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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

FORREST GREGG STONE,
a Minor, etc., et al.,

Plaintiffs,

-vs- CASE NO. 396873

CORAZON O. GO., M.D.,
et al.

Defendants.

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Deposition of PHILIP NOWICKI, M.D., taken as if upon cross-examination before Sandra L. Mazzola, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Childrens Hospital, 700 Childrens Drive, Columbus, Ohio, at 9:35 a.m. on Wednesday, February 13,2002, pursuant to notice and/or stipulations of counsel on behalf of the Plaintiffs in this cause.

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PHS Deaconess Hospital and
Paul A. Hudock, M.D.

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PHILIP NOWICKI, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF PHILIP NOWICKI, M.D.

BY MR. LEVIN:

Q. Could we have your name for the record?
A. My name is Philip Theodore Nowicki.
Q. Dr. Nowicki, you are an expert witness in this case?
A. Yes, I am, sir.
Q. Okay. I was told, because i do what I am told, I was told you would only testify if you had a check in hand.
A. Not quite. I would testify -- I charge a flat rate for my depositions of $1,500, and the last --what a guy. And the last time I did this the opposing counsel, when he got the bill, was very upset at the fee and he stiffed me for seven months.

MR. LEVIN: Let the record show that I'm tendering $1,500 between the witness and Mr. Scott per the instructions of this

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witness.

Q. And doctor, I appreciate --
A. You have made my wife very happy.
Q. And that is my goal.
A. That's my goal.
Q. Let me just see if we can get this formally down here. You charge $1,500 for a flat rate whether the deposition goes one minute or two days, is that fair?
A. That's correct.
Q. Okay.
A. Never gone m e minute. Never gone two days. But you're right.
Q. I just want to have it on the record.

I'm not going to mark this, but you provided a curriculum vitae. I assume this is a fair and accurate representation of your history?

A. That iscorrect.
Q. Let me see if we can go through a couple of things briefly. You were born in 1952, correct?
A. That's correct.
Q. And you went to Perdue University and graduated in 1974?
A. Correct.
Q. And Tufts Medical School and graduated in 1978?

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A. Correct.
MR. SCOTT: You're about to be 50.
A. That's correct. Sad.
Q. Where do you work right now? Where are you employed?
A. I'm employed by the Department of Pediatrics at the Ohio State University College of Medicine. In that capacity I am a professor of both physiology and pediatrics, pediatrics being my primary appointment.
As a member of the Department of Pediatrics, I am also a member of and employed by the pediatric practice plan which is called the Pediatric Academic Association, or PAA, and I receive compensation from both the Ohio State University on a monthly basis and from the PAA on a biweekly basis. And that's where my salary comes from.
Q. Okay. How much of your time, if you can tell me, is spent with the Department of Pediatrics and how much of your time is spent with the Pediatric Academic Association?
A. It's really coalesced. They really don't -- they merge together. As being a pediatric faculty member, I have responsibilities of teaching

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medical students, but the teaching of medical students that I do primarily occurs during their clinical years, third and fourth years, and that usually occurs when I'm involved in the practice of medicine. Now, as a research based physician 50 percent of my time is spent doing clinical work and 50 percent of my time involved in research and my teaching activities occurring when I'm involved in clinical research.
Q. Your areas of research are what as you state them?
A. I have for the past roughly 19 years been involved in the study of vascular biology, which is the biology of blood vessels as they pertain especially to the developmental changes that occur in the intestinal circulation of newborn infants as that would occur -- as that would pertain to their capacity to live after birth and begin to function after birth and absorb nutrients and such.
Q. I have a description of your research put out by Ohio State University. I'm going to show it to you and ask you if it accurately states your research interests.
MR. LEVIN: John, I pulled this off

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the website.
A. That's correct. I wrote it. I know it's correct.
Q. Let me just read it into the record. Developmental vascular biology on several organizational levels, including total organ, isolated microvessels, cell culture, vascular smooth muscle differentiation, integration of molecular differentiation, physiological outcome and endothelial cell biology, especially as regards nitric oxide and endotholin. Is that correct?
A. Correct.
Q. Now, part of this research is on humans and part is on animals, is that correct?
A. Almost all of it up to very recently has been on animals. We recently have commenced human work, or work using human tissue. It's just beginning.
Q. I see from your publications you do research on pigs?
A. Pigs.
Q. Okay. Have you ever done any research in hemophilia?
A. No, sir.
Q. Have you ever done any research with clotting

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disorders or with coagulation issues?
A. No.
Q. Now, are you the primary care physician for any patients or are you someone who gets called in as a consultant?
A. My clinical responsibilities are primarily involved in the provision of intensive care to preterm and ill newborns. And I do all of my clinical work now at University Hospital, thus if a baby is born at University Hospital and is born preterm, or if born at term and after birth is ill, that child would come to the intensive care nursery where I would be the primary caretaker.
It's not primary care in the sense of being a family physician. It's specialized care. However, as part of that, I also am responsible when we have -- as well as an intensive care nursery at University Hospital, we also have what's called a well infant nursery, which is where anticipate percent of the babies that are born there go.
In other words, you deliver a child at University Hospital. If they do not have a pediatrician, if the mother does not list a pediatrician when she comes in, it's mandated by

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the State of Ohio that a pediatrician see the child before discharge. The staff physicians, which would be me, would do so.

So I'm providing care to well infants, infants that are not ill, just to examine them, perform circumcisions, provide counseling and information to mothers, and referral of those infants to pediatricians in the community.

Q. Let me ask this. Simpler question. Do you have any patients that you follow when they leave the hospital?

A. No.

Q. You deal only with neonates or do you also deal with children who are older than neonates, however you would characterize them?

A. We have --

Q. And by you, I mean you personally.

A. There is a follow-up program such that babies that go through our intensive care nurseries are followed by the physicians that saw them in the intensive care nursery here as well as their pediatricians on the outside. At this point in my life I do not participate in that care at all. So I do not follow any of the infants. The only patients I see are newborn infants.

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Q. How long has that been the case?

A. Since December of 1996.

Q. What percentage of -- strike that. I'm trying to get some numbers here. You say you spend 50 percent of your time in research and 50 percent of your time in clinical, is that correct?

A. Correct.

Q. And the clinical is divided between teaching and rendering patient care, correct?

A. Correct.

Q. How would you divide that 50 percent clinical between those two?

A. Oh, I would say 5 to 10 percent teaching, 40 percent clinical care. More -- you know, I don't know how it's done in law school, but I mean basically third and fourth year medical students follow staff physicians around and watch them in all their practices basically. So whenever I provide care to a newborn at University Hospital, invariably there is a third or fourth year medical student right behind me in a white coat watching what I do, and I'm talking to them and teaching them. So it happens at the same time.

Q. Do you consider yourself -- let's see if we can just go through in terms of what you consider.

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You consider yourself an expert in pediatrics, correct?

A. Yes.

Q. And you consider yourself an expert in neonatology, correct?

A. Yes.

Q. By the way, do you have a rule of thumb as to when neonatology ends and just being little kids begins?

A. Technically, the neonatal period is define as the first 28 days after birth. That is a very romantic conception. It's based on ancient history.

Q. What do you call it in your practice?

A. I think in my practice what I do is I'll take care of a baby in the intensive care nursery until that baby goes home. And if that baby requires more than one month of hospitalization as oftentimes is the case for very preterm infants, then, you know, if the kid is in the hospital for three months, then I'll take care of it for three months.

Q. That's really developmental and able to thrive more than just chronological?

A. Precisely.

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Q. Do you consider yourself an expert in hematology?

A. No.

Q. Do you consider yourself an expert in neurology?

A. No.

Q. Do you consider yourself an expert in neurosurgery?

A. No.

Q. Do you consider yourself an expert in radiology?

A. No.

Q. And I assume that you do not consider yourself an expert in the subfield of neuroradiology?

A. No.

Q. And do you consider yourself an expert on nursing standards?

A. Nursing standards as they pertain to the normal delivery and care of well infants, yes, I have worked with nurses and worked in well baby nurseries ana intensive care nurseries for almost 20 years, and you know, nursing standards and medical standards in that particular venue, walk hand and hand. And so I would consider myself to be very well-versed in what I would expect a nurse in either a well baby nursery or an intensive care nursery to be responsible for, yes.

