothing.

BY MR. NOVAK:

Q. Let's talk about the picture at the time of delivery. You're aware that there was fetal

distress, aren't you?

A. Well, they wrote it down. I mean, to me fetal distress is a lot like that car alarm we just heard go off. They go off all the time, but how many of them actually represent somebody breaking into your car I think is another matter. I think fetal distress is one of those things. It's like an alarm bell that rings. In the Perinatal Collaborative Study, for every baby that was actually truly in harm's way, there were 20 that were totally normal, so fetal distress just means to me that somebody sort of pulled an alarm bell. It doesn't mean much.

Q. And the fact that there was thick meconium in this, case does that concern you at all?

A. As far as I know neurologically it's irrelevant.

Q. Would you tell me what your understanding is as respects the difference between light meconium staining and thick meconium?

A. It has no meaning.

Q. So you don't think there's a difference at all?

A. Zero.

Q. And what about the fact that the thick meconium in this cord was suctioned four times below

the cords?

A. It has no meaning to me.

Q. Okay.

A. I'm sure to the person sucking, it was important.

Q. So from a standpoint of fetal distress, at the time of delivery when we looked at the sheet which has been called the initial newborn profile at Elyria Memorial Hospital Medical Center, the only recording that's important for you is the Apgar score; is that right?

MS. SCHOENLING: You're asking him on the initial newborn profile, which is page 4 of the infant's Elyria Memorial records, you're asking him, is the only thing that he deems relevant on this entire sheet, would that be the Apgars, is that the question?

MR. NOVAK: Yes.

MS. SCHOENLING: Okay.

MR. NOVAK: From his standpoint.

THE WITNESS: Well, I think it's all relevant. I think that the established criteria for trying to link asphyxia to a neurologic problem include, number one, whether there was asphyxia, which there wasn't; two, whether there was

encephalopathy, which in this case I think is debatable, although certainly you have to say there was some encephalopathy, and then the third leg of the stool is whether there was a plausible connection with asphyxia to the brain damage as visualized by MR scanning, which there wasn't. So having said that, I think every bit of information here is relevant. The fetal distress happens to be particularly less relevant than the rest because that is so commonly seen, and as we know, if we use fetal heart rate monitors, that the false positive rate for positive fetal heart rate tracings is, I think, generally accepted to be in the range of 95 to 99 percent.

BY MR. NOVAK:

Q. I'm not trying to be argumentative, Doctor, but somebody obviously thought it was important enough to write down fetal distress under the newborn data; is that right?

A. It was important at the time it was written just as the person whose car has their alarm ringing right now is very concerned about going down and checking it. Now, once they go down and find out that nothing's happened, that maybe it was just a little bump, it rapidly loses significance, and that's the state I'm in. I'm not in the driver's

seat here, I'm not caring for this baby. Years later we're looking now, and I'm saying from my standpoint in terms of the causation, it's not very relevant. It obviously was very relevant for the person who wrote it down.

Q. Would you agree with me that a knot in the cord can cause asphyxia?

A. The latest data I heard was Thursday when Karen Nelson and I were both lecturing side by side to the American Academy of Cerebral Palsy in Washington, and as far as I know the only cord-related problem that has been associated with cerebral palsy is a tight nuchal cord. I've never heard that a knotted cord is associated, but that's -- I'm sort of giving you the entire database I have on that.

Q. Can you have a knotted cord which is tight?

A. See, there I don't know. I couldn't comment.

Q. But that's not within your realm of expertise?

A. Yeah. Sort of perinatologist or somebody like that.

Q. Okay. I have a question for you, and it

relates to something you wrote in 1989 in a volume called Contemporary Issues in Fetal and Neonatal Medicine, and it's called Birth Asphyxia: Issues in Neurologic Management, and on page 106 of that article you write about anticonvulsive -- convulsant prophylaxis or treatment for seizures, and it says the following: Aside from maintenance of adequate cerebral perfusion, prevention of convulsions or -- their rapid control when they occur has the strongest rationale of any intervention in the asphyxiated infant. As outlined above, seizures are likely to add a major insult to the preexisting injury and vigorous but safe anticonvulsant therapy is strongly indicated. Attention needs to be given to the identification of infants who should be placed on prophylactic anticonvulsants after asphyxia since the seizures are difficult to stop once they begin. .

