

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

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1 IN THE COURT OF COMMON PLEAS
2 OF LORAIN COUNTY, OHIO

3 ----- X

4 JASMINE MERRIWEATHER by and :

5 through her next Friend and :

6 Parent RHONDA MERRIWEATHER :

7 and RHONDA MERRIWEATHER, :

8 Individually and ORLANDO :

9 MERRIWEATHER, Individually, :

10 Plaintiffs, :

11 vs. : Case No. 98CV120349

12 ELYRIA MEMORIAL HOSPITAL :

13 and LIENGKONG SIEW, M.D., :

14 Defendants. :

15 ----- X

16 Baltimore, Maryland

17 Saturday, September 18, 1999

18 Deposition of MICHAEL V. JOHNSTON, M.D., a

19 witness herein, called for examination by counsel for

20 Plaintiffs, in the above-entitled matter, pursuant to

21 notice, the witness being duly sworn by ANN L.

22 BLAZEJEWSKI, a Notary Public in and for the State of

23 Maryland, taken at the offices of Salomon Reporting

24 Service, 200 East Lexington, Baltimore, Maryland at

25 1:10 p.m., Saturday, September 18, 1999, and the

2

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

3

4 APPEARANCES:

5

6 On behalf of the Plaintiffs:

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13 On behalf of the Defendant Elyria Memorial
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1 APPEARANCES (Continued):

2

3 On behalf of the Defendant Dr. Siew:

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C O N T E N T S

WITNESS EXAMINATION BY COUNSEL FOR
MICHAEL V. JOHNSTON, M.D. PLAINTIFFS DEFENDANTS
By Mr. Novak 5
By Mr. Jeffers 62

E X H I B I T S

JOHNSTON EXHIBIT NO.	PAGE NO.
1 Letter, 5/18/99	6
2 Letter, 6/23/99	6

1 P R O C E E D I N G S

2 Whereupon,

3 MICHAEL V. JOHNSTON, M.D.,

4 business address at 707 N. Broadway, Baltimore,

5 Maryland, was called as a witness by counsel for

6 Plaintiffs, and having been duly sworn by the Notary

7 Public, was examined and testified as follows:

8 EXAMINATION BY COUNSEL FOR PLAINTIFFS

9 BY MR. NOVAK:

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

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

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

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

24 MR. JEFFERS: Is this the 18th?

25 MS. SCHOENLING: Yes.

6

1 THE WITNESS: Time flies.

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

4 BY MR. NOVAK:

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

10 A. Yeah.

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

If A. I don't remember.

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

20 A. No.

21 Q. Would it be more than one?

22 A. I have no memory.

23 Q. Do you remember who Beverly Harris is?

24 A. No.

25 Q. Have you ever testified in the Cleveland,

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

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

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

6 A. No.

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

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

12 Q. Reminger & Reminger?

13 A. Yeah, Reminger.

14 Q. Gary Goldwasser, does that ring a bell?

15 A. Could be, yeah.

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

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

24 Q. Bernadine Healey is married to --

25 A. Yeah, so she knew Bernadine.

8

1 Q. Floyd Lupe.

2 A. That's the only way I remember.

3 Q. Have you ever testified for the plaintiff
4 in any cases?

5 A. In Cleveland?

6 Q. Anywhere.

7 A. Yeah. I think overall it's 10 to 15
8 percent of the cases.

9 Q. 10 to 15 percent plaintiff versus about 90
10 to 85 percent defense?

11 A. Yeah, around 80 to 90 percent defense.

12 Q. And I also noticed you're buddies with
13 Dr. Bonn; is that right?

14 A. Well, we were on the faculty at Michigan
15 for eight years.

16 Q. You've written some articles with him?

17 A. Yeah.

18 Q. As you sit here today, do you have any
19 patients in the hospital right now?

20 A. Yeah, we have about -- I forgot to check
21 the census, but I think we have about 45.

22 Q. Did you make-rounds this morning?

23 A. No.

24 Q. Did you make rounds yesterday?

25 A. No.

1 Q. Did you make rounds Thursday?

2 A. Thursday? I think I made rounds

3 Wednesday.

4 Q. Now, when you make rounds, would it be
5 fair to state that your conduct during rounds is as a
6 teaching neurologist; is that right?