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Q. Do you have a list of what you reviewed in this case?
A. I have it right here in front of me. I reviewed the --
MR. SCOTT: Actually, not to interrupt you, but I think there is a heading.
MR. LEVIN: If we can read it into the record, it would be faster, if there is a list somewhere.
MR. SCOTT: If that helps.
A. Okay.
Q. Can I see that front page?
A. Sure.
Q. Let me read this into the record. Doctor, you reviewed records from MetroHealth?
A. That's correct.
Q. And also neurological surgery at MetroHealth?
A. Correct.
Q. From Carol Crowe at MetroHealth?
A. Correct.
Q. And also five groups of records at University Hospitals, Shurin, correct?
A. Correct.
Q. Therapy records, physical therapy records?

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A. Yes.
Q. Some emergency department records?
A. Yes.
Q. An evaluation actually not from University but from Southwest, speech language?
A. Yes.
Q. And the records of Dr. Walker?
A. Yes.
Q. Have you reviewed anything else?
A. I have had the opportunity to review the deposition of Dr. Go in this case that was given to me by Mr. Scott. And I have had the opportunity to review the expert witness reports from all of the witnesses in this case, both yours and Mr. -- Mr. Scott's. Pardon me. Brain failure.
Q. And there were records of experts' reports from Dr. Go's side?
A. Correct.
Q. Have you reviewed those as well?
A. Yes, I can give you that. For Dr. Go --
Q. Okay. Let me ask you before we get to that.
A. Sure.
Q. Dr. Go had a two-part deposition that was, I believe, at least a month apart. Were you given

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both parts? It will say in the beginning whether it's volume I or volume II, but it doesn't say volume I.
A. It doesn't say. I guess it would be volume I.
Q. You were not given volume II?
A. To the best of my knowledge, no.
MR. SCOTT. I don't think so.
Q. Okay. And you were given no other depositions?
A. That is correct.
Q. Are you aware that other depositions have been given in this case or not?
A. As I was not given them, I could not tell you.
Q. This says volume II of II.
A. Could I see what volume I looks like?
Q. I'm going to get to the reports in a minute. Don't worry about it. So volume I represents further records that you were given?
A. Correct.
Q. Okay. And let me read them. There are six. There are antenatal lab records, there are admission records from Dr. Hudock, and it says delivery of Forrest Stone, there's admission records for Forrest Stone, there's the records of Dr. Hudock, records of Dr. Go, and the records of Cleveland Clinic, is that correct?

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A. Correct.
Q. You have no way of knowing, for instance, whether or not during all the hospital stays and hospital visits that this child has had, whether the records you were given are all the records? You would have no way of knowing that, would you?
A. That's correct.
Q. Okay. Do you have a list of the reports you have?
A. Yes, I do.
Q. May I see that, please?
A. Okay.
Q. So we have -- these records were sent to you on February 11, is that correct?
A. That's correct.
Q. And your report is dated?
A. Much earlier than that. September of last year, I think.
Q. So you did not have the benefit of these -- of any reports when you did -- strike that. At the time that you prepared your report, had you read anybody else's report?
A. No.
Q. At the time you had prepared your report, did you review Dr. Go's deposition?

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A. Yes.
Q. At the time you had made your report, had you reviewed all the records that you now have?
A. Correct. Just the medical records regarding this case. Yes. But I reviewed -- the only deposition that I reviewed was Dr. Go's. I had not been given access to any of the reports. The only reports that I have were given to me by Dr. Scott and that was the 11th of this month.
Q. Mr. Scott. We don't want to promote him.
A. Mr. Scott. I'm not sure it's a promotion or demotion, to be honest.
Q. My question is simpler. Did you receive any new records after the initial set of records you got --
A. No.
Q. -- before your report?
A. No.
Q. Doctor, let me read these in, just for the record. You took a look at reports of Dr. McClead, Dr. Neufeld, Dr. Goessler, Dr. Rothner, Dr. Lanzieri, Dr. Miller, Dr. Shurin, a Nurse Penny Buchholtz, a Nurse Linda DePasquale, correct?
A. Correct.

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Q. You were also sent another copy of your own report?
A. Correct.
Q. Why was that?
A. I don't know.
Q. Has your review of these other expert reports changed any of your opinions in any way at all?
A. No.
Q. I know I asked you this, and I can't remember. Did you get Dr. Go's depo after your report?
A. No, I got it before.
Q. Okay. Have you ever taken a look at any films, CAT scans or other radiological records with regard to Forrest Stone?
A. No.
Q. Do you normally read those yourself?
A. No.
Q. Are you aware that Dr. Lanzieri as a neuroradiologist read them and rendered an opinion?
A. Yes.
Q. And would you agree with me that whatever the validity of his reading, that neuroradiology is not a field to which you hold yourself out as an expert, correct?

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A. That's correct. That doesn't mean that I agree with what he interpreted, but --
Q. I didn't ask that actually.
A. -- I would never argue with him, no. No. He is a radiologist. I'm not.
Q. In fact, have you ever used neuroradiologists to assist you in taking care of your patients?
A. Oh, yes.
Q. For what kind of cases would you bring a neuroradiologist in to help you consult?
A. Any time that we have a scan of a baby's brain, whether it's a CT scan, an MRI, a vascular study or an ultrasound, I would expect a pediatric neuroradiologist to review that scan and to provide me with an interpretation of that scan. It's become a very sophisticated field. They can see things in those shadows that only they can see.
Q. Do you know Dr. Lanzieri?
A. No, I do not.
Q. Do you know him by reputation?
A. No.
Q. Do you know personally or by reputation any of the people testifying on behalf of the plaintiff, that is Dr. Shurin, Dr. Lanzieri, Dr. Miller,

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Dr. Likavec, Penny Buchholtz or anybody else?
A. No.
Q. Do you know Susan Shurin?
A. No.
Q. You understand that Susan Shurin does pediatric hematology?
A. That's what I understand from reading her report.
Q. Okay. Do you use -- do you ever bring in pediatric hematologists to assist you in the care of treatment of your patients?
A. Yes.
Q. Under what circumstance or under what circumstances?
A. Primarily when we have concerns regarding bleeding disorders when we are not able to ourself determine what the problem is causing the bleeding diathesis. We also have done it on occasion when we are giving hormones io stimulate the production of either red blood cells or white blood cells. We have occasionally done it in instances where we were concerned about the presence of a congenital malignancy of the blood cells.
Q. Doctor, will you agree with me that the Childrens Hospital and University Hospitals that you're

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associated with are tertiary care centers as that term is used?
A. Yes.
Q. Okay. And University Hospitals, just for the record, since we are in Cleveland is University Hospital of Columbus, not University Hospital of Cleveland, which the jury may know as a separate institution?
A. That is correct.
Q. They're not affiliated?
A. No, they are not.
Q. Okay. Now, there are primary care centers, there are secondary care centers and the tertiary care centers, sometimes they are called level I, II and III, correct?
A. Correct.
Q. What is the difference between a primary and a secondary and a tertiary, if you could just explain briefly?
A. Secondary is kind of an -- I'm not sure I can identify a secondary care center. There is really more primary and tertiary.
Q. Secondary being squeezed at both ends?
A. Right. A primary care center is a smaller institution, a smaller hospital, whose patient

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volume is relatively low. They see the average litany of problems in medicine and surgery. They do not offer more sophisticated care. They often have some specialists that are on staff and provide consultative work in that hospital, but for specialized treatment or diagnostic procedures, the patients usually are moved to a tertiary care center.
A tertiary care center by contrast is going to spend most of its time providing subspecialty type care at the most complicated level, and has on its staff people virtually in all disciplines that are available to engage in providing care within their particular specialty.
Q. Under what circumstances do primary care hospitals have a duty to send patients to tertiary care centers?
A. That's an exceedingly broad question.
MR. SCOTT: You mean hospitals or doctors?
Q. Hospitals.
A. Hospitals don't. Hospitals don't refer patients. Doctors do.
Q. Okay.
A. In other words, a doctor, if you are a patient in

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a hospital, and you are patient in a hospital who is under the direct care of a specific physician, and that physician may or may not be on staff -- or I'm sorry -- on staff obviously, but may or may not be paid by a hospital, but it's the physician who's responsible for that patient. Hospitals don't write orders. Doctors write orders.
Q. Okay. Let me rephrase that. And we can talk about hospitals' responsibility, if any, to the patient.
A. Yes.
Q. Do you believe hospitals owe some duty to their patients?
A. Yes.
Q. We will come back to that. Under what circumstances do physicians then have a duty to send patients who are in primary care hospitals to tertiary care hospitals?
A. A primary care physician has a responsibility to engage the services of a specialist either on site at the primary care facility or by referring the patient to another institution or sending the patient to another institution when the primary caregiver's capacity to provide appropriate care

