IN THE CIRCUIT COURT OF THE CITY OF ST. LOUIS

STATE OF MISSOURI

Dexpert
Acute ⓑ MCA & ACA Strokes

MARIAM MOSTAFAVIFAR, a disabled individual, by SUZUANNE MOSTAFAVIFAR, her duly appointed Next Friend,	}	
Plaintiff,	}	
vs.	}	No. 012-09612
WASHINGTON UNIVERSITY,	}	
Defendants.	}	

DEPOSITION OF MARVIN D. NELSON, JR., M.D.

Los Angeles, California

Thursday, July 10, 2003

Reported by:
ELIZABETH PADILLA
CSR No. 9048
JOB No. 885837A

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vs.	)	No. 012-09612 Division 1
WASHINGTON UNIVERSITY, Defendants.	)	

Deposition of MARVIN D. NELSON, JR., M.D., taken on behalf of Plaintiff at 4650 Sunset Boulevard, Los Angeles, California, beginning at 9:47 a.m. and ending at 11:09 a.m. on Thursday, July 10, 2003, before ELIZABETH PADILLA, Certified Shorthand Reporter No. 9048.

APPEARANCES:

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INDEX

EXHIBITS

Los Angeles, California, Thursday, July 10, 2003

9:47 a.m. - 11:09 a.m.

MARVIN D. NELSON, JR., M.D.,

having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. ZWIBELMAN:

Q. Tell me your name, please.

A. Marvin D. Nelson, Jr.

Q. Where do you live, sir?

A. Los Angeles, California.

Q. You're aware that you've been endorsed as an expert by the defendants in this case?

A. Yes.

Q. When were you first contacted?

A. Last spring, February, March.

Q. Of this year?

A. Yes.

Q. Who contacted you?

A. I don't remember.

Q. Have you ever dealt with them before?

A. I've dealt with several law firms in St. Louis. I don't recall if this was one I've dealt

with in the past.

Q. May I see your file or your correspondence or whatever you've got there.

It appears, chronologically that the first correspondence that you got was -- I don't know when it was. In any event, you were supplied with the deposition of a Dr. Edwards-Brown; is that correct?

A. Yes.

Q. And you were supplied with an MRI and the report of an MRI; is that right?

A. Yes.

Q. And some reports of radiology studies that were done in 1983; is that correct?

A. Yes.

Q. You were sent the report of an EEG. Did you see the EEG itself --

A. No.

Q. -- or just the report?

As a curiosity, why was that of significance to you?

A. It wasn't.

Q. They just sent it to you?

A. Yes.

Q. Did you ask for it?

A. No.

Q. And then you were sent a letter on May 8th about an MRI, and you were sent the petition, and then, on July the 2nd, you were sent a letter confirming this deposition; is that correct?

A. Correct.

Q. And you've actually seen what films? Tell me what films that you've seen.

A. The CT scan that was done on November 15th, 1983. One film of a cranial ultrasound done on 21 November, 1983, the MRI done on January 14th, 2003.

Q. And the reports of those -- were you sent the reports of the initial ultrasound?

A. Yes.

Q. Did you ask for any additional records?

A. I briefly looked at the medical records as well.

Q. When was that, sir?

A. This morning.

Q. And what medical records did you look at? And if you could tell me what page, that would be great.

A. This is the initial Barnes-Jewish Hospital medical records.

Q. Of the child?

A. Of the child.
Q. Was there anything in there that you looked at or that were you looking for that was of any significance to you?
A. Well, at the time, I was looking over the discharge summaries of the child's initial hospitalization and was looking, specifically, for the time that the initial ultrasound was performed, as it wasn't on the report.
Q. Did you find that, sir?
A. Yes.
Q. And what time did you think -- do you think it was performed?
A. 12:40 hours on the 13th.
Q. And so that would be how many hours of life?
A. 32.
Q. Anything else you were looking for in those records?
A. That was, principally, what I was looking for.
Q. Did you make any notes either of your review or the records or your discussions with Mr. Rosenthal or anyone else?
A. No. All I have are a listing of the

exams and their timing.

Q. Telling me what the timing is that you believe from the date of birth, the time that they were done and how many hours or days they were from date of birth, you say the first ultrasound was done at 32 hours of life; correct?

A. Correct.

Q. What about the CT scan?

A. Three days and 13 hours.

Q. So that's 85 hours of life?

A. Roughly.

Q. If, in fact, there was testimony that it was done at two days of life, that would just be wrong; is that correct?

A. Well, that would suggest that they mis-marked the film. I mean, the films state when it was done, with a date and time on the actual CT. And I would believe that before --

Q. In other words, if someone testified that the CT scan was done at two days of life, that would just be, by your calculations, wrong; is that correct?

A. Well, I have to go by what the evidence states.

Q. And the evidence states 85 hours; is that right?

A. That's what the films indicate.
Q. And then, the last ultrasound was done when?
A. On the 21st of November.
Q. So that would be, roughly, nine days of life?
A. Yes.
Q. Okay. Any other notes that you made?
A. No.
Q. Were you told anything -- I mean, you've read the deposition of Dr. Edwards-Brown. Are you aware that a deposition of a Dr. Gotto has been taken?
A. I know that he read the first CT scan. I'm not aware that his deposition has been taken yet.
Q. And has Mr. Rosenthal or anyone told you what he will testify to?
A. Not directly, no.
Q. Did he say something indirectly?
A. Well, he just said that -- that Dr. Gotto's opinion is different than what his initial report stated.
Q. Did he tell you how it was different, sir?
A. Yes. That he, basically, believed that it's an infarct, as is my opinion, and was before I

was made aware of that.

Q. Are you aware of any other experts other than yourself and Dr. Edwards-Brown that either side is going to be using in this case?

A. No.

Q. Do you know Dr. Edwards-Brown?

A. Yes.

Q. How do you know him?

A. Professional association.

Q. Do you know Dr. Gotto?

A. Yes.

Q. How do you know him?

A. Same way.

Q. Is he a neuroradiologist?

A. Dr. Gotto?

Q. Yes, sir.

A. Well, he comes from an era when -- before there really was formal training programs. But he's been a practicing neuroradiologist for -- oh, since the late '60s, early '70s.

Q. Do you know if he does work on a regular basis in pediatric neuroradiology?

A. I know that he has written in the subject. I know he's been in St. Louis for many, many years.

Q. Can you tell me what topics in the area of pediatric neuroradiology he's written in?

A. I'd have to go and look at his C.V. to be specific. I'm aware of some of the papers that he's written on topographical localization using CT scans.