7 A. Well, I'm the chief medical officer, so
8 I'm in charge of everything and hopefully there are
9 no crises.

10 Q. But I guess what I'm saying is that your
11 practice doesn't require you to be there on a daily
12 basis, but you're there more in the position of a
13 teacher for residents under you; is that right?

14 A. Well, it's sort of **24** hour responsibility,
15 so sometimes I'm actually there, sometimes I sleep
16 there, but usually that's confined to several months
17 a year.

18 Q. Out of the course of a year, how much of
19 your time is spent actively treating patients,
20 percentage wise?

21 A. Percentage wise, about 60 percent.

22 Q. And the other percentage, 40 percent,
23 would be what?

24 A. 5 percent classroom teaching, 15 percent
25 pushing papers, and 20 percent research.

10

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

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

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

8 A. Probably 15 percent.

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

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

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

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

19 MR. JEFFERS: Nobody remembers plaintiffs
20 lawyers.

21 BY MR. NOVAK:

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

1 tell me what materials were sent.

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

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

10 BY MR. NOVAK:

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

14 A. Yeah.

15 Q. Is that a fair statement?

16 A. Right.

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

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

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

12

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

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

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

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

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

22 BY MR. NOVAK:

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

1 no mention of the CT scan, fair statement?

2 A. Right.

3 Q. Would it be fair to state, then, that you
4 didn't even have those when you wrote this report?

5 A. You mean the reports?

6 Q. Yes.

7 A. I'm not sure. I mean, I had -- Dr.
8 Tucker, I think, recited a lot of this in his report,
9 but I don't think at that point I actually had seen
10 the MR reports from January; from November, January.
11 I knew the MR and CT from 11-92 were normal, but I
12 didn't know that the one in August of '93 was very
13 abnormal because I would have probably put that in
14 because that's, you know, absolutely critical to
15 showing that this obviously had nothing to do with
16 asphyxia, so I think I probably would have put that
17 in if I had it.

18 Q. You don't have any opinion that there's a
19 congenital microcephaly in this case, do you?

20 A. You mean the -- well, I saw the plot that
21 Dr. Reiley did, and I think that -- I mean, the head
22 was on the small side. I'm not sure if I would call
23 it microcephaly, but to me the most telling part of
24 that was that the head growth grew normally for a
25 while and then fell off after about six months.

14

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

3 A. Yeah.

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

6 MR. JEFFERS: Objection.

7 M^S. SCHOENLING: Objection.

8 MR. NOVAK: ~~Are you going to start again?~~

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

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

14 MR. JEFFERS: Right now.

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

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

19 MR. NOVAK: Let's go.

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

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

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

1 THE WITNESS: We can deal with facts.

2 BY MR. NOVAK:

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

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

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

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

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

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

16

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

5 A. You mean that they put that down?

6 Q. Yes, they did.

7 MR. JEFFERS: Someone wrote it.

8 MR. NOVAK: One of your employees, John.

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

12 MR. NOVAK: Which is an accurate
13 statement.

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

17 BY MR. NOVAK:

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

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

1 age.