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for that condition has been exceeded.
Now, as I said, that can be done in one of two ways. If you have a patient in your primary care venue who has a problem that you think needs to be seen by a specialist but is not a life-threatening process, the specialist can then come to the primary care facility. That's usually what's done.
If by contrast, in the course of a diagnostic workup it's obvious that that patient is going to require the type of procedures that would only be made available in a tertiary care hospital, then transfer of the patient would be in order.
A good example. If I have a newborn infant in a well baby nursery and hear a heart murmur with my stethoscope, I will want the cardiologist to see that baby. The cardiologist usually will bring his own ultrasound machine, or there are ultrasound machines available at the hospitals that you can use. So he can see that patient in the level I nursery. If he determines that the child has congenital heart disease that requires surgical intervention, then that patient would be transferred to a level III nursery, level III

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hospital.
By contrast, somebody comes into a level I hospital in massive chest pain, an adult, an ER physician or primary care physician diagnoses a massive myocardial infarction. That patient is going to require catheterization and probably stent placement. That's not done at the level I hospital. Then you immediately move the patient.
So it's really a function of the patient's condition and what has to be done to that patient.
Relevant to this case, which is what you are getting at --
Q. Doctor, I appreciate actually your giving me long answers and I'm learning a lot. I don't know if we're going to get through the deposition that way. And I will not cut you off again. When you say relevant to this case, I just want to get through --
A. Okay.
Q. I appreciate your candor. I really do. You are giving me very long answers and I have a lot of short questions I've got to get through today.
A. Okay.

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Q. If you want to continue, go ahead. I don't want to cut you off.
A. No. I give you long answers when long answers are mandated, and there is no short answer to the question you gave me, and the fact is it's a function of what the situation dictates at the time, what the patient would require.
Q. Is hemophilia normally able to be treated at primary care hospitals?
A. It can be diagnosed and treated in primary care hospitals very easily, yes.
Q. Okay. And to treat it, it would require a factor VIII or factor IX, is that correct, in general?
A. That is correct.
Q. Do you know whether factor VIII or factor IX is available at Deaconess Hospital?
A. I'm absolutely certain that it was.
Q. What do you base that on?
A. Every hospital in this country is going to have access to fibrin --
Q. Access meaning on site?
A. On site, yes. I mean it's --
Q. That is my only question.
A. Yes, they do. They have it. Guaranteed.
Q. Again, I'm not trying to cut you off, doctor.

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A. Okay. Goahead.
Q. What duties -- you said that the hospital owes certain duties to the patient other than what the doctors owe. What duties do the hospital owe the patients?
A. And if you want short answers, start making relevant intelligent questions. I'm serious. That's a ridiculous question. Okay?
A hospital has a responsibility to provide care for the patient, to provide an environment in which the patient can be properly cared for, to provide staff that are intelligent, well-trained and know what to do with the patient.
Now, I'm not a hospital administrator. I'm not an administrator in any capacity, way, shape or form. So outside of an obvious answer, that's the best I can tell you. That's what the hospital's responsibility is.
Q. Do you have an opinion about the appropriateness or need for protocols for nursing in hospitals?
A. Virtually all hospitals that I have ever -- actually every hospital that I have ever worked in has protocols, not only for nursing care but for medical care. Especially nurseries. And

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that is done because it is imperative that the most up to date, most appropriate care be given to every patient, that the care not be altered by an individual caregiver's level of experience.
So for example, when a patient in a nursery has -- a newborn infant has a problem, say he's breathing too fast, there will be a book in that room that tells the nurse, tells the doctor what exactly they should be thinking about. That happens everywhere in the world, or in this country that I'm aware of.
Q. Have you seel? protocols or procedures for Deaconess Hospital in this case?
A. No.
Q. Bid you ask for those?
A. No.
Q. Do you have any opinion as to whether the procedures ana protocols that were in place at Deaconesswere reasonable? Do you have any opinion on that?
A. I haven't seen them, so I have no opinion.
Q. And do you have any opinion as well as to whether they were followed?
A. I haven't seen them, so I have no opinion.
Q. Have you asked Mr. Scott for any additional

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information that would inform you about anything else before you testify at trial in this case?
A. No.
Q. Do you expect to do any further reading or research about any matters that would be relevant to your opinion before trial in this case other than what you have already done?
A. No.
Q. Have you consulted anyone else in rendering an opinion, talked to one of your colleagues?
A. No.
Q. Do you know any of the defense experts in this case?
A. Dr. McClead is a colleague of mine on staff here at Childrens Hospital. He was approached by the defense counsel for Dr. Go. I learned that only after I read Rick's -- Rick's expert report on the 11th when I received them.
I saw -- Rick works in a building three blocks down, so I don't see him very often. I told him that I was being deposed in this case today and made it clear to him that we should not be discussing the case at all.
Q. And you know no one else involved in this case including treating docs or experts?

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A. That's correct.
Q. Do you know how Mr. Scott found you?
A. I have done reviews for Reminger & Reminger for several years now. I suspect that my name is on their Rolodex.
Q. Have you ever testified before?
A. Yes.
Q. How many times have you testified -- I'm going to ask you first how many times have you testified in the courtroom?
A. Twice.
Q. Both for Reminger?
A. Yes.
Q. And in what cities, Cleveland, Columbus?
A. One in Cleveland and one in a town outside of Cleveland, south and west, and I can't remember its name. That was the first one I ever testified in, And I don't recall.
Q. Medina?
A. No, it wasn't Medina.
Q. Elyria?
A. It was a small town. Elyria, no.
Q. Ashland, Mansfield?
A. No. it wasn't Mansfield or Ashland.
Q. I'm going to run out of county seats, so let me

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go on. Do you recall the captions of either of those cases?
A. No.
Q. Do you recall who the plaintiff's lawyer was in either of those cases?
A. The plaintiff's lawyer for the first case, it was a woman. Her husband is also a lawyer. She works in the Cleveland area.
Q. Claudia Eklund?
A. Yes. Claudia Eklund. Thank you.
Q. You are welcome.
A. Yes.
Q. Small community. Do you know who the plaintiff's lawyer was in the other case?
A. No, I don't remember.
Q. How many times have you testified in depositions?
A. I don't have an accurate record. I would say probably about 25.
Q. And that would include also giving depositions in the two cases that you ended up trying, is that correct?
A. Yes.
Q. How many of those 25 were for Reminger & Reminger?
A. 15.

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Q. And the other times were they defense or the plaintiff or both?
A. They have been both.
Q. Primarily one way?
A. I would say 75 percent for defense, 25 percent for plaintiff. It's purely a function of who calls. I mean I don't -- I don't advertise. I don't solicit cases --
Q. Well, let me -- I'm sorry. I didn't mean to cut you off.
Let me see if I've got the number right. Of the 25 times you've testified, you said 15 times for Weminger?
A. About that.
Q. And about ten times for others?
A. I would think so.
Q. And of those ten times for others, would you say about three-quarters defense and one-quarter plaintiff?
A. That's reasonable.
Q. Do you know the names of any plaintiff lawyers who deposed you?
A. No.
Q. Any of them in Columbus or Cleveland?
A. I don't recall.

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Q. Just Claudia Eklund made an impression on you?
A. Yes. And the reason that she did was because one of the cases that I did for plaintiff was from Claudia after I worked with her on that -- or after I worked in that case, she apparently was impressed with my testimony and she called me for the plaintiff for the next case.
Q. It is your intention to testify live at trial in this matter?
A. Yes.
Q. What do you charge for trial?
A. $3,000.
Q. Flat fee?
A. Correct.
Q. How many patients have you ever had that have had hemophilia that you know of?
A. I have no way of accurately giving you a count. It's an interesting disease, and when you see it, you usually remember the cases. I can recall from the time of my residency through today at least a half dozen cases of hemophilia that I have seen presenting in one way or another during the newborn period. It's a very interesting disease and it presents in different ways. And it makes an impression on you. I can't give you

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a statistic, but --
Q. In order of magnitude?
A. -- it's one of those diseases that's not rare, but it's not common.
Q. One in a thousand, one in ten thousand, one in a hundred thousand?
A. I would just be giving --
Q. Do you have any idea? And it comes in different degrees of severity, is that true?
A. That is my understanding.
Q. You have no real expertise on that issue, that is, assessing severity?
A. Yes, that's correct.
Q. And you have no expertise on differentiating the two main types of hemophilia?
A. Right.
Q. And how one judges that at the lab level?
A. I know roughly how you judge it. I mean, you know, what I would do as a neonatologist, I would have a child with a bleeding disorder and would order the standard battery of tests that one orders whenever one is confronted with that condition. And if they come back abnormal, I scratch my head and say, well, that's the problem he has. But in my own -- because I work in a

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tertiary care center, before I would engage in treatment, I would always get a hematologist involved.
Q. How many primary care centers have you worked in in your life?
A. I've only worked here.
Q. Here meaning?
A. Childrens Hospital and University Hospital.
Q. You never worked at a primary care center?
A. In a small hospital, no.
Q. I don't mean to quibble with you, but we have talked about primary care centers. We can agree you have never worked in a primary care center?
A. That's not true actually. For a short time I worked as a part of a group -- when Mt. Carmel East Hospital here in Columbus lost its neonatologist about, oh, perhaps eight, nine years ago, the group of neonatologists that are based here at Childrens took over that venue, and that's a primary care facility.
Q. And you did some rotations there?
A. Correct.
Q. How long was that for?
A. About two years.
Q. And how many people were in your group?