Q. That's on adults, though, isn't it?

A. Well, you can use it on children as well.

Q. But the studies are on adults?

A. No matter.

Q. I'm sorry?

A. I said that doesn't matter.

Q. I'm not arguing. It's just the studies that he was doing in those articles were on adults; is that correct?

A. It may well be. I'd have to see the specific articles to see what patient population was involved.

Q. Other than Mr. Rosenthal, have you talked to anyone else about this case?

A. No.

Q. Have you done any independent research on this case?

A. No.

Q. Are there any books that you consider to be authoritative in pediatric neuroradiology?

A. No.
Q. Are there any standard textbooks that are used by pediatric neuroradiologists to keep them abreast of modern techniques or diagnoses or treatments?
A. No.
Q. You believe, do you not, that standard textbooks in this area are Ann Osborne's book; is that correct?
A. Well, she's an adult neuroradiologist.
Q. What about Barkovitch's book? Do you believe that's that a standard text?
A. These are texts that are used, but I don't understand them to be authoritative. They're the opinions of the authors and editors.
Q. Do you have one in your library?
A. I have one available for our teaching program.
Q. What about Newton and Pollow? Is that a standard textbook used in pediatric neuroradiology?
A. Newton and Potts.
Q. Potts. I'm sorry.
A. Yes.
Q. Do you use that in your teaching program?
A. Yes. It's kind of the gold standard for

cerebral angiography.

Q. You don't use any of the textbooks by Zimmerman, do you, sir?

A. I don't have any of those textbooks.

Q. Do you ever look at them? Have you ever looked at them?

A. Only briefly, at shows where the vendors are showing the books.

Q. I notice -- we are in your office; is that correct?

A. Yes.

Q. I notice that you have a book by Volpe, "Neurology of the Newborn." Is that, as far as you know, a standard text in pediatric neurology?

A. It's a standard text.

Q. Other than the notes that you have in front of you that are -- we talked about the timing of them, you have no other notes; is that correct?

A. That's correct.

Q. No reports of any -- nothing in writing?

A. That's correct.

Q. We talked about Dr. Edwards-Brown and Dr. Gotto. Do you know a Dr. Shackelford?

A. Gary Shackelford?

Q. Yes.

A. Yes.
Q. How do you know him?
A. Professional association.
Q. Do you know where he is these days?
A. No, I don't know, specifically, where he is these days.
Q. Is he a pediatric neuroradiologist?
A. I believe he's a pediatric radiologist. I'm not sure if he claims to be a pediatric neuroradiologist or not.
Q. Do you know a D. Belding, B-e-l-d-i-n-g?
A. No, I don't know a D. Belding.
Q. I believe her current husband is a Mr. Rosenthal. Do you know --
A. Yes.
Q. What about an A. Claybourne?
A. No.
Q. What about Marilyn Siegel?
A. Yes.
Q. How do you know her?
A. Professional association.
Q. Do you know a Dr. Benjamin C.P. Lee?
A. Yes.
Q. He's at Washington U., isn't he?
A. Yes.

Q. And Dr. Lee is a pediatric neuroradiologist, is he not?

A. I believe that's what he does at that institution.

Q. And he has written on neonatal cerebral infarcts, has he not?

A. I believe so.

Q. Have you read any of those articles, sir?

A. Yes.

Q. When was the last time you read any of those articles?

A. I have no idea.

Q. Okay. Now, in terms of your involvement in this case, you are going to testify about your interpretation of the films; is that correct?

A. Yes.

Q. You are not going to testify about standard of care of any of the physicians?

A. That is correct.

Q. Are you going to testify about -- you indicated, I think, when we talked about Dr. Gotto's deposition -- I think your words were Mr. Rosenthal said that he is going to -- that Dr. Gotto believes this was an infarct, as you do. Are you going to testify about the cause of the infarct?

A. Yes.
Q. Are you going to testify about any future costs that the child might incur?
A. No.
Q. Are you going to testify about life expectancy?
A. No.
Q. Are you going to testify about the kinds of limitations you would expect to see with the head films?
A. I don't understand your question.
Q. That was a bad question. Let me rephrase it.
We'll ask you in some detail about what you see on the films; okay? Are you prepared to answer questions about what kind of physical limitations, if any, that those findings on the films would produce?
A. Physical limitations of --
Q. Or mental limitations.
A. Of the child?
Q. Yes, sir.
A. No.
Q. So, for example -- and this is just a hypothetical. If you're going to say that there's an

infarct in a certain territory of the brain, would you be in a position to say what kind of physical limitations the child will have as a result of what you see on the films?

A. No. And I think that that is out of the scope of a neuroradiologist to do so.

Q. Okay.

A. You could give a general idea, but when infarcts occur in young children like this, in infants, it's completely impossible to predict what they're, ultimately, going to end up like.

Q. Okay. And I appreciate it.

Let's put it another way. If I were to tell you -- if I were to describe for you what the child's present condition is, would you, as a neuroradiologist, be in a position to tell me what kind of damages you would expect to see on the films?

A. No. And that's impossible to do in reverse as well.

Q. Okay. And I guess -- and this isn't the situation, but for example, a child who's born at 26 weeks might have a condition of spastic diplegia, clinically. Could you, as a pediatric radiologist, say, "Well, based on the physical findings of this child, I would expect to see on the films A and B and

C"? Could you do that?

A. No.

Q. How many depositions have you given in your career?

A. Well over a hundred.

Q. You know, basically, that I'm going to ask you some questions, and if you have any -- if you don't understand my question, you're going to stop me. Do you understand that? You'll do that?

A. I already have.

Q. This incident, as you know, occurred in 1983. That's what the films show; is that right?

A. Correct.

Q. I'm going to be asking you some questions about your interpretation of the films and the causation and things like that. If, for whatever reason -- my questions are going to be about 1983. If, for some reason, the technology has changed or the measure of interpretation has changed, will you be sure to tell me that so that the deposition is clear as to what you're referring to?

A. Of course.

Q. Before we start, let me ask you if you'll define some terms for me. What is your definition of "perinatal asphyxia"?

A. Well, the term "asphyxia" means "without respiration." The term "perinatal" refers to the time period from, approximately, 20 weeks post-ovulation/fertilization up until, depending on who you want to read, four to eight weeks after birth. That's the perinatal period. So that term would mean -- literally, it means a problem with respiration in the time period from 20 weeks' gestation to one to two months after birth.