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

4 A. No.

5 MR. JEFFERS: I think there were multiple
6 measurements.

7 MR. NOVAK: At Elyria Memorial Hospital.

8 MR. JEFFERS: Go ahead.

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

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

15 BY MR. NOVAK:

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

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

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

25 MR. JEFFERS: I want to object.

18

1 MS. SCHOENLING: I'll object, too.

2 MR. JEFFERS: You're not telling him that
3 there were two others at 32.

4 MR. NOVAK: John, you can ask him what you
5 want. I'm asking him my questions.

6 MS. SCHOENLING: I'm objecting to the
7 question;

8 MR. JEFFERS: It's going to give an
9 improper inference.

10 MR. NOVAK: Whatever.

11 THE WITNESS: I think my position is that
12 the head size was on the small side, and that it's
13 been characterized as microcephaly, which is probably
14 not a word that I would use, but I think it's a
15 semantic issue in terms of whether you call the head
16 size -- my point is that it looked like the head was
17 accelerating pretty normally for the first four to
18 six months, and then kind of plateaued after that,
19 which would be inconsistent with perinatal asphyxia
20 as the cause.

21 BY MR. NOVAK:

22 Q. But would you agree with me that -- I want
23 you to assume 33.2 centimeters is recorded on a chart
24 at University Hospital at the time that this infant
25 is there during the first admission. Would you agree

1 with me that that is not consistent with congenital
2 microcephaly?

3 MR. JEFFERS: Same objection.

4 MS. SCHOENLING: Same objection here as
5 well.

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

8 BY MR. NOVAK:

9 Q. And there is also a chart for the infant
10 in January of 1993 at University Hospital, and that
11 chart has the recording at the 50th percentile.

12 Would that be consistent with congenital
13 microcephaly?

14 A. No, not that measurement.

15 Q. Then there is a recording at --

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

18 BY MR. NOVAK:

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

23 A. No.

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

20

1 fetal heart monitoring, don't you?

2 A. A little bit, yeah.

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

6 A. Oh, okay, sure.

7 Q. **IS** that a fair statement?

8 A. Sure.

9 MS. SCHOENLING: You're asking him
10 generally?

11 BY MR. NOVAK:

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

15 MS. SCHOENLING: Generally?

16 MR. NOVAK: Generally.

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

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

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

4 MS. SCHOENLING: He has already told you
5 that.

6 BY MR. NOVAK:

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

11 A. Yeah, sure.

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

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

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

24 A. It might, sure.

25 Q. Do you have an impression as you sit here

22

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

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

6 MR. NOVAK: No, skill as a practitioner.

7 MR. JEFFERS: Objection.

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

12 MR. NOVAK: Right.

13 MS. SCHOENLING: Objection.

14 BY MR. NOVAK:

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

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

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

21 A. Yeah.

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

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

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

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

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

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

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

19 MR. JEFFERS: Objection.

20 MS. SCHOENLING: Objection.

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

24

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

5 MR. NOVAK: Uh-huh.

6 MR. JEFFERS: Say yes.

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

9 THE WITNESS: That's good.

10 BY MR. NOVAK:

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

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

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

20 MR. JEFFERS: Objection.

21 THE WITNESS: It would depend on the
22 Circumstances.

23 BY MR. NOVAK:

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

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

5 MS. SCHOENLING: Objection.

6 MR. JEFFERS: Objection.

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

9 BY MR. NOVAK:

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

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

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

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

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

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

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

25 MR. JEFFERS: It is not dealing with HIE

26

1 versus metabolic injuries.

2 MS. SCHOENLING: Same objection.

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

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

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

10 BY MR. NOVAK:

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

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

19 MS. SCHOENLING: Was the question three
20 hours?

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

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

25 BY MR. NOVAK:

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

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

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

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

18 BY MR. NOVAK:

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

22 MR. JEFFERS: Objection.

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

28

1 there was a large base excess, usually in the minus
2 20s, very low bicarbonates, that sort of thing. So I
3 think really that's the critical issue is how much
4 metabolic acidosis was there.

5 BY MR. NOVAK:

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

13 MR. JEFFERS: Objection.

14 MS. SCHOENLING: Objection.

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

21 BY MR. NOVAK:

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

1 episode at 1:30 in the morning, we don't know how
2 long it lasts, and I want you to assume that it lasts
3 20 minutes. Can that result in cerebral palsy?