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A. Five.
Q. So how often would you get to that hospital?
A. I can't tell you times.
Q. Once a month?
A. Oh, no more frequently than that.
Q. Once a week?
A. About once a week.
Q. And that was, say, five, six -- how many years ago did you say?
A. Eight or nine.
Q. Eight or nine years ago, and that would be your only experience working in a primary care hospital, is that fair?
A. That is correct.
Q. Now, you say if children have a condition of hemophilia, you would run tests?
A. Well, if you have a child that -- if you have a patient in which you believe the clotting system is not working properly, then you run a battery of tests.
Q. What would cause you to run those tests?
A. In a newborn infant it would be several different things. First, if the child had a continuous bleeding from a wound, whether it was a venepuncture site or a circumcision, that went on

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for more than 48 hours. If a child had evidence of bruises or petechia that were well beyond what one might expect under normal conditions in the birthing process, because the birthing process is a rough process and it's not unusual for kids to get bruised.

And then finally, if a child had any manifestation of internal bleeding. And two of the primary problems would be either neurologic dysfunction would be bleeding into the brain space itself or to the space between the brain and the membrane that surrounds the brain. or in newborn infants in particular, bleeding into or around the adrenal glands, adrenal hemorrhage, is very common.

Q. Let's talk about these three things. The first one, continual breeding from a wound, and that would include a circ site, correct?

A. Correct.

Q. And that would be continuous bleeding, or I believe you said for more than 48 hours, correct?

A. Correct.

Q. What is the normal period at Childrens Hospital that children stay from the time of delivery to the time of discharge if there are no

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complications?

A. Children are not born at Childrens Hospital. University Hospital.

Q. I'm sorry. At University Hospital.

A. It's changed in the 18 and a half years I've practiced.

Q. Well, in the last three years.

A. Last three years, 24 to 36 hours.

Q. Okay. And so you would agree with me it wouldn't be possible to assess at the hospital whether the child has been bleeding for more than 48 hours under normal circumstances if in fact they're only there for 24 to 36 hours. You would agree with that statement, is that right, doctor?

A. No.

Q. Okay. Then let me go on to the next question. When are circumcisions normally done at University Hospital? In terms of how many hours after delivery?

A. Probably the earliest is about six to twelve hours after delivery.

Q. Do you know when, how many hours after delivery Forrest Stone had a circumcision?

A. Well, he was born on the 25th and he was circumcised on the 27th, wasn't he?

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Q. Yes.

A. Yes.

Q. Okay. So that would have been, to your understanding, two days later, correct?

A. Correct.

Q. So how many?

MR. SCOTT: I object to this.

Q. How many hours?

MR. SCOTT: He asked two questions.

Q. How many hours after the circumcision do you believe he was discharged?

A. I have to look that up.

Q. Why don't you look it up?

MR. SCOTT: Well, are we going to carry on like this?

MR. LEVIN: We're going to test his knowledge, yes. That's what I'm entitled to do.

MR. SCOTT: You're testing his recollection.

MR. LEVIN: Correct.

A. Looks like he was born on 3-25 at 8:08 in the morning. And let's see when he was discharged. It's in my report, I believe.

Q. Doctor, if you talk under your breath, the court

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reporter will not know whether to take it down. I'm happy to have you speak while you are looking or not speak, but I just want to tell you that you have -- if you mumble, it's hard to know whether she should take it down.

MR. SCOTT: You know, Joel, you want the deposition to go by quickly and you're asking him to go through lots of records when you know the answers. What's the purpose of that?

A. That's fine.

MR. LEVIN: I want to know what he knows.

MR. SCOTT: What he recollects. This should not be a guessing game.

MR. LEVIN: I'm asking him to look at the records, John.

MR. SCOTT: You're asking him to look at all records including the circumcision records.

MR. LEVIN: I don't know how he's going to testify at trial if he can't recall the times --

A. Careful.

Q. No need to be careful. You are hired in this

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case to give opinions and I can address -- I can test your opinions, doctor.

MR. SCOTT: You need to be courteous and professional to everybody.

A. You need to be a professional person because it's going to get ugly.

Q. Get as ugly as you want, doctor. I need to know.

A. I don't have a precise time as to when the child was discharged. Now, if you want to sit there and wait until I find it --

Q. I was waiting until your counsel --

A. -- it's your --

MR. SCOTT: That's fine. But what's the purpose, Joel? Why don't you give him the pertinent times and dates which are contained in the record?

A. He was discharged when, John, on that following --

MR. SCOTT: Is that okay with you, Joel, that we disclose when he was discharged?

MR. LEVIN: No. I think he's either competent to find it in the record or he is not, and I'm allowed to test that.

MR. SCOTT: Why don't we just go

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through the records and you can take all the time you went then.

MR. LEVIN: I don't believe you can help him find it in the records, John.

MR. SCOTT: Well, I don't think that's accurate. As a matter of fact, I can do anything I wish in terms of what's contained in the records.

MR. LEVIN: Let the record show that John Scott is showing the doctor how to find records because the doctor seems unable, without assistance, to understand the chart,

MR. SCOTT: I object. And I move to strike. And you are really asking for a lot of headache in this case and I'm going to give it to you.

MR. LEVIN: I'm very worried, John.

A. He was discharged to home, counsel --

MR. SCOTT: And this is silly.

A. -- on 3-27-99 at 8:30 in the morning, the order was written.

Q. Is that when he left the hospital?

A. I don't know when he left the hospital.

MR. SCOTT: Is that your next question?

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A. Counsel.

MR. SCOTT: Is that your next question?

A. I wasn't there.

MR. SCOTT: All of this was unnecessary, Joel.

MR. LEVIN: Can I ask questions, John?

MR. SCOTT: Go right ahead.

A. Ask questions.

MR. LEVIN: Let the record reflect that the doctor is yelling.

MR. SCOTT: I object to that. The doctor is not yelling.

A. I'm not yelling, sir.

Q. Doctor –

MR. SCOTT: You're the one playing games here.

Q. My question to you -- perhaps you lost it -- is when was the circumcision done?

MR. SCOTT: Do you want him to look at the records?

MR. LEVIN: Yes.

MR. SCOTT: I presume so. Look at the records.

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A. I have that here actually. He was circumcised -- he was born on March 25,1999 at 808 am. He was circumcised by Dr. Hudock in the afternoon of the next day without difficulty, which would have been March 26,1999.

MR. SCOTT: Now, what was the purpose of that, Joel?

A. That evening, and again, in the morning his circ site was noted to be bleeding. Dr. Go and Dr. Hudock examined the infant and applied a topical procoagulant, and he was discharged on the next day.

MR. SCOTT: Next question.

Q. How many hours to your understanding was there between the circumcision and discharge, doctor?

A. I don't have any way of knowing exactly how many hours. If he was circumcised on the afternoon of his -- the day after ne was born ana ne was discharged the next day, I would estimate that there would have been approximately 24 hours, possibly a little bit less. Possibly a little bit more.