And I guess my question for you is the following: It's my understanding that your opinion in this case is that whatever injury there was in this case antedated labor and delivery; is that right?

A. No, that's not quite right.

Q. Well, when do you then feel that the injury occurred in this case?

MR. JEFFERS: Objection.

THE WITNESS: Well, I think -- let me make sure what I said here. Okay. Let me be -- because I think I tried to write this in very clear English. I'm reading from my report of June 23rd. The records indicate that both the child's current neurologic condition and the neonatal seizures with stiffening cyanosis in the neonatal period reflect a serious preexisting disorder of brain development that antedated by a considerable period.

MR. NOVAK: Right.

THE WITNESS: You asked me just now about damage, when did the damage occur.

MR. NOVAK: I'm sorry, and I apologize.

THE WITNESS: What I'm saying is that this child has a preexisting disorder of brain development which caused the seizures but has continued to unfold with brain damage that we know even from January '93 when the MRI was normal, so that even months later, so this is sort of like a time bomb waiting to unfold in this child's brain, and that the damage unfolded from January to August.

BY MR. NOVAK:

Q. Would you agree with the statement that you have on page 106 of this article?

A. Yeah, I would because -- and I can -- I've updated it recently. I think citation 72 --

MR. JEFFERS: What is that citation 72?

THE WITNESS: Where is that CV? This is still an area that people are looking into, the issue of phenobarbital. Now, I think what I said was that it had the most plausible rationale or the strongest rationale; right?

MR. NOVAK: Uh-huh, right.

THE WITNESS: So I don't think that quite says that you've got to do it. I think it says of any of the things that you could do that might do harm, that might have the strongest rationale. Now, on page 25 of the CV there's an article that should be coming out soon, number 72, that's called -- it's published in Current Treatment Options in Neurology, and that's a brief article, but that goes over the same territory because there's a study by Hall from Kansas City that was published in '98, where they specifically looked at a trial of phenobarbital versus no phenobarbital for seizures and felt that maybe there was some protection, but it's not really clear.

BY MR. NOVAK:

Q. I guess the reason I'm asking this is that

if you assume that there were seizures that occurred at 1:30 and at 4:00 on the morning of the 12th, I guess is the reasonable approach to treat seizures as early as they occur because if you treat them earlier, you would like to think that you're going to have somewhat of a preventive role for seizures occurring down the road?

MR. JEFFERS: Objection.

THE WITNESS: Well, that would be the rationale. That's why it says the strongest rationale. Now, whether that works or not, as I said, is still under debate. Ten years later people are still giving trials. So I think when people -- there's this concept of equipoise in clinical investigation that you don't do a trial if it's already accepted that you've got to do it, so if it were known, then there would be no trial.

BY MR. NOVAK:

Q. But in an ideal situation what you would like to do is if you saw an infant that was having seizure, you would personally like to treat it with phenobarbital for seizure?

MR. JEFFERS: Objection. You're asking what he personally would do.

THE WITNESS: Yeah. Not knowing, though,

whether you're really doing any good and not knowing in 1989, not knowing in 1998.

BY MR. NOVAK:

Q. But the theory is if you treat the first one, you're hoping that it's going to have a limiting impact on seizure activity down the road?

MR. JEFFERS: Object.

MR. NOVAK: I mean, that's the theory?

THE WITNESS: Yeah, it's a hope. Yeah.

MR. NOVAK: I think I'm almost done. Let me just think for a couple more seconds. You've behaved yourself today.

MR. JEFFERS: I thought I've been very calm other than things where you've provoked me.

MR. NQVAK: Oh, yeah, I do have one last question, two last questions.

MR. JEFFERS: Oh, my.

BY MR. NQVAK:

Q. Did you ever hear of a corrected pH? Do you know what a corrected pH is? I've got to tell you, as long as I've been handling these cases, I've never heard of a corrected pH. Do you know what one is?

A. You mean like tried to back calculate or something?

Q. Yeah, have you ever heard of anything like that?

A. I've seen people do that.

Q. Have you? I mean, what's the purpose of it, do you know?

A. No.

MR. NOVAK: Okay. I'm done. Thank you.