4 MR. JEFFERS: Objection.

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

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

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

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

21 MR. JEFFERS: In this baby or in general?

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

24 MR. JEFFERS: Objection.

25 THE WITNESS: I think you're saying just

30

1 apnea, though, not other --

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

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

10 BY MR. NOVAK:

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

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

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

19 MR. JEFFERS: Other than inferential?

20 BY MR. NOVAK:

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

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

1 be in that 3 or less Apgars.

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

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

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

12 BY MR. NOVAK:

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

15 MR. JEFFERS: Begin to what? Choke?

16 MS. SCHOENLING: Being fed and begins to
17 choke?

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

20 THE WITNESS: Yeah.

21 BY MR. NOVAK:

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

25 A. Sure.

32

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

4 A. Yeah.

5 Q. And I guess my question for you, just this
6 question, can you have an apneac episode that lasts
7 20 minutes that can result in cerebral palsy?

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

10 MR. JEFFERS: Objection.

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

14 BY MR. NOVAK:

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

21 MR. JEFFERS: Objection.

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

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

8 BY MR. NOVAK:

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

14 A. Yeah, I was interested in that.

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

17 A. Yeah.

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

22 A. No.

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

40

1 MR. JEFFERS: Not his total opinion.

2 MR. NOVAK: I understand. But one of them
3 was written by John Freeman and Karen Nelson, who
4 work under you at Johns Hopkins, don't they?

5 THE WITNESS: No, Freeman was -- Freeman's
6 still there. He was one of my teachers.

7 BY MR. NOVAK:

8 Q. How about Karen Nelson?

9 A. She's a colleague down at NIH. They're
10 both --

11 Q. You know both of them?

12 A. Yeah.

13 Q. Let me ask you if you agree or disagree
14 with this statement.

15 MS. SCHOENLING: Referring to the interim
16 part of asphyxia and cerebral palsy article of
17 Freeman and Nelson?

18 MR. NOVAK: Yes.

19 MS. SCHOENLING: What page?

20 MR. NOVAK: Page 244 at the bottom.

21 Although nonpreventable factors can cause neonatal
22 seizures, such seizures during the first 48 hours of
23 life are now suggested as possible indicators in
24 groups of patients of a quality of intrapartum
25 obstetrical care and evidence of intrapartum

1 asphyxia.

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

4 MR. NOVAK: '87.

5 MR. JEFFERS: '88.

6 BY MR. NOVAK:

7 Q. Do you agree with that statement?

8 A. Yeah, I agree with that, sure.

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

15 THE WITNESS: Yes.

16 MS. SCHOENLING: This is the paragraph on
17 245?

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

20 THE WITNESS: Right.

21 BY MR. NOVAK:

22 Q. Okay.

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

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1 seizures because of asphyxia.

2 MR. NOVAK: Right, right.

3 BY MR. NOVAK:

4 Q. And then on page --

5 MR. JEFFERS: This is the article about
6 asphyxia?

7 MR. NOVAK: Right.

8 BY MR. NOVAK:

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

16 MS. SCHOENLING: Where are you, Bill?

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

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

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

25 BY MR. NOVAK:

1 Q. Do you agree with that statement?

2 A. Yeah, if that infant had sufficient
3 asphyxia to result in permanent deficit, then signs
4 and symptoms are likely to have been present in the
5 delivery room as well.

6 Q. Okay.

7 A. Which they weren't here.

8 Q. Let's kind of hold on to that thought for
9 a minute. Then in the very top of the second column
10 on that same page it says, acidosis (cord or scalp pH
11 of less than 7.1), is probably the best evidence of
12 intrauterine asphyxia and of its duration/severity,
13 but unfortunately in this case we don't have the cord
14 or scalp pH; am I right?

15 A. Right.

16 MR. JEFFERS: Wait, wait. There's two
17 questions there.

18 BY MR. NOVAK:

19 Q. You're not going to render an opinion in
20 this case as to what you think the cord or scalp pH
21 would have been had it been analyzed?