I should note, counsel, that it is never written in a medical record when the patient actually exits the hospital. The patient's exit

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from the hospital is based on when the discharge order was written. You should know that.
MR. SCOTT: Next question, counsel.
MR. LEVIN: Don't interrupt.
MR. SCOTT: What goes around comes around, counsel. Next question.
MR. LEVIN: John, you know the local rule says you are forbidden from talking --
MR. SCOTT: Baloney.
MR. LEVIN: I don't want to take it to court.
MR. SCOTT: Take it to court. Take it, Joel.
A. Let's go.
MR. SCOTT: I'm really upset that you take that kind of line of questioning and that attitude towards the witness, and you ought not to do that. What's the purpose?
MR. LEVIN: To test his knowledge of this case.
MR. SCOTT: Recollection. It's not knowledge. Go ahead. Go.
Q. Do you have any estimate as to how much of the time between the circumcision and the discharge

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this child was bleeding from the circumcision site?
A. In my reading of the medical record, my understanding is that the child bled between the time of the circumcision, which was done on the 26th, and the time when the doctors were rounding in the hospital on the next day, the 27th. Both of the doctors were in the hospital when the nurse took the infant's diaper off on that day noticing that there had been blood present in the diaper. And both of the doctors, Dr. Hudock and Dr. Go, in the medical records it's stated that they examined the child.
So that there was bleeding that was occurring or that had occurred at the time of -- between the time of the circumcision and the examination of the child on the next day.
Q. At that time, at that time. At that time when they noticed that, do you believe there was any concern for hemophilia?
A. There had to be.
MS. METZ Objection.
A. Because Dr. Go in her orders ordered blood tests to be done. That would have been the initial screening evaluation looking for coagulation

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disorders.
Q. That would include a PTT, correct?
A. That's correct.
Q. And is the PTT a dispositive test for hemophilia?
A. No.
Q. What is?
A. The only way to diagnose hemophilia completely is to actually measure the percentage of the clotting factor's activity. You actually do a factor VIII percentage level.
Q. The initial test is PTT is to see whether further tests should be done, is that fair?
A. That is correct.
Q. So do you believe that Dr. Go acted appropriately in being concerned that there may be a clotting disorder in ordering a PTT?
A. To be honest, I thought at that time it was overkill. I would not have. I've done well over 2,000 circs in my career and I would say that a full 15 percent of them are bleeding 24 hours later. It's purely a function of how the Gomco clamp was placed with respect to the anatomy of the child's penis, and when you take into consideration the number of circs that bleed 24 to 48 hours after the procedure versus the

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percentage of hemophilia in the community at large, it's a vast difference.
So I would -- personally, if the house officer had called me or I had seen the circumcision that was bleeding at 24 hours, I would probably not have ordered a PT and a PTT and a platelet count.
Q. Was there any bruising on this child?
A. There was some bruising, yes.
Q. Where was the bruising?
A. I believe it was on the face with petechiae on the face and some bruising on the limbs as I recall.
Q. Are either of those indication of possible hemophilia or clotting disorder?
A. Once again, they certainly would be a harbinger of undercoagulation disorder. However, at least 35 percent of infants that are born through the birth canal will have some degree of bruising. The degree of bruising is the function of how long the labor was, how precipitous it was, what the configurations of the woman's pelvis were. If it was small and pointed with the issue of tuberosity in close proximity, then the bumping of its head would be somewhat more substantial

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and you would get more bruising.
Q. What about the bruising on the extremities? That would not be related to birth trauma, is that fair?
A. No. First of all, you are using -- the words, birth trauma, is a very difficult concept. And we are not talking about birth trauma here. We are talking about the normal passage of a normal infant through a normal birthing canal.
Birth trauma is something that is out of the -- out of the ordinary. When you fracture a limb. When you pull a nerve. When you damage -- when the infant is damaged.
Q. Let me withdraw the question then.
A. Good.
Q. Do you think that the bruising on the forehead was related to the bruising on the extremities?
A. I have no way of knowing in this particular case. Bruising anywhere in the body is a function of how the infant is handled as he or she comes out of the birth canal. Now, if the head is the presenting part, the head normally gets the bulk of the bruising.
But as the obstetrician brings the child around after the head has been delivered,

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normally the obstetrician will twist the baby so that the shoulders are in a 12/6 position to extract the shoulder girdle from the pelvis. In doing that, oftentimes he will squeeze the infant's arms, or the infant's arms will become hit against bony structures in the mother, and that will cause bruising on the infant's extremities.
Q. Where was the bruising on the extremities of Forrest Stone?
A. I have to look. I don't recall specifically. I recall the infant was bruised to a modest degree. That was noted in Dr. Go's initial examination.
Q. Was there bruising that was found after the initial examination at an injection site?
A. Yes.
Q. Okay. What do you believe that would indicate?
A. That would indicate that when the injection was given, that the needle transected a blood vessel that otherwise it would not have. And you can get bruising at an injection site whether you're a hemophiliac or not.
Q. What percentage of the time -- you put it at 35 percent earlier. I'm trying --what percentage

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of the time do you think you get this kind of bruising from an injection site?
A. I'm a diabetic. I take insulin four times a day. I bruise myself at least twice a week. Would you like to see one?
Q. If that's going to be the basis of your expert opinion, I'm happy to have you provide pictures. What I'm going for is in neonates -- let me make that clear. Doctor, I'm not asking about your personal medical issues. I'm asking in the treatment of neonates. You are here as an expert neonatologist.
Now, with regard to newborn children, not your personal medical issues, can you tell me what percentage of the time there is bruising at an injection site?
A. It's hard to say. I would say perhaps ten percent.
Q. Thank you. Now, you said evidence of petechiae that was higher than normal would be some kind of possible sign of a clotting disorder, is that fair?
A. Petechiae happen frequently during the birthing process. They occur because of the pressures that are faced by the skin, and capillaries

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rupture. It's very common to see petechiae, especially on the face and head of newborn infants. I would say at least 50 percent of newborn infants have some petechiae at birth.
Q. My question was is it your testimony that evidence of petechia that is higher than normal is a possible sign of a clotting disorder?
A. Higher than normal is the hard part. If you have a child that's covered with petechiae, then I would say that a coagulopathy should certainly be considered.
Q. One of the obvious symptoms of petechiae is redness of the face, that's one thing clinically that presents, correct?
A. No. A petechiae is a small, bright red mark which indicates that a capillary or arteriole in the dermis of the face is ruptured. It's a very small red dot.
Q. Is it sometimes multiple?
A. Almost invariably multiple.
Q. If the child's face is extremely red, is that something that is indicative of potentially higher than normal petechiae?
A. No.
Q. Is that -- is that a concern for any possible

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disorder?
A. No.
Q. Do you know whose decision it was not to repeat the PTT?
A. I assumed that it was Dr. Go's. I assume that the nursing staff called Dr. Go with the fact that the PT and PTT could not be obtained and that it was her decision not to proceed further.
Q. You say could not be obtained. Would it be fair to say that it was not obtained the first time and it would require a reinjection?
A. Correct.
Q. Do you know who made the first injection, whether it was the nursing staff or whether it was a physician?
A. I don't believe it was the physician. It would have been probably somebody from the lab staff actually.
Q. Do you know whether the lab staff had the authority to reinject?
A. No, they do not. If a sample cannot be drawn in a normal one time pass, then especially in a child, the lab staff backs off or the nursing staff backs off and calls the doctor. That's very, very important. Parents become extremely

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upset when their child is repeatedly punctured.
Q. Are you going to offer an opinion on the prognosis of this child?
A. No.
Q. Are you going to offer an opinion about the need for neurosurgery of this child?
A. No.
Q. Are you going to offer an opinion as to whether or not earlier neurosurgery would have given a better prognosis?
A. No.
Q. We can agree from what you have said in your report that -- strike that. Let me start from the beginning. It is your opinion that the bleeding began at birth, correct, that's the subdural hematoma?
A. Correct.
Q. And in the normal course of a subdural hematoma that is not resolved, there is going to be swelling or edema, correct, typically?
A. Of what?
Q. Some part of the neural cavity, some part of the brain.
A. No.
Q. Is there going to be any edema or swelling?