EXAMINATION BY **COUNSEL** FOR DEFENDANT

BY MR. JEFFERS:

Q. Doctor, there's clearly no question in your mind that hypoxia or anoxia had nothing to do with the damage that we witness today in this patient, correct?

A. Right. I think from -- I think the experience with imaging, with brain imaging, that in a child with such a severe disability, that if asphyxia were the cause, we would definitely see it on the MRI scan, and I think we would see it, you know, within a couple months of the injury, so I think it's not going to be silent. So the fact that the brain really looked normal on imaging until January '93 and then showed some white matter changes and atrophy after that time indicates that this is some other yet-to-be-diagnosed process.

Q. And as such, then as far as you're

concerned, whatever treatment occurred during labor and delivery or post-labor and delivery at Elyria Memorial Hospital is irrelevant to your conclusions, correct?

A. Yeah, and that's the way that I think any neurologist works back from what's the child's condition, what could be the explanations and working back, and if it looks like that that's just not in the range of possibilities, then I think you would spend less time on the events actually in that period.

Q. With what's going back and forth on the use of phenobarbital relative to the treatment of seizures, you can't say based upon reasonable medical certainty and probability that the use of phenobarbital will necessarily improve the status of an infant suffering seizures, correct?

A. No. I think the -- that's right. I think it's debatable, and specifically those comments were directed not at a child with any kind of seizure, but seizures in the context of asphyxial injury, so if it's established that the asphyxia has occurred and the seizures are truly reflecting the expression of the asphyxial injury, then the rationale would be, well, maybe you can do some good by reducing the

seizures. I think in this case where it looks like the baby was expressing the beginnings of a lifelong epileptic encephalopathy, in those situations I don't think there is much evidence at all that control really does much, so I think it depends on the disorder that you're treating, and seizures are pretty nonspecific expression of many brain disorders in children.

MR. JEFFERS: Thank you. That's it.

EXAMINATION BY COUNSEL FOR PLAINTIFFS

BY MR. NOVAK:

Q. In light of Mr. Jeffers' questions, I guess I just have one general question. I understand that your opinion is going to be based on the CT and the MRI films, and the fact that they were normal in November and January, and then there was a change in August, and that based on those reports you feel that it's impossible that this could have been a situation related to labor and delivery; is that right?

MS. SCHOENLING: Note my objection. His opinions are not exclusively reliable on just those items, but --

MR. NOVAK: I understand. But in large part you're basing it on those films, the reports?

MS. SCHOENLING: Objection.

THE WITNESS: Yeah, I think they're very --

BY MR. NOVAK:

Q. I guess the only thing that puzzles me is that throughout the stay of this infant at University Hospital during November of 1992, in spite of the normal CT that was recorded, physicians continued to write down HIE secondary to tight nuchal cord, HIE secondary to perinatal asphyxia, birth depression, birth related, and we see this go all the way through up until even in the Cleveland Clinic where we see cause as perinatal asphyxia recorded in this chart, and I guess my question is, why do all these physicians keep writing these kinds of notes down in the face of the CT scan and the MRIs which they all had access to?

MS. SCHOENEING: Objection. They also wrote down metabolic deficiency, congenital deficiency, and you forgot to mention that in your question, so I think if we're going to address what was written down in the neonatal phase, let's address everything that was written down in the neonatal phase, not just portions of it.

MR. NOVAK: Would you kindly --

THE WITNESS: I see what you mean. I

66

think the -- and I looked over that. I was just reviewing that before the deposition because the Cleveland Clinic notes, when they did that MRI scan, really focused more on genetic metabolic.

BY MR. NOVAK:

Q. They didn't find any, did they, genetic metabolic?

A. Well; not so far. In the discharge summary on August 9th, they say that the --

MS. SCHOENLING: These are the UH records.

THE WITNESS: Yeah, University Hospital. Seizure disorder was evaluated and its etiology was searched for, so on 8-5 they were doing metabolic workup, skin biopsy for fibroblast culture for enzyme, mitochondrial assay, so they weren't looking for asphyxia there. They were looking for --

BY MR. NOVAK:

Q. What's the date of that?

A. That's on August 5th. August 4th they were looking for -- bloods were drawn, including metabolic screens, ammonia, creatine. Then on August 4th they were talking about, they said further evaluation of etiology of seizure disorder per neurology, metabolic workup on blood.