Q. If there is a reference to birth asphyxia, how would you define that?

A. Well, as you probably realized, I don't like the term "perinatal asphyxia" and don't use it, and likewise, the term "birth asphyxia" is, kind of, a wastebasket term that most people would imply that it means a problem acquired during parturition.

Q. And what does "parturition" mean?

A. Labor and delivery, the birth of the child.

Q. What is your definition of the "term infant"?

A. "Term infant" is a child that's 36 to 40 weeks -- at least 36 to 40 weeks post-ovulatory age.

Q. Have you ever heard the term -- the phrase "near-term infant"?

A. Well, people use it, but what does it mean?

Q. That's my -- if you see in a book the phrase "near-term infant," what do you think it means?

A. That means that somebody hasn't done their homework and they're implying that the kid is around 40 weeks, plus or minus a few weeks, is my guess.

Q. And your definition of the phrase "hypoxic ischemic encephalopathy"?

A. Well, "hypoxic" means a decrease in oxygen. "Ischemic" means a decrease in blood flow. And "encephalopathy" means injured brain.

Q. Okay. And when the term "hypoxic ischemic encephalopathy" is used, do they break it down like that? Or is it something other than the sum of those parts?

A. It's a general term that people use to describe -- usually describe an infant that has an injured brain following labor and delivery.

Q. And your definition of the word "infarction"?

A. "Infarct," sure, means necrosis in the vascular distribution.

Q. Would that be caused by an interruption

in the blood supply to an area of the brain that, subsequently, causes cell death and then necrosis

A. Yes.

Q. What is a stroke?

A. "Stroke" is a layman's term for an acute neurologic event. You have an acute loss of some neurologic function, and it could be from any number of causes.

Q. "Acute," what does the word "acute" mean?

A. New, recent.

Q. And "chronic"?

A. Old.

Q. What about "low perfusion injury to the brain"? What is a low perfusion injury to the brain?

A. Low perfusion injury to the brain is when the cardiac output drops and the blood supply to the brain -- the blood pressure for perfusing the brain tissue drops so that you end up with necrosis in vascular border zone territories. Some people call it "watershed." Again, that's another poorly used term.

Q. And could a low perfusion injury to the brain cause an infarct?

A. Infarct in the vascular border zone material.

Q. Is that what happened in this case?

A. No.
Q. Have any of the definitions that you've given changed since 1983?
A. To who? To the way I've used them?
Q. Yeah.
A. Or the way anybody's used them?
Q. First of all, to the way you've used them.
A. Well, in 1983, I would have used "watershed" because I didn't know any better. But now I use "border zone."
Q. Anything else?
A. No.
Q. What about any of the other terms? Have they -- in general parlance, have they taken on a different meaning than they did in 1983?
A. People, in general, use the HIE, hypoxic ischemic encephalopathy, term. That came in vogue in the early 1990s. That wasn't used before. Before, people just used the term "perinatal asphyxia."
Q. And, again, I know you haven't seen the records -- or did you see, in some of the records that Mr. Rosenthal showed you prior to the deposition, that, in these children's records that happened in 1983, there was a mention of hypoxic ischemic

encephalopathy? Did you see that?

A. I think it's written in the records in several places.

Q. What did you think, when you saw it, it meant, if it didn't come into vogue in the 1990s?

A. I'm just saying that there was a lot of controversy of using these terms in the late '80s and early '90s, and there were some consensus conferences at the NIH that generally stated that the term "perinatal asphyxia" was not a good one and should not be used.

Q. Was that one of the ones you were in?

A. I was at one of those. There were multiple ones.

Q. At the one that you were at, was there a discussion of the term "perinatal asphyxia"?

A. Yes.

Q. And it's your testimony that, at that meeting, one or more of the individuals who were there said you should not use the term "perinatal asphyxia"?

A. Yes.

Q. Were the proceedings of that meeting transcribed?

A. Yes.

Q. Put in a book?

A. Yes.
Q. And if I were to look at the book -- have you ever looked at the book?
A. Yes.
Q. And in that book, did you see in there any physicians that said the term "perinatal asphyxia" should not be used?
A. Well, there were references to better ways of describing what was happening.
Q. And that's in the book too?
A. Yeah, I believe so.
Q. Did Dr. Nelson, in any of his discussions, say that the term "perinatal asphyxia" should not be used?
A. You mean Dr. Nelson, me?
Q. Yes.
A. No.
Q. Were you in any of the discussion groups at the end of the meeting that were transcribed?
A. Yes.
Q. In terms of asphyxial events, following an acute asphyxial event, when will you first see swelling of the brain on ultrasound?
A. Well, when do you start to see parenchymal changes of injury?

Q. Yeah. What are parenchymal changes of injury?

A. Echogenicity on an ultrasound.

Q. When do you first start to see that?

A. You start to see them between 24 and 48 hours and usually more towards 48 hours.

Q. Okay. And when will you have the period of peak or maximum swelling or edema?

A. Around 72 hours after the injury.

Q. And when will the swelling disappear, the edema disappear?

A. Over the next week.

Q. In the next week after the 72 hours or after the incident?

A. After the 72 hours.

Q. So that, roughly, ten days after the insult, it will go away; is that correct?

A. The swelling goes away?

Q. Yes, sir.

A. Yes.

Q. The ultrasound of 11/13 was done at, approximately, 36 hours of age; is that right?

A. 32.

Q. 32 hours of age. And you have in front of you, the report of that?

A. Yes.

Q. Do you have any reason to believe that Dr. Shackelford interpreted that first ultrasound incorrectly?

A. No.

Q. Okay. Now, can you tell -- Why don't you put up the 11/15 scan.

MR. ROSENTHAL: CT scan?

MR. ZWIBELMAN: Yes, sir.

MR. ROSENTHAL: We were talking about the ultrasounds. I don't want any confusion.

THE WITNESS: Okay.

BY MR. ZWIBELMAN:

Q. If you would have been there in 1983 and you would -- I suppose what you do is look at films and then you get on your dictating machine or whatever you did and you dictate a report; is that correct?

A. Correct.

Q. If you were there in 1983 and they had dictating machines back then, would you dictate aloud? How you would interpret those films?