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A. A subdural hematoma or hemorrhage is -- occurs when the veins that traverse the dural membranes from both the calvarium bone and from the brain cell stems are sheared and thus becomes disrupted, you get bleeding between the bone and the subdural membrane.
Q. Is there any edema here in this boy's head?
MR. SCOTT: When?
Q. Ever.
A. I believe that on one of the CT scans there was a discussion of edema. I was getting to that. The hemorrhage gets bigger because it's -- it is not tamponaded. The baby's brain or the baby's calvarium, unlike yours, is not fused. The bones are not fixed.
And as a consequence, there is no pressure that stops the bleeding initially. Over the course of time as the pressure does build up, then there will be a pressure delivered to the brain substance below the dura. And when this occurs, the brain substance certainly can become injured and become edematous. The dura itself does not become edematous. The brain space becomes edematous. The edema which is an excessive amount of water outside the vascular

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space occurs to brain tissue.
Q. Do you know when the pressure, as you put it, began? Or is that something that's outside your expertise with regard to this point? I don't know what you mean by pressure.
A. This baby's hemorrhage occurred at the time of the delivery. There is no other time it could have occurred. A subdural hematoma or hemorrhage just doesn't happen. It's not like a stroke. You have to have trauma to the head, sort of a sheering process to occur. And the only time this baby would have experienced trauma to his head was at the time of delivery. So the hemorrhage began then.
Now, we know now that he had hemophilia so that his ability to stop that hemorrhage would have been -- would have been somewhat decreased. Over the course of days the bleeding continued, and as the bleeding continued, the space between the bone plates and the brain became more and more compromised so that pressure eventually developed such that the brain tissue was being pushed down by the dura.
Q. My question is --
A. When did it start. The child became clinically

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abnormal on that Tuesday and Wednesday, I believe. So it wasn't until that time that the subdural hematoma became clinically evident -- and that, by the way, is classic for a subdural hematoma or hemorrhage in a newborn baby. They very rarely present at birth. If they present at birth, they are usually huge and the child dies immediately because the major vein has disrupted.

The more common issue is a small parietal hemorrhage that occurs because of the bone plate being pushed in and you don't see it usually for six or seven days, and the child is bought back to the doctor's office because of lethargy or twitching on one side as the hemorrhage gets worse.

Q. Do you have any criticisms of Dr. Go?

A. No. I thought she did a very outstanding job.

Q. Is it your understanding that prior to discharge the physicians were able to stop the bleeding from the circumcision site?

A. Yes.

Q. Okay. And of course, the fact that they stopped that wouldn't rule out hemophilia, would it?

A. No.

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Q. Do you have any opinion as to how long the hemostatic agents would have stopped the bleeding from that time going forward?

A. There are a mixture of fibrin and fibrin polymers that can be placed onto the area that you can't specifically clamp off. They usually will sit there until they are traumatically abraded off the area at which time the bleeding may recur.

Q. Do you have any idea how long that would be?

A. No.

Q. Or would that be just sort of idiosyncratic depending on the handling of the child?

A. At the very, very shortest, it would be hours.

Q. Do you have any opinions as to whether or not this child should have been kept in the hospital another day until the issue of clotting from the -- or bleeding from the circumcision site was further investigated?

A. No. I believe that the child had no reason to have his discharge held up. At the time of his discharge he had a bleeding circumcision that had been stopped. He was neurologically active. He was thriving and feeding well. There were no neurological symptoms whatever.

I would further go on to say that even if

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the diagnosis of hemophilia had been made on that Saturday, nothing would have been done differently. The child would have been given cryoprecipitate. The child wasn't bleeding. The hemorrhage had happened before. He would have had no reason to obtain a CT scan or ultrasound.

Q. Did you read Dr. Shurin's -- you have not read Dr. Shurin's deposition, correct?

A. That's correct.

Q. Have you read her report that was issued this week?

A. Yes.

MR. SCOTT: No, I don't think you have. You have read another report. You just faxed to me her report, did you not? I'm not sure if I faxed that to the doctor or not.

A. Maybe you did. Let's see.

MR. SCOTT: You just faxed to us another report from Dr. Rothner, correct?

MR. LEVIN: Correct.

MR. SCOTT: Even though the report from Rothner to you was received about two weeks ago.

MR. LEVIN: That's false. You know

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what, John, that's false. It's false that Rothner gave it to me two weeks ago.

MR. SCOTT: All right.

A. I have a report here from Dr. Shurin on February 7, 2002.

MR. SCOTT: Okay. He's answered.

MR. LEVIN: I'm going to go on record here and tell you that the cover sheet from Rothner on that fax is 2-12-02.

MR. SCOTT: Okay.

MR. LEVIN: And whatever you think -- whatever you think of my integrity, on the record it is clear that this is when he faxed it to us. I don't know when he prepared it at the Cleveland Clinic. He could have prepared it ten years ago at the Cleveland Clinic and made it up for this child. I know wnen it was faxed io me. I know what it says. It was faxed yesterday. That's what the fax sheet shows.

If you want to make your vague allegations that it was drafted earlier and I was sitting on it, you can do as you want. It's contrary to the evidence as so many of your other statements in this case

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and that's what this fax shows.
MR. SCOTT: You know, you become too excited about too much. We can talk back and forth without each other getting excited.
MR. LEVIN: I did not sit on the report.
MR. SCOTT: I'm not saying you did.
MR. LEVIN: I got sent it to you within minutes of when I got it.
MR. SCOTT: Okay. I'm happy to hear that.
MR. LEVIN: I don't care if you're happy or not.
MR. SCOTT: Go ahead. Now the doctor answered the question. Be calm. Do you want me to saying anything more? Go ahead.
Q. Doctor, if the PTT comes back and reveals a possible bleeding disorder, would it be fair to say that the treatment issues would be handled by a hematologist?
A. Yes.
Q. And would it also be fair to say that in general, without talking about this case, there are

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sometimes treatment protocols that require prophylactic treatment while one is trying to understand the full picture of a patient?
A. The only time I have ever seen a hematologist offer cryoprecipitate in a patient who is not actively bleeding is in preparing that patient for an invasive or surgical procedure.
Q. Are you aware of studies that actually say that where there is a chance of possible neonatal hemophilia, that even before tests are run, prophylactic anticoagulant therapy is given immediately?
A. No, I'm not.
Q. If there are such studies in the hematology literature, you wouldn't know whether they exist one way or another, would that be fair?
A. If there are reports that are relevant to the field of newborn infants, I should be aware of them, yes.
Q. I didn't say you should. Do you read hematology journals?
A. No. I do read -- I do read papers that have been xeroxed from journals that are relevant to hematology.
Q. Somebody sends them on to you?

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A. Or that I obtained myself through literature searches.
Q. Let's go back to what you are testifying to. Can we agree that as a general rule treatment decisions when a PT comes back and shows possible clotting disorders are decisions made by the hematologist under normal conditions?
A. When a physician receives a PTT that is prolonged and cannot explain it on the basis of other phenomena, or if the PTT is very, very prolonged, then a hematologist in my opinion should be contacted immediately and the case discussed.
Q. Do you know what the PTT of Forrest was upon presentation to Metro?
A. I believe it was over a hundred seconds.
Q. Is that very prolonged?
A. Yes, it is.
Q. Do you know in terms of the way this disease presents whether it was likely that that was the PTT at the time of discharge from Deaconess, or is that something that you would be able to give an opinion on?
A. No.
Q. Would you agree with me that in general the ebb and flow of PTT's with regard to hemophiliacs

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would be something that you would expect a hematologist to be able to give an opinion on?
A. Oh, yes.
Q. You use the words, competent parents. What do you mean by competent parents?
A. Very obvious. A competent parent is one that's going to be able to provide care for the infant, that's going to have the wherewithal to feed, clothe, bathe and house the infant in a proper fashion. And also has the -- and also has the moral turpitude to be concerned about the infant's welfare, placing it above their own welfare.
Q. You say that an oozing circ site is not grounds hold up discharge to competent parents provided that follow-up is in place. What do you mean by follow-up is in place with regard to a patient who presents with an oozing circ site?
A. That they have been given literature by the hospital, which all hospitals have, that is constructed in language that is readable by a person with an education of eighth grade or more. That they have a phone number, at least one phone number to call that will be -- and that a person will answer that phone and provide them

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with assistance should they have any questions or concerns. They should also have an appointment premade before the time of discharge with a health care provider and/or have arrangements made for somebody to go into the home to check on the patient.

Q. There is an issue in this case involving the Visiting Nurses Association. Have you been given any information about what the Visiting Nurses Association did in this case or did not do?

A. My understanding is that the referral was not called to the Visiting Nurses Association on Saturday at the time of the infant's discharge because the nurses felt that it would not be received properly because of the weekend, and as such, they held it until Monday, and it was their understanding that if they had sent the visiting nurse referral in on Monday, the child would have been seen no later than Tuesday afternoon.

Q. And does your hospital, that is, University Hospital, sometimes use visiting nurses or use home nurses?

A. Yes.

Q. And does it sometimes ask nurses to come sooner than 48 hours?

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A. Yes.

Q. Were you told or given any information as to what the Visiting Nurses Association said about how they received information on the weekends from either the deposition of the Visiting Nurses Association or from any other source?