22 A. I think your earlier question was exactly
23 what it was. I mean, I think an hour later there
24 really was no metabolic acidosis. I think the bicarb
25 was 26, the base excess was minus 4.

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1 Q. But the pH was 7.21?

2 A. Right, which is normal for the average.

3 It would certainly be normal for a cord pH, but you
4 couldn't have had a pH in the asphyxia range in the
5 cord when an hour later you have a bicarb of 26.

6 Q. Except an hour later this infant was on
7 oxygen, was it not?

A. Yeah, but oxygen doesn't affect the
9 bicarb.

10 Q. Now, are you aware that Dr. Reiley
11 testified that at 1359 that blood study was acidotic?

12 A. Oh, yeah, it was acidotic, but the key
13 thing for the hypoxia is not the pH, it's the base
14 excess and the bicarb because it's sort of like the
15 old baking soda and vinegar experiment that you add
16 the vinegar, and then the baking soda gets turned
17 into CO₂, and once that happens to a point where the
18 baby is asphyxiated, there's no way to replenish that
19 bicarb unless somebody infuses it.

20 Q. Except the HCO₃ is never mentioned in any
21 of these articles. They always talk about the cord
22 or scalp pH, don't they?

23 A. Well, it's not mentioned in this article.

24 Now, I think the publication that supersedes this is
25 the NIH consensus meeting on the definition of acute

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

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

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

16 Q. Would you agree with me there's nothing in
17 your article about the HCO₃; your article limits the
18 blood study to a pH of less than 7 at five minutes;
19 is that right?

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

23 THE WITNESS: Let me read that again.

24 MR. NOVAK: Right. Right.

25 MS. SCHOENLING: And the year of that

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1 publication?

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

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

10 MS. SCHOENLING: What page is that, Bill?

11 MR. NOVAK: Page 14.

12 MS. SCHOENLING: Thank you.

13 BY MR. NOVAK:

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

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

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

4 A. Right.

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

6 A. Yeah.

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

9 A. Well, just during the seizures.

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

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

18 A. Yeah.

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

23 A. Say that again.

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

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1 delivery?

2 A. Yeah.

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

6 A. Sure.

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

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

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

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

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

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

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

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

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

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

11 THE WITNESS: Yes, the serum creatinine.

12 BY MR. NOVAK:

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

17 A. No, it's not elevated.

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

20 A. Yeah, I think they were.

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

23 A. Yeah, sure.

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

1 something wrong?

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

4 MR. NOVAK: You don't like this?

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

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

12 BY MR. NOVAK:

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

20 A. Yeah, I agree.

21 Q. Okay.

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

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

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

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

6 MR. JEFFERS: What page is this, Bill?

7 Mk. NOVAK: Page 63.

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

12 BY MR. NOVAK:

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

17 MS. SCHOENLING: What page?

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

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

23 BY MR. NOVAK:

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

1 distress, aren't you?

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

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

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

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

20 A. It has no meaning.

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

23 A. Zero.

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

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1 the cords?

2 A. It has no meaning to me.

3 Q. Okay.

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

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

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

18 MR. NOVAK: Yes.

19 MS. SCHOENLING: Okay.

20 MR. NOVAK: From his standpoint.

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

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

14 BY MR. NOVAK:

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

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

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

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

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

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

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

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

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

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

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

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

23 A. No, that's not quite right.

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

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1 MR. JEFFERS: Objection.

2 THE WITNESS: Well, I think -- let me make
3 sure what I said here. Okay. Let me be -- because I
4 think I tried to write this in very clear English.

5 I'm reading from my report of June 23rd. The records
6 indicate that both the child's current neurologic
7 condition and the neonatal seizures with stiffening
8 cyanosis in the neonatal period reflect a serious
9 preexisting disorder of brain development that
10 antedated by a considerable period.