A. I would say that there's a large zone of low attenuation in the left middle and partially anterior cerebral artery territories with swelling of the left hemisphere compressing the left lateral

ventricle and causing a mild left-to-right midline shift. And I would say there's no hemorrhage present. And my impression would be that this represents an acute left middle and partial anterior cerebral artery territory infarct.

Q. Left middle -- I'm sorry.

A. And partial anterior cerebral artery territory infarct.

Q. Would you put anything else in your report?

A. Probably not.

Q. Had you been there in 1983, would you have reviewed the ultrasound of 11/13?

A. Yes.

Q. As I understand, here at Children's Hospital in Los Angeles, you review ultrasounds, do you not?

A. Yes. I review all the cranial ultrasounds.

Q. Do you dictate reports on them?

A. Yes, I do.

Q. That's kind of unusual. I think Dr. Gotto said he doesn't review ultrasounds. Is the typical thing for a pediatric neuroradiologist to review neonatal ultrasounds or not to?

A. Depends from institution to institution.
Q. But certainly, here, you do?
A. That's correct. And have for 15 years.
Q. Did you see on that film, the CT scans -- first of all, which of the frames are most representative?
A. Well, there are a lot of frames involved here.
Q. I notice you're looking at two of the films.
A. I picked two of the films out. And if I could just see how the frames are numbered here. I would say -- well, those are all labeled the same. Okay. So I suppose the best way is, down in the bottom left-hand corner, there's a symbol that says, "P," and then there's a number, and then it lists a number going on the frame. So the one that says P0, P minus 8, and P minus 16, those are probably the best ones.
Q. Did you see, in the films that you looked at, bilateral infarctions much worse on the left than on the right?
A. No.
Q. Did you see massive swelling of the left cerebral hemisphere?

A. Well, I don't know if I would use "massive," but there is considerable swelling.

Q. Did you see any disease or infarction or anything in the right cerebral hemisphere?

A. No.

Q. Did you see a massive lucency involving gray and white matter?

A. Yes.

Q. And you did say there was a mass effect --

A. Mass effect, yes. That refers to the swelling that we already talked about. Midline shift, yes. I already mentioned that in my report. The term "lucency" is not one that really is a legitimate CT term. And "density" is really not a legitimate term. He's referring to the low attenuation of the hemisphere. I understand what he means but --

Q. If you look at page 129 of the records, which are the report of Drs. Belding and Gotto, they say there's a massive swelling of the left cerebral hemisphere which shows, also, massive lucency involving the gray and white matter as well. You say "lucency" is not a term that's used in description of CT scans?

A. It was never a term that I was taught to

use. I understand what he means.

Q. No, I understand. But was that something that was used in 1983 and is not used now, or in your thought, it was never used?

A. I know some people used it back then. I'm sure that no one would be taught to use that term today.

Q. It says, "The right cerebral hemisphere is, likewise, involved but to a much less degree, and the swelling is not obvious." Do you see that in the report, sir?

A. Yes.

Q. You disagree with that?

A. Yes. This is a premature infant, roughly, about 34 weeks of gestational age, and that's what the normal premature appearance is like.

Q. The normal premature appearance of the right?

A. Yes.

Q. Was that known in 1983 that the normal premature appearance looks this way?

A. Well, there were not very many babies of that age that were scanned at that time period. So I don't know. I don't know the answer to that.

Q. You say there were not very many babies.

Where were you in 1983?

A. 1983?

Q. Uh-huh.

A. I was in Spain, doing military duty.

Q. In the Air Force, as I recall?

A. In the Air Force.

Q. Did you do any scans of babies in Spain in 1983?

A. They would be transferred into Madrid. We didn't have a scanner at our hospital, but I would refer those to there. But generally, babies that require this kind of care, even today, don't get scans like we would do on older children. Because they require so much support from being, like, in an incubator or whatever, to bring them to the radiology department is a major undertaking. So that's why ultrasound has always been the principal diagnostic method.

Q. Why would they do them in 1983 if it was so difficult and required so much support?

A. I can't, specifically, state why they would choose to do that. Apparently, they felt it was necessary at the time.

Q. And then we talked about the right cerebral hemisphere is, likewise, involved, and you

said that that is just what a premature baby looks like; is that right?

A. By and large, yes.

Q. Is there some book that I could go to that it would say that?

A. Sure.

Q. What book would that be, sir?

A. There are some atlases that have had pictures, and principally, they're of MR these days. I'm trying to think of CT that would have pictures of that age. I would have to look through my books to find some, but I know they exist.

Q. I mean, is that something that today is common knowledge that the -- a CT scan of a 34-week or a premature baby would show some lucency involving gray and white matter?

A. Yes.

Q. That's something that was known in '83; is that right?

A. Probably.

Q. And then it says, "The infratentorial structures seem to be normal, although one cannot exclude a similar type of change, but to a lesser degree, in the brain stem and cerebellum." Do you agree with that?

A. Well, what does that mean?
Q. I'm asking you. I don't know. That's kind of nonsensical.
A. I don't really know what that means so --
Q. Okay. And then it says, "The findings are most probably those of extensive damage due to asphyxia." You disagree with that; is that correct?
A. That's correct.
Q. And here we are. You're a pediatric neuroradiologist, and you're the chairman of the department, and you're looking at this report, and I'm sure you're thinking to yourself, "I wonder what they were basing that on?" Do you have any idea? Can you, kind of -- do you have any opinion as to what they saw on the film that would have led them to believe that this is extensive damage due to asphyxia?
A. Well, you're asking me to speculate about --
Q. No. What I'm saying is you're looking at the film. Can you say, by looking at the film, "Gee, I see what they were thinking about. They may have been wrong, but I can sure see what they were thinking about," or is it just dead wrong?
A. Well, if you go back and look at the literature from that time period, there were many

articles that virtually every abnormality in the brain that occurred in a newborn was attributed to asphyxia.

Q. And tell me some of the articles, some of the authors back then that would say that?

A. I'd have to do a literature review to go back and dig them all up. But they're there.

Q. Are there any authors that come to mind?

A. No one in particular.

Q. And you're saying that everything back then was attributed to asphyxia and now it's attributed to infarction or what?

A. No. I'm saying that a lot of the literature published in that time period was research that did not include control groups, that did not -- that were just anecdotal listings of findings that occurred in these children without any real proper investigations into what happened. I mean, it was bad stuff.

Q. Okay. Turning to the 11/21 ultrasound, would you read that for me, sir.

MR. ROSENTHAL: One page from that ultrasound?