A. No.

Q. So you're not rendering an opinion as to whether or not the concern of the nurse or nurses that the VNA wouldn't see this information for a couple days in this case is justified. You're not rendering that opinion?

MR. SCOTT: Objection. The doctor has written a report saying that the nurses met accepted standards. What are you saying?

A. I'm sorry. State your question again. I'm sorry.

Q. You are not giving an opinion as to whether or not there was any justification for the nurses to believe that the VNA wouldn't look at this over the weekend, are you?

MR. SCOTT: Objection.

A. I have no basis to know that. I will say that putting myself in Dr. Go's shoes, if I had been

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there on that Saturday afternoon and all I had was a bleeding circ with competent parents that understood me, that seemed to be able to facilitate care of the baby, and if they had the information at hand, they had my phone number, I would have had no problem in sending that baby home knowing that the visiting nurse would not be there until Monday or Tuesday.

Q. All right. Aside from the bleeding circumcision, we can agree that this child had presented during his course with petechiae, with a bruise on the forehead and with the bruise from the injection site, correct?

A. Yes. That would also have made no difference. Those are very common things that happen.

Q. What is your understanding as to how much blood there was on the day of discharge before the hemostatic procedures were applied? Was there a lot of bleeding, a little bleeding. Do you have any understanding?

A. It's -- it's very difficult to obtain an objective understanding from the records, primarily because the bleeding -- the blood would have gone into gauze pads, into a diaper, and the distribution of that blood into the gauze pads

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and diaper would have also been contingent upon the frequency of the child's urination and also how much Vaseline had been applied to the circumcision site, thus diluting the blood out, making the spot bigger. It's hard to say.

Q. What is your understanding of what the records indicate?

A. My understanding was that there was some blood noticed.

Q. Do you have any understanding as to whether or not the blood was greater that second day than would he typical, the amount of blood?

A. I do not have an understanding, no.

Q. Would it be significant if the amount of blood was significantly greater than normal the second day?

A. One would have to examine most importantly the child's penis and the circumcision site specifically. If there was a jagged edge of skin. If it had been clear that -- you know, if it had been clear that in the course of applying the Gomco clamp, the entire 360-degree arc of skin around the head of the penis had not been clamped off and crushed, then that would explain why the bleeding was ongoing.

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In other words, when you do a circumcision, you pull the penis up through the clamp, place the Gomco bell over the head of the penis and you then create a 360-degree area where the vessels going into the skin are crushed. And there is a blade.

Now, occasionally what will happen is that when the skin is pushed through, you don't get the arc. You get less than 360 degrees. That's the most common reason you get a bleeding circumcision.

So having a lot of blood on the second day would be more likely to have been the consequence of a circumcision that had led to the presence of a blood vessel which had not been completely crushed during the process of the procedure itself.

Q. That's more likely -- less likely would be hemophilia?

A. Much less likely hemophilia.

Q. Do you know whether -- is there anything in the records that indicated that any physicians looked to see whether it was the surgical technique or the results of the surgery itself that caused this additional bleeding?

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A. No.

Q. Do you know whether the nurses here knew the signs and symptoms of hemophilia?

A. No.

Q. Do you believe nurses ought to know the clinical signs of hemophilia? Or are you going to be rendering an opinion on that issue?

A. I believe that a nurse, a registered nurse, should have an understanding of how blood coagulation occurs and should have an understanding of the signs and symptoms that their relevant patient base might manifest if the coagulation system is not working properly.

Now, to have a precise working knowledge of hemophilia is a different matter. I would suggest that if you lined up a hundred practicing pediatricians right now today, fully 50 percent would not get beyond the fact that it's a factor VIII deficiency.

A nurse, however, should clearly know that in the course of his or her work, when a patient that she or he has been given care of has manifestations of a significant clotting abnormality, in the context of this particular care, a nurse who is experienced with the act of

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circumcision should know when a circumcision site is bleeding more than you would expect it to normally bleed. I would expect any nurse that I work with at University Hospital to have that knowledge, yes.

Q. Let me see if I can restate that fairly and shorter. Would you agree that at a minimum any registered nurse ought to know that if a newborn has more than the usual bleeding, one should consider as a possibility hemophilia, is that fair?

MR. SCOTT: Object.

A. One should consider calling the physician that did the circumcision, and in the process of doing that, certainly in the nurse's head as she or he is doing that, a possible differential diagnosis might pop up.

Q. Which would include hemophilia?

A. Yes.

Q. There is mention of a lump and bruising noted to an injection site. Is that significant to you for anything, that was not -- that was new in the record. I can show you the record. Is that significant to you?

A. No. Not really. Babies get vitamin K

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immediately after birth. As I said before, what kind of a mark you get is a function of what the needle hits on its way in, who is giving the injection. If you have the misfortune of traversing several blood vessels on the way in, you might get a bit of a knot at the injection site.

Q. I believe you said that was about a ten percent chance?

A. Yes.

Q. And I believe you said the petechiae was about a 50 percent chance?

A. Yes, that's correct.

Q. And I think you said that the facial bruise was about a 30 percent chance?

A. Correct.

Q. Okay. And bleeding in the circ site for more than a day, what chance is that?

MR. SCOTT: Object.

A. I would say one in 25.

Q. Now, we can agree, doctor, that these different percentages are not necessarily linked absent a bleeding disorder, can we not?

A. Phrase that again.

Q. Well, doctor, there are some things that are

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linked in terms of signs and symptoms and there's some that are coincidental. Just in the most general sense, right?
A. Correct.
Q. So for instance, you know, one could have different small scrapes and that may be due to the fact that one is playing some active sport. As each different one is inspected, it may indicate that if one looks closely at the scrapes, that they're actually part of some kind of underlying disease, correct?
A. Yes.
Q. If in fact petechiae and bruising and bruising from the injection site and prolonged bleeding from the circumcision occurred, one thing that might link them as to the possibility making a differential diagnosis would be a clotting disorder, correct?
A. Yes.
Q. Is there anything else that would link them?
A. A disorder of coagulopathy, whether it's a clotting factor or platelet dysfunction, would be the primary potential linkage.
Q. Doctor, you are often called in to make differential diagnoses of patients given your

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expertise as a professor of medicine, correct?
A. Correct.
Q. And so sometimes one gets an odd collection of clinical signs and symptoms and one has to sort of be a medical Sherlock Holmes, put it together and see what it is, correct?
A. Correct,
Q. And one thing one wants to worry about is coincidence versus something that is related, right? I mean one wants to look at that?
A. Correct.
Q. Would you agree with me the only thing that would not be coincidence, but would link the following symptoms, in the abstract, prolonged bleeding from the circ site, facial bruising, bruises and lumps from the injection site, and greater than normal petechiae, would be some kind of blood disorder? Any other collection of that in the same patient would be coincidental?
A. No, Idon't.
Q. What other reason other than a blood disorder would link those other than coincidentally?
A. If the child had just been born and gone through the birthing canal, and in the process of doing that, had exposure to shear stresses and

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pressures that would have caused bruising and caused petechiae and that would have -- and also that he required a deep intramuscular injection of a medication of a volume of 1 cc, which is fairly substantial to put into a muscle, that occasionally would cause a knot.
You know, again, you have to -- I see where you're going and I'm trying very hard in a legitimate way to put you in the shoes of a practitioner. I'm sure you have heard this phrase before from other doctors. You know, if you are sitting in, you know, in Ohio and behind you you hear hoofbeats, the probability of it being a zebra is very small. It's going to be a horse.
Hemophilia is not common. I have seen in my practice, which is purely neonates, I have probably -- I've probably seen well over ten thousand infants since 1983 when I first came here. And I have told you at the beginning that I perhaps have seen five or six hemophiliacs. It's a very rare condition.
You don't -- facial bruising, petechiae and a knot at the site of a vitamin K injection are such common phenomenon that you don't necessarily

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-- you don't say, oh, gosh, this kid may have a bleeding diathesis. Without equivocation when you see a bleeding circumcision, the last thing on your list is the kid maybe a hemophiliac.
If I had a house officer under my tutelage ordering PT's and PTT's and platelet counts on every kid that had a bleeding circ, he wouldn't last long here because I would be hearing from the HMO's as to why I'm spending so much money getting stupid tests.
Circumcisions bleed. It's a barbaric, stupid, unnecessary, very American procedure. It happens. They bleed. The Gomco clamp happens and they bleed.
What I am trying to get you to understand is that when you are confronted on the second day after the circumcision with a penis that is bleeding, the first thing in your mind is not, I better go get a PTT, PT and platelet count. My first thought is I probably didn't tighten the clamp properly and that's the problem.
Q. Doctor, from what you just said, in your practice, because I have done the math, you have seen hemophilia in between one in 1,500 and one in 2,000 of your patients?