11 MR. NOVAK: Right.

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

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

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

23 BY MR. NOVAK:

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

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

3 MR. JEFFERS: What is that citation 72?

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

9 MR. NOVAK: Uh-huh, right.

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

24 BY MR. NOVAK:

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

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

8 MR. JEFFERS: Objection.

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

18 BY MR. NOVAK:

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

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

25 THE WITNESS: Yeah. Not knowing, though,

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

3 BY MR. NOVAK:

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

7 MR. JEFFERS: Object.

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

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

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

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

15 MR. NOVAK: Oh, yeah, I do have one last
16 question, two last questions.

17 MR. JEFFERS: Oh, my.

18 BY MR. NOVAK:

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

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

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

3 A. I've seen people do that.

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

6 A. No.

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

8 EXAMINATION BY COUNSEL FOR DEFENDANT

9 BY MR. JEFFERS:

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

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

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

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

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

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

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

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

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

10 EXAMINATION BY COUNSEL FOR PLAINTIFFS

11 BY MR. NOVAK:

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

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

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

25 MS. SCHOENLING: Objection.

1 THE WITNESS: Yeah, I think they're

2 very --

3 BY MR. NOVAK:

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

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

24 MR. NOVAK: Would you kindly --

25 THE WITNESS: I see what you mean. I

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

5 BY MR. NOVAK:

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

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

10 MS. SCHOENLING: These are the UH records.

11 THE WITNESS: Yeah, University Hospital.

12 Seizure disorder was evaluated and its etiology was
13 searched for, so on 8-5 they were doing metabolic
14 workup, skin biopsy for fibroblast culture for
15 enzyme, mitochondrial assay, so they weren't looking
16 for asphyxia there. They were looking for --

17 BY MR. NOVAK:

18 Q. What's the date of that?

19 A. That's on August 5th. August 4th they
20 were looking for -- bloods were drawn, including
21 metabolic screens, ammonia, creatine. Then on August
22 4th they were talking about, they said further
23 evaluation of etiology of seizure disorder per
24 neurology, metabolic workup on blood.

25 Q. But the Cleveland Clinic, there was no

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

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

5 Q. At the Cleveland Clinic?

6 A. Oh. This is University Hospital's.

7 Q. I'm talking about the Cleveland Clinic

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

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

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

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

23 A. Yeah.

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

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1 A. No, I don't remember.

2 Q. They were 10.

3 A. They were 10. So it was like a
4 cliffhanger.

5 MR. NOVAK: All done.

6 (Whereupon, at 2:40 p.m., the signature
7 of the witness having been duly waived, the
8 taking of the instant deposition ceased.)

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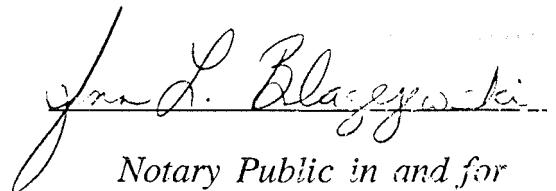
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CERTIFICATE OF REPORTER

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.


Notary Public in and for

the State of Maryland

My Commission expires: 10-26-99

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Michael V. Johnston, M.D.

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5/19/99
M.D.
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May 18, 1999

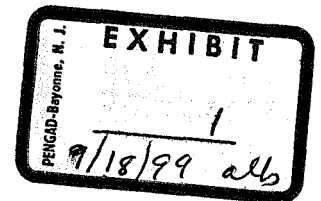
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*Neonatal Seiz
w/ Apgar 6, 8 ABG's
Persistent Seiz = Abnl par-E's*

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



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.

REPLY TO

☐ CLEVELAND: 100 FRANKLIN'S ROW, 34305 SOLON ROAD, CLEVELAND, OHIO 44139 (440) 248-7906 FAX: (440) 248-8861
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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 CQ., L.P.A.


Lynne K. Schoenling

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

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



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Senior Vice President
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June 23, 1999

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15.54 - Act Ph -

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11-92 NL CT + MR

1-93 NL MR

8-93 Atrophy + white matter A MR
Searching for met abal

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 specifically. 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