MR. ZWIBELMAN: I thought there were two?

THE WITNESS: There's only one.

MR. ZWIBELMAN: I thought Dr. Gotto had it in his records.

MR. ROSENTHAL: No. And you told me you were given just one page. Because you initially indicated you had two pages in the initial one, and then, when we recontacted your office --

MR. ZWIBELMAN: That's fine. I could have sworn there were two.

MR. ROSENTHAL: If you have another page, I'd like to see it.

MR. ZWIBELMAN: I don't. I thought that -- my recollection of Dr. Gotto's deposition is there was two. But that's okay.

MR. ROSENTHAL: To my knowledge, there were two at one point, but we don't know where the other one is.

MR. ZWIBELMAN: That's fine.

THE WITNESS: So this is a limited ultrasound including six coronal views of the brain that shows that there's an abnormality in the left cerebral hemisphere, in the middle cerebral artery territory, which includes a rim of echogenicity along the border of the abnormality with a zone of lower echogenicity beyond it. The ventricles appear to be fairly symmetric at this time. So the left lateral ventricle has increased in size since that previous CT. And I don't see any abnormalities on the right -- on the

right hemisphere. So I would say that this appears to be consistent with an evolving left middle cerebral artery territory infarct.

BY MR. ZWIBELMAN:

Q. I appreciate your answer. It was a bad question. What I wanted you to do is the same as with the CAT scan. Could you dictate the report?

A. Oh, I thought I just did.

Q. Oh, okay. If you look, sir, at page 131 of the records, which is the interpretation of the head ultrasound, do you agree with the findings on that?

A. Well, since I never had the first one to look at, I can't comment about how it's changed from the first one.

Q. Okay.

A. However, apparently, by report, the first one showed the brain parenchyma to be echogenic. And now this report indicates that the parenchyma is no longer echogenic, as it was before. Again, there is a comment that there's been an increase in the size of the ventricles and no evidence of hemorrhage.

Q. Now, there's no mention in this report about infarction, like you said that you would have interpreted; is that right?

A. That's right. It's clearly there, though.

Q. I appreciate that. But I guess my question is, again, it's your opinion that the report of the head ultrasound is wrong also; is that correct?

A. Well, I would have worded it differently.

Q. I understand. You would have worded it differently, but you saw, in the head ultrasound of 11/21, an evolving infarct; is that right?

A. Correct.

Q. The physicians there didn't see an evolving infarct, did they?

A. Well, they didn't mention it.

Q. Well, if they saw it -- I mean, is that a significant finding?

A. I would think so.

Q. So you would say that their interpretation is wrong by not including the infarct; is that right?

A. Yes.

Q. Okay. We talked about timing before. Can you time an infarct in the same way you time an asphyxial incident? And by that, I mean there's edema; there's echogenicity; the echogenicity reaches a peak. Could we use the same thing, this timing an

infarct, as we can timing an asphyxial incident?

A. What we're timing is a reaction of the injury to the brain cells no matter what the cause is. So when brain cells die, it sets up a certain pattern that we see in combination on CT, MRI, ultrasound.

Q. Would the reaction of the brain cells to an infarct be the same as the reaction of brain cells to an asphyxial incident, in terms of timing?

A. Yes.

Q. So here you have an infarct, and you described it as an acute left middle and partial anterior cerebral artery infarct. That's what you said was there; is that correct?

A. Correct.

Q. I notice, in your description of the -- your dictation, you didn't mention cause, did you?

A. No.

Q. As part of your job here as a clinician, pediatric neuroradiology clinician, is part of your job to ascertain cause, or is that just something you do in medical-legal matters?

A. Generally, that would be something that I would talk about in referring directly with the clinicians, but I would -- I don't usually include

that as part of my official report.

Q. Here at Children's Hospital, do they come to you for interpretation, or do you go to them?

A. They come to me.

Q. Okay. Is there any indication in this case that any of the treating physicians went to Dr. Shackelford or Dr. Belding or Dr. Gotto or Dr. Claybourne or Dr. Siegel?

A. I have no idea of that.

Q. Certainly, it would be your impression that they should have; is that correct?

A. And probably did.

Q. I appreciate it, but it's your impression that they should have gone to these neuroradiologists for their interpretations; is that correct?

A. Yes. To discuss the findings of the film and what they mean.

Q. This facility that we're at, is this a teaching institution with residents?

A. Yes.

Q. And when you, as a -- attending? Is that the right phrase, "an attending"?

A. Yes.

Q. When you, as an attending, interpret films, do the neonatologists and the neurologists come

to you, or do they come to the resident?

A. They come to me on a daily basis. Usually at 8:30 in the morning.

Q. Okay. And so the internists, you say, probably did go to the attendings, which would have been Dr. Shackelford, Dr. Gotto and Dr. Siegel. That's what your testimony was; is that right?

A. Well, again, this is pure speculation, but that's what generally happens in practice.

Q. And that's good medical practice; is that correct?

A. Yes.

Q. Now, if, in fact, one of the physicians came -- one of these physicians in 1983, not the neuroradiologists but the neonatologists or the neurologist or whoever it was came to you, would you have rendered an opinion as to your differential as to the cause of the infarct?

A. Yes.

Q. And what would you have said would be the differential?

A. I would have said, "This looks like an embolus. Go find the source of the emboli."

Q. Could it have been a thrombus? Would that have been in your differential?

A. Yes. But thrombus just implies that the occlusion developed at the site of the occlusion. For instance, the occlusion formed right where the occlusion occurred, like an arterial sclerotic vascular disease thing. An embolus implies it formed someplace else and --

Q. Could the cause of this infarct have been ischemic?

A. Well, ultimately, every infarct is ischemic in that vascular territory that causes the necrosis of the brain. So, in effect, it -- in a focal aspect, yes, it's ischemic. In a general aspect of dropping the blood pressure, as occurs in babies that get in trouble during labor and delivery, no, because that would produce the low perfusion pattern of injury, also known as the watershed pattern of injury, which is not present in this child.

Q. You said, with some resoluteness, that it was an embolus, "Go find it." What is it -- or what can you tell me about your findings on the film that cause you to believe it was an embolus, relatively certain it was an embolus?

A. Because of discrete vascular territory that died.

Q. Now, can an embolus be caused by trauma?

A. Yes.

Q. Let's go back a minute. When you say, "It's an embolus. Go find it" --

A. The source.

Q. -- "Go find the source," can you, based upon what you see on the film, what you see on the reports -- well, scratch that.