Q. But the Cleveland Clinic, there was no

mention at the Cleveland Clinic, was there, of any metabolic disorders, was there?

A. Yeah, I mean the chart's filled with discussion of possible metabolic disorders.

Q. At the Cleveland Clinic?

A. Oh. This is University Hospital's.

Q. I'm talking about the Cleveland Clinic

A. Cleveland Clinic. I'm not sure about that. Here's another note, University Hospitals, August 3rd. The sentence says, Neuro feels possible metabolic genetic disorder.

Q. But that wasn't positively ruled in or ruled out, was it?

A. Right. They haven't found -- I don't think the child has really been diagnosed yet, but I think it's --

Q. I do have to ask one more question. Nucleated red blood cells, last one. Are you familiar with the theories about nucleated red blood cells that say if you have ten or less it's an indication of an insult that occurred closer to delivery than if you have greater than ten?

A. Yeah.

Q. Okay. Are you aware of what the nucleated red blood cells were on this newborn at 1359?

A. No, I don't remember.
Q. They were 10.
A. They were 10. So it was like a cliffhanger.
MR. NOVAK: All done.
(Whereupon, at 2:40 p.m., the signature of the witness having been duly waived, the taking of the instant deposition ceased.)

CERTIFICATE OF REPORTER

UNITED STATES OF AMERICA) ss.:

STATE OF MARYLAND)

I, ANN L. BLAZEJEWSKI, CM, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

Ann L. Blazejewski

Notary Public in and for

the State of Maryland

My Commission expires: 10-26-99

5/19/99

V.P. MEDICAL & COMMUNITY PROGRAMS

MAZANEC, RASKIN & RYDER CO., L.P.A.

ATTORNEYS **AND** COUNSELLORS AT LAW

THOMAS S. MAZANEC
TODD M. RASKIN
EDWARD M. RYDER
KAREN E. LEE
JOHN T. McLANDRICH
JAMES A. CLIMER
BEVERLY A. HARRIS
EDWIN J. HOLLERN
CHRISTOPHER J. RUSS
DENNIS M. PILAWA
JOHN T. HANNA
D. CHERYL ATWELL
JOSEPH F. NICHOLAS, JR.
ROBERT H. STOFFERS
R. MICHAEL O'NEAL
LESLIE W CHAVERS
JOSEPH H WANTZ
RICHARD G ROSS
DEANNA L DiPETTA

e-mail: lschoenling@mrrlaw.com

tl. DONAL LEWIS
DOUGLAS G LEAK
COLLEEN H PETRELLO
LYNNE K SCHOENLING
KIMBERLY A BRENNAN
JOHN L CULLEN
SUSAN E RUSNAK
PAUL J CRKTALLO
ROBERT B SUTHERLAND
DEBORAH W YUE
DAVID A GOLDSTEIN
ELISABETH D GENTILE
MICHAEL E SNAVELY
CYNTHIA J WORTHING
JEFFREY T KAY
DAVID R FENN

ROBERT D KENSEY
(19601993)

May 18, 1999

VIA FACSIMILE AND OVERNIGHT MAIL
(410) 502-9524

Neonatal Seiz
NL Apgar 6, 8 ABG(-)
Persistent Seiz = Abnl MRI's

Michael Johnston, M.D.
John Hopkins University Hospital
707 N. Broadway, 6th Floor
Baltimore, Maryland 21205

Re: *Jasmine Merriweather, et al. v. Elyria Memorial Hospital, et al.*
Lorain County Common Pleas Court
Case No.: 98 CV 120349
Our File No.: 74137

EXHIBIT
1
9/18/99 alb
PENGAD-Bayonne, N. J.

Dear Dr. Johnston:

I received your name from Beverly Harris, a partner in our firm, who has worked with you in the past and highly recommended you as a potential pediatric-neurologist expert in the above-captioned matter.