If reports were available to you -- as a neuroradiologist talking to the clinicians about the case, you'd have the reports in front of you, would you not?

A. Reports of what?

Q. The films.

A. Generally.

Q. And you'd have prior films, if they were there; is that right?

A. Yes.

Q. Would you ask to see the medical records other than the reports or the films?

A. Well, I'd expect them to know the medical history of the child and tell it to me.

Q. Based upon your experience and as an expert witness today, are you in a position to tell us anything other than it was an embolus, go find the source?

A. No.
Q. Can you tell me, as you sit right here, what the source was?
A. No. There is no way to know from the imaging studies what the source was.
Q. Emboli can be caused by trauma; is that correct?
A. They can be.
Q. Emboli can be cautioned by asphyxia, can't they?
A. I don't know how that would work.
Q. Have you ever read in any of these books, including Volpe, that perinatal asphyxia can cause emboli in this very territory?
A. I've never seen controlled research that verifies that.
Q. So, basically, your testimony today and your testimony at trial will be that you see an acute left middle and partial anterior cerebral artery infarct and that's your opinion in reading the films. Your opinion is that this was caused by an emboli, but you're not in a position to say where the emboli came from. You would leave that to the clinician; is that correct?
A. That's correct.

Q. Is perinatal asphyxia with attendant hypoxia the most common cause of focal cerebral ischemic lesions in the distribution of the middle cerebral artery?

A. Again, those are a lot of terms that I don't like to use because they're too general.

Q. Okay.

A. And would I agree with that statement?

Q. Yeah.

A. No.

Q. What is the most common cause of focal cerebral ischemic lesions in the distribution of the middle cerebral artery?

A. Emboli.

Q. When do you think it was that this -- scratch that.

What was the process that caused this infarct? There was an emboli?

A. Yes.

Q. And then what happened?

A. Plugged the vessel. Stopped the blood flow to that region of the brain. Brain cells died, resulting in swelling and an influx of the normal crew of cells that come in to remove damage and dead brain tissue. And then it was removed over the next month.

Q. Can you render any opinions as to when the emboli plugged the vessel?

A. I can give you a general time frame.

Q. Why don't you do that. Let me -- go ahead. Let me just see if my analysis is right and you agree with me or disagree with me.

There was an ultrasound that was done at 32 hours; is that correct?

A. Correct.

Q. Okay. And there was this echogenicity, and it would have been more than 24 hours before that; is that correct?

A. Yes. More like 48.

Q. Okay. And probably less than ten days?

A. Oh, yes. Absolutely.

Q. So based upon the findings on the ultrasound -- the first ultrasound, that's all -- tell me what your conclusions would be as to when it was. Just that first ultrasound.

A. I think the earliest it could have occurred is around 48 hours before that ultrasound. So sometime during the last day during -- before delivery.

Q. And so, if, in fact -- if, in fact, we see -- if, in fact, it was taken at 32 hours of life,

then your timing would have been more than 48 hours before that or within 48 hours?

A. If I were just basing it on the ultrasound that showed the echogenicity, then it would be anywhere from 48 hours to, without showing any dead cavitated tissue, 48 hours, two days, up to five, six days.

Q. So that would be -- based upon the ultrasound, that would be 13:00 on 11/11 to, roughly, 13:00 on 11/6; is that right?

A. Yes.

Q. Now, the CAT scan -- can you tell, sir, whether the echogenicity, the edema on the CAT scan at 84 hours of life was at the maximum?

A. No. There's no way to know if you're actually at the maximum.

Q. Would you think, sir, that a physician who said that what he sees on the CAT scan was the maximum, that would just be wrong?

A. Well, I think that that's a very hard determination to make. There's certainly a lot of swelling there. It may be at the maximum.

Q. I understand. But if the doctor says, "That's the maximum," you're --

A. I would not be so absolute.

Q. Based upon what you see on the CAT scan, when do you think it was -- putting the CAT scan together and the ultrasound together, give me some parameters.

A. The CAT scan looks like that infarct -- just looking at the CAT scan alone, I would say that infarct was anywhere from three to five or six days old.

Q. And why do you say that?

A. Because of the degree of the low attenuation, the amount of swelling that's present.

Q. Okay. So based upon that, the CAT scan, you say it could have been three days, which would have been 11/12, at 17:00, and five or six days before that would be the earliest, which would be 11/9 at 17:00; is that correct?

A. Yes.

Q. Okay. And when you put -- do you put the two together, or do you just depend on the CAT scan?

A. Put the two together.

Q. So if you put the two together, it would then be somewhere between 13:00 on 11/10 and 13:00 on 11/11; is that right?

A. Thereabouts, yes.

Q. Okay. And then, does the last ultrasound

help at all?

A. No.

Q. So is that what your opinion is, it's between 13:00 on 11/10 and 13:00 on 11/11?

A. Yes. That would be my best guess.

Q. Okay. In terms of the five or six -- you said three to five or six days. Is there some book that I could go to that would say -- that would tell me those figures?

A. I can't pick out a particular source. A lot of books have talked about it.

Q. But you can't tell me --

A. Could I pick one out?

Q. -- Barkovitch?

A. Some of that stuff is in Barkovitch's book. Some of that stuff about ultrasound is in Barkovitch's book.

Q. Based on what you see on the CAT scan, that it would have been 11/9 at 17:00 to 11/12 at 17:00; is that correct?

A. That's, roughly, the time frame. That's where I would have focused my attention.

Q. And I suppose, if we had the ultrasound of 11/12, you could be even more specific than you are today; is that right?

A. Possibly.
Q. In 1983, you were in the Air Force; is that right?
A. That's correct.
Q. Up through 1983, how many -- how much pediatric neuroradiology had you done?
A. Just during my residency.
Q. Okay. And --
A. But I was doing cranial ultrasounds during my residency.
Q. Okay. Your residency, was it in general radiology, or is it pediatric radiology?
A. Diagnostic radiology.
Q. How much of the time in diagnostic radiology? Was it a three-year program?
A. Four years plus an internship.
Q. So it's five years total?
A. It didn't turn out to be completely five. Six months internship.
Q. How much of that four years six months post-medical-school training was in neonatal neuroradiology? What percentage of the time?
A. Well, there were -- it got scattered throughout the whole time. There were four months of pediatric radiology of which you were doing everything

in pediatrics. There were four -- as I recall, somewhere between four and six months of neuroradiology. And I already knew at that time that I liked pediatric radiology and that's what I wanted to do. So I, kind of, focused on that when I was there.