I represent Dr. Liengkong Siew, a OBGYN, who, along with Elyria Memorial Hospital, has been sued by Rhonda and Orlando Merriweather in a medical malpractice action arising out of the labor and delivery of their daughter, Jasmine Merriweather. Plaintiffs allege that Dr. Siew was negligent and fell below the standard of care in the prenatal care given to Rhonda Merriweather and in the labor and delivery management of the infant. In essence, it is Plaintiffs' allegation that Dr. Siew fell below the standard of care in failing to properly monitor the fetus and take appropriate steps to perform a @-section to avoid injury to the infant. It is alleged that the infant suffered hypoxic ischemic encephalopathy during labor and delivery which, it is alleged, directly and proximately resulted in cerebral palsy, epilepsy and mental retardation to the child.

This case is filed in the Lorain County Court of Common Pleas in Elyria, Ohio. It is set for Trial on November 1, 1999. The Court has not imposed a discovery cutoff date. The Court has ordered that Defendants' expert reports be exchanged by June 1, 1999; however, I am requesting a three (3) week extension which I fully expect the Court to grant, allowing us until June 22, 1999 to provide defense expert reports.

By separate overnight package, I am also forwarding you the following:

(1) Elyria Memorial Hospital records 11/11/92 through 11/13/92 (infant's records);

(2) Elyria Memorial Hospital records 11/11/92 through 11/13/92 (mother's records);

(3) Fetal monitoring strips;

(4) Deposition transcript of Dr. Liengkong Siew;

(5) Report of Howard J. Tucker, M.D., Plaintiffs' neurological expert; and

(6) Report of John Engel, M.D., Plaintiffs' gynecological expert.

After you have had the opportunity to review the information outlined herein, as well as the overnight package, I would appreciate it if you could contact me via telephone to discuss your initial opinions and findings.

I would also ask that your offices fax me your current curriculum vitae and fee schedule.

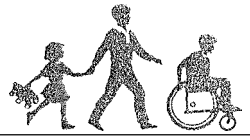
Your attention and cooperation in this matter is appreciated.

Very truly yours,

MAZANEC, RASKIN & RYDER CO., L.P.A.

Lynne K. Schoenling

LKS/jem
Enclosures
G:\LKS\74137\lks-021.johnstonltr.doc



Kennedy Krieger Institute

Michael V. Johnston M.D.
Senior Vice President
Chief Medical Officer
Director, Division of Neurology and Developmental Medicine

Professor of Neurology and Pediatrics
Johns Hopkins University School of Medicine

June 23, 1999

Dr F: 1 10 AM
13,99 - Art fh -

11-92 NL CT + MR
1-93 NL MR
8-93 Atrophy + whiten A Mat
Seeding for not abl

Ms Lynne K Schoenling
Mazanec, Raskin and Ryder
250 Civic Center Drive
Suite 400
Columbus, Ohio 43215

RE: Jasmine Merriweather v. Elyria Memorial Hospital

Dear Ms. Schoenling,

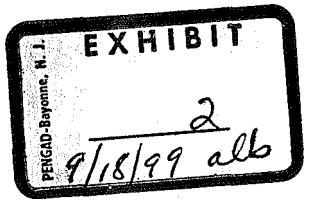
I reviewed the records you sent me on this case including Elyria Hospital records from 1992, the deposition of Dr. Siew and written reports by Drs. Tucker and Engel.

The records show that the infant experienced neonatal seizures associated with cyanotic episodes and stiffening soon after birth. She has continued to have a serious neurologic disorder that includes intractable seizures, mental retardation and cerebral palsy. So far, the underlying cause of this neurologic disorder has not been diagnosed specificially. There is absolutely no evidence that the clinical picture relates to diffuse hypoxia during labor and delivery, nor is there evidence that hypoxia after birth caused it. First, this would not be a typical picture for a disorder caused by "diffuse hypoxia." Secondly, the 5 minute Apgar score of 8 and arterial blood gases showing a total absence of severe metabolic acidosis document that there was no significant hypoxia during labor and delivery.

The records indicate that both the child's current neurologic condition and the neonatal seizures with stiffening and cyanosis in the neonatal period reflect a serious preexisting disorder of brain development that antedated birth by a considerable period of time.

Sincerely,

Michael V. Johnston, M.D.
Professor of Neurology and Pediatrics



707 North Broadway Baltimore, Maryland 21205 (410) 502-9492/Telephone (410) 502-9524/Facsimile
E-mail: Johnston@kennedykrieger.org