Q. You were in the Air Force at the time this baby was born; is that right? November of 1983?

A. Yes.

Q. And that was, roughly, a three-year period?

A. Yes.

Q. Were you doing any neuroradiology then?

A. I was doing general radiology then.

Q. Were you doing any neuroradiology?

A. Some. Not much.

Q. Were you doing any pediatric neuroradiology?

A. Some. Not much.

Q. The overall -- would you agree that the overall state of CT imaging of the neonate was fairly well developed in 1983 and institutions were pretty close to their third or fourth generation of CT scanners? This is 1983.

A. Yes.

Q. Can you look at the CT scan that was taken on 11/15 of '83 and tell me what kind of scanner it was?

A. Yes.

Q. What kind was it?

A. Looked like an EMI scanner.

Q. Is that a fairly sophisticated scanner?

A. For 1983, no. It was already an outdated scanner.

Q. At the institution of Washington University, they were using outdated scanners?

A. Well, like in a lot of places with budget crises, you use the instruments until they wear out.

Q. In 1983, there was an extensive body of writings, literature about cerebral infarcts of the neonatal family; is that so?

A. Probably.

Q. Now, you and I talked about this, and I just want to make sure. Are you going to render any opinions about what long-term injuries you would expect to see based upon what you see on all of those films?

A. The only opinion I will render is that it's impossible to predict from the imaging studies.

Q. If the child was described as having --

let me describe cerebral palsy, which is primarily spastic, all four extremities involved, although the function in the left upper extremity is very good. If a clinician came to you and said, "Doctor, I have a patient," and that is the description of the physical problems that the child has, can you, as a pediatric neuroradiologist, give me any idea what you would expect to see on the films?

A. No. In fact, I've even seen cases that were completely normal with MRI in those situations.

Q. I guess, as a lay person, if I told you that all four extremities are involved, wouldn't you expect that both hemispheres of the brain were involved?

A. They may be. They may not be. It may be spinal cord. It may be any number of different things are possible.

Q. What about if I were to go through and -- or a clinician were to go through and say, "Doctor, my patient has a number of mental -- not physical but mental limitations, such as mental retardation" or whatever it might be. Could you see manifestations of those on head films?

A. Well, we usually scan those patients to see if we can find the cause. And sometimes we do,

and many times, we don't.

Q. Could you, on the CAT scan -- on the MRI that was recently taken of this child, could you see any lesions -- I guess that's the word -- which would cause all four extremities to be involved?

A. No. I can't point to any particular place that it would cause all four.

Q. Is that because they're there and the MRIs aren't just sophisticated enough to pick up on them, or it's just not there?

A. I can only describe what I can see as abnormal.

Q. No, I appreciate that. What I'm trying to figure out is, arguably, if the resolution was greater or it was more sensitive, would it pick these things up?

A. I don't know the answer to that question.

Q. How much time did you spend -- have you spent on this case?

A. Two or three hours.

Q. How much time did you spend reviewing Dr. Edwards-Brown deposition?

A. About 40 minutes.

Q. Obviously, your interpretations of the films are different, and you disagree with her on

that. Is there anything else that you disagree with in terms of what she said?

A. Well, that's a very broad question. Can you be more specific?

Q. Well, in going through the deposition, did you mark anything as just being -- that you disagree with or whatever it is?

A. Well, I disagree with the way that she speculates that things have to be there or how she speculates that this has to be perinatal asphyxia because of the clinical symptoms. She's going out of her realm as an imaging specialist when she makes those statements.

Q. When you say it's out of her realm, you believe that an imaging specialist, a neuroradiologist, should look at the films and base her findings on what's on the films and her opinions on what's on the films and not go beyond that?

A. Correct.

Q. Can you render -- I want you to assume that mom was a diabetic and that, in the delivery room, the child had a blood glucose of 300. Does that mean anything to you, as a neuroradiologist, in putting the cause of the thrombus or the cause of the embolus in any clearer view?

A. No.
Q. Okay. The C.V. that you've supplied us, do you have a copy of it? Is that the one that Lisa sent me?
MR. ROSENTHAL: This is through January of 2003. So I don't know.
MR. ZWIBELMAN: I think that is. Let me see.
Q. Can we mark that? Is that an extra copy sir?
A. Yes.
Q. Can we mark that as --
A. Exhibit 1.
Q. We're almost done.
Doctor, Plaintiff's Deposition Exhibit 1 is your C.V.; is that correct?
A. Yes.
Q. Is that current and up to date?
A. Pretty much so.
Q. Are there any articles or book chapters or anything that you have written that deal with acute left middle and partial anterior cerebral artery infarcts or cerebral artery infarcts?
A. Well, nothing directly. There are some indirect things.
Q. Tell me what, indirectly.

A. Well, I already see a mistake that my secretary made in duplicating one of my articles here.

Q. I've got one that's dated 6/3/03. Is that the one you have sir?

A. That's probably more up-to-date.

Q. Well, why don't we mark this.

MR. ROSENTHAL: Mark it as 1?

MR. ZWIBELMAN: Yeah, I think so.

(Plaintiff's Exhibit 1 was marked for identification by the court reporter.)

THE WITNESS: Probably the one that would be most relevant would be a book chapter that was listed in here as No. 12.

BY MR. ZWIBELMAN:

Q. What's the title of that, sir?

A. "Neuroimaging of Perinatal Asphyxia in Term Infants." This is the Report of the Workshop on Acute Perinatal Asphyxia -- and I hated that title, but I was forced to use that title for them.

Q. Is that book -- is it a book?

A. Well, it's a paperback book that they issue.

Q. Was their mention in your discussion of cerebral infarcts?

A. Well, there was about timing. The

business about timing the injuries was what I was asked to talk about.

Q. And in that, did you not say it was 72 hours was the maximum --

A. Yeah.

Q. -- as opposed to --

A. No. 72.

Q. The maximum is 72?

A. Yes.

Q. Any other articles that deal with infarcts or embolus?

A. Not that I can recall.

Q. Okay. Do you have a specific research or writing interest?

A. It's been all over the board, but my primary area of interest is how the blood vessels develop in the brain.

Q. Okay. Does that have anything to do with here?

A. No.

Q. At present, are you the chairman of the Department of Radiology?

A. At Children's Hospital Los Angeles.

Q. And as such, it's my understanding that approximately 35 percent of your time is spent

administratively?

A. Yes.

Q. And 20 percent of your time is research?

A. I wish. That's what I'm scheduled for, but I don't hardly ever get it.

Q. How much of your time is research?

A. Maybe 5 percent.

Q. And how much of your time is spent on medical-legal?

A. Less than 5 percent.

Q. So, roughly, 60 percent is clinical?

A. Yes.

Q. Of the clinical, how much of it deals with neonates. How much of your of 60 percent of your time is dealing with neonates?

A. 20 to 30 percent.

Q. So, roughly, 12 to 18 percent of your time deals with neuroradiology of the neonates; is that correct?

A. Absolutely.

Q. And what is your definition of "neonate"?

A. "Neonate" is the first 30 days of life.

Q. Before you became chairman, was it the same breakdown or --

A. No. I didn't have as much administrative

stuff before this.

Q. You've been doing malpractice since 1987, 1988; is that right?

A. '88.

Q. Since you became chairman, has your work in medical-legal come down?

A. Considerably.

Q. You're limiting your testifying; is that right?

A. Yes.

Q. Before you became chairman, you were doing what? 50 cases a year? Reviewing about 50 cases a year?

A. You've done your homework. You've read my previous depositions. About 50 cases a year, about ten depositions a year, about three trials a year.

Q. And now what is it?

A. Maybe 20 cases. Ten, 15 cases a year, two or three depositions, and maybe one trial a year.

Q. Before you became chairman, you indicated in previous testimony that, of the reviews, 75 percent of them were for the defendant?

A. Yes.

Q. And 90 percent of the depositions were for the defendant, and 97 percent of the trials were

for the defendant; is that right?

A. Yeah. That still holds.

Q. Have you ever been retained in the state of Missouri to testify on behalf of a plaintiff? That's a bad question.

Have you ever been retained to testify in a Missouri case for a plaintiff?

A. Yes. For a plaintiff?

Q. Yes, sir. Plaintiff's counsel.

A. Not that I recall.

Q. Do you advertise your services?

A. No, I do not.

Q. Have you ever been connected with an expert witness service?

A. No.

Q. You said less than 5 percent of your time presently is spent on medical-legal; is that right?

A. Yes.

Q. What percentage of your income presently comes from medical-legal?

A. Way less than 5 percent.

Q. How many lawsuits have you been personally involved in where either you, personally, have been sued or your institution has been sued based upon something that you allegedly did?

A. One that went to trial. And I think, because I read a film in a case, there's one that's pending, but it's not related to the case. They just named everybody that had their name on the chart.

Q. The one that went to trial, what was that all about? Do you remember?

A. Yes. Very specifically. I ended up spending six weeks in a courtroom downtown. And it had to do with giving a sidewalk consult to the neurosurgeon on some films that came from Long Beach that had to do with a child that had a vascular malformation.

Q. Not a neonate?

A. Not a neonate.

Q. You put on a seminar for a group of defense lawyers about ten years ago?

A. Oh, at last. I was invited to come and just talk about imaging of brain injuries and timing.

Q. Any notes on that or any --

A. No.

Q. -- hand-outs?

A. No.

Q. And basically, we've talked about your opinions about timing. We've talked about your opinions about the interpretation. Your opinion is

that it was caused by an embolus. You don't know the source of those emboli. And those are all your opinions; is that right?

A. That's right.

Q. Thanks.

MR. ROSENTHAL: Just so the doctor -- you mentioned the MRI but --

MR. ZWIBELMAN: Oh, yeah, yeah, yeah.

MR. ROSENTHAL: He reviewed the MRI and has opinions about what the MRI shows as well.

BY MR. ZWIBELMAN:

Q. Tell me what your opinions are on what the MRI shows.

A. This shows the end result of the injury that occurred at the end of the time period where all the brain tissue damage has been removed. It shows the area of necrosis has been removed.

Q. Anything else?

A. In the left middle cerebral and partly in the anterior cerebral artery territory.

Q. And basically, the MRI is the end product of what was going on; right?

A. Yes.

Q. Any other opinions?

A. No.

MR. ZWIBELMAN: Mr. Rosenthal, maybe you can help us.

MR. ROSENTHAL: He's going to testify about his interpretation of the films and that sort of thing and his opinions on cause and the timing.

BY MR. ZWIBELMAN:

Q. As we've discussed today; right? Have we covered all your opinions in this incisive questioning today?

A. I believe so.

Q. Okay. Thank you, sir.

Oh, do you want to waive -- what do you want to do about your signature?

MR. ROSENTHAL: Read the depositions.

THE WITNESS: Yeah.

MR. ZWIBELMAN: Okay. Why don't you send me the original but send him the original signature page, and he'll see that it gets to the doctor to sign it so we'll get you out of the loop.

THE REPORTER: Okay.

MR. ROSENTHAL: I'd like a mini and an ASCII.

MR. ZWIBELMAN: Let's go back on the record. I'm sorry.

Q. How much do you charge for this?

A. $500 an hour.

Q. And deposition, the same?
A. Same.
Q. And if, perchance, it's possible to leave Los Angeles in the morning and you can be back at night, to testify at this trial, how much would you charge for that?
A. I charge for the number of hours that I am not available for work, my normal hours at work, which I usually work about ten hours a day.
Q. And if you had to come back the next day, it would be $5,000 a day, roughly?
A. Yes.
Q. Have you been asked to come to St. Louis for this trial?
A. Not yet.
Q. Thank you.
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I, MARVIN D. NELSON, JR., M.D., do hereby declare under penalty of perjury that I have read the foregoing transcript; that I have made any corrections as appear noted, in ink, initialed by me; that my testimony as contained herein, as corrected, is true and correct.

EXECUTED this _____ day of _____, _____, at _____, _____.

(City) (State)

_____

MARVIN D. NELSON, JR., M.D.

I, the undersigned, a Certified Shorthand Reporter, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were placed under oath; that a verbatim record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction; further, that the foregoing is an accurate transcription thereof.

I further certify that I am neither financially interested in the action nor a relative or employee of any attorney of any of the parties.

IN WITNESS WHEREOF, I have this date subscribed my name.

DATED: _____

_____
ELIZABETH PADILLA
CSR No. 9048