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A. Something like that, something of that nature.
Q. Okay. Now, doctor, when you make a differential diagnosis, you want to measure at least two different kinds of things. One is the commonality, that is, what's most frequent, and also the severity, that is, even if it's not most frequent, what might be life or death, correct? Those are always two considerations?
A. No. The differential diagnosis is a series of diseases that may explain the symptoms and signs that that patient presents with. Severely is what I have to do to keep the patients alive while I make my differential diagnosis list.
Q. Well, doctor, there could be something that maybe occurs one percent of the time as opposed to 50 percent of time, but if you don't treat it right away, one percent of the time the patient may die. That's a possibility, correct?
A. But the treatment of --
Q. Is that a possibility? That's all I'm asking.
A. In the abstract, yes.
Q. Okay. And sometimes physicians are more concerned to worry about the riskiest possibility early on even though it's less probable, sometimes, is that fair?

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MR. SCOTT: Objection.
A. Sometimes.
Q. Thank you. Was Dr. Go a house officer?
MS. KMETZ: Objection.
A. No, she was a practicing pediatrician.
Q. Well, I just -- you mentioned about criticizing house officers. And I just want to know whether you consider her --
A. Oh, no, she was a practicing pediatrician. She is a doctor.
Q. Okay. In your practice have you ever seen an order to draw a PTT if able to draw enough blood?
A. Oh, yes. And you know, in preciseiy this scenario. I guess I don't think -- putting you in my shoes, you have to understand what it's like to go to a patient and say we had trouble getting blood from the baby and the lab has to come back and stick them again; Mothers hate that. I mean they don't want their baby being stuck by a needle.
Q. Do they like being told the baby has brain damage and needs four brain surgeries?
MR. SCOTT: Oh, objection.
A. Never mind.
MR. SCOTT: Go on.

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MR. LEVIN: I asked a yes or no question. If he wants to volunteer life, then I'm allowed to follow up.
MR. SCOTT: Go on, Joel. Baloney. Go on.
MR. LEVIN: How are you going to protect him from all this at trial, John, if you jump up every second?
MR. SCOTT: Believe me, it won't be a problem.
A. No, it won't be a problem. No, it won't. I suggest strongly that you read my trial testimony.
Q. I'm sure you're very proud of it, doctor.
A. I am very proud.
MR. SCOTT: We are not going to do that. You either ask a legitimate question --
MR. LEVIN: Why does he think I want to be in his shoes?
MR. SCOTT: Stop, Joel. I expect more from you. Come on.
MR. LEVIN: I'm just asking questions. I didn't raise my voice, I didn't insult anybody. I'm asking

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questions.
MR. SCOTT: The content of the question is precisely --
A. Goaheadnow.
MR. LEVIN: Let's take a break.

(Thereupon, a recess was had.)
- - - -

Q. Doctor, you said there was -- I'll try to get your language as my colleague wrote it down as closely as possible --that there were a standard battery of tests for diagnosing bleeding disorders?
A. Correct.
Q. What would they be?
A. A PTT, a PT and a platelet count.
Q. Doctor, you work in the NICU, in the neonatal intensive care unit, is that right?
A. I work in both the NICU and the well baby nursery.
Q. Is critical care the same at Ohio State as intensive care? Are those terms used interchangeably here?
A. Yes.
Q. Now, is there a group at Ohio State that's the

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critical care group for pediatrics?
A. There is a group, a division of neonatology within the department of pediatrics at the Ohio State University. We provide the newborn intensive care and well infant care at University Hospital, Childrens Hospital and Mt. Carmel East Hospital.
Q. You are part of the critical care group?
A. Correct.
Q. Are you part of the neonatology group?
A. Same thing, same group.
Q. Are there different divisions within this group?
A. No.
Q. Is there an adolescent health medicine division?
A. I think so.
Q. And there is an ambulatory services division?
A. I think so.
Q. And I won't go through all this whole long list. You are not part of the adolescent health group?
A. No.
Q. And you are not part of the ambulatory services group?
A. Correct.
Q. I may go through this list. There is a behavioral pediatrics group. Are you part of that

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group?
A. No.
Q. The cardiology group, are you part of the cardiology group?
A. No.
Q. There is a cardiothoracic surgery group. Are you part of that?
A. No.
Q. There is a critical care group. Are you part of that?
A. They are the ones that take care of pediatric older patients in critical care. No; I'm not.
Q. There is emergency medicine. You are not part of that?
A. No.
Q. And there is endocrinology. Are you part of that?
A. Nope.
Q. And there's gastroenterology. You are not part of that?
A. No.
Q. There is hematology oncology. You are not part of that, correct?
A. No.
Q. That would be the group that you would refer a

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patient who you had some strong suspicion of hemophilia to, correct?
A. Yes.
Q. There's the human and molecular genetics group. Are you part of that group?
A. No.
Q. The infectious disease group, are you part of that?
A. No.
Q. There is the metabolism group. Are you part of that?
A. No.
Q. There is the neonatology group. Are you part of that?
A. Yes.
Q. There's the molecular medicine group. Are you part of that?
A. No.
Q. Doctor, I downloaded this from your website. A very good likeness of you, I believe, on the picture.
A. Uglyguy.
Q. I warn you, doctor, you are under oath.
A. I'm still ugly.
MR. LEVIN: Let me just point out,

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and I don't want to keep this from you, John.
MR. SCOTT: Oh, go ahead. Keep it from me.
MR. LEVIN: I've had it for some long time.
Q. You are listed under molecular medicine and you are not listed under neonatology.
A. Yes.
Q. What is the explanation for that?
A. In December of 1996 the former director of the division of neonatology and I had a falling out. He and I were both at about the same level as far as seniority. We were both the two most senior people. I went to.
My chairman and said that I could no longer work in the situation where that individual was proviaing my scheauie ana my caii scheduie. My chairman, feeling that I was an extremely valuable member of this department, said, Fine, no problem. We will shift you over to a different division. You will still conduct your practice in neonatology, and I will have Dr. Dave Fisher, who is the academic director, coordinate scheduling for you on your clinical practice in

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neonatology.
That went on until July of this year when the individual that was a problem was removed from his position and has now been replaced by Dr. Steve Welty, who is now the division director. And Dr. Steve Welty is now the division director in neonatology, and I have been -- as of July, I was moved back into the division of neonatology.
But that's purely a matter of where my name appears on a website. I was still conducting or carrying out my clinical work in the division of neonatology.
Q. This download suggests that it was downloaded on 2-8-02. Do you have any reason to think that's false?
A. No, it just hasn't been updated.
Q. You believe that you were in molecular medicine until what date?
A. July of 2002.
Q. What is molecular medicine?
A. It's a -- it's a division that is constructed of people who have an interest in research activity that involves molecular genetic techniques, which I do. People that work in this building here,

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this is the research building, and whose offices are here, people that work here have a 50 percent or more interest in research activity, and most importantly, people who have funded research grants from the National Institutes of Health. So right now in the division of molecular medicine, the NIH funded people are in that division.
Q. How much time do you spend seeking grant money? I mean I know that's part of the practice in research.
A. It's not part of the practice. I have been funded by the National Institutes of Health for the last nine years consecutively. The grants are renewed once every four years. It takes time to renew the grant, I would say probably about two or three weeks, but that's when I'm on my research time.
Q. You've published a number of articles. Have you published anything involving hemophilia?
A. No.
Q. Have you ever published anything involving blood disorders?
A. No.
Q. Have you ever published anything involving

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circumcision or circumcision techniques?
A. No.
Q. Have you ever published anything involving the standard of care of either nurses or hospitals?
A. No.
Q. Have you ever -- you said that you have testified a number of times for Reminger. I assume other than testifying you have reviewed a greater number of matters than you've just testified about, is that fair?
A. When you say testify, do you mean give a deposition or in court?
Q. Either one. That is, you've testified for Reminger either in deposition or court, I believe you said 15 times, is that --
A. Well, no, I would say --
Q. Is that about right?
A. Yes, that's about right.
Q. My question is how many cases have you reviewed for them, hundreds?
A. Oh, no, no, no.
Q. Thousands?
A. No, no. Much, much, much less.
Q. Oh.
A. Perhaps a total of maybe 25. This is not --this

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is a very small percentage of what I do.
Q. And how many times if ever have you told them that the doctor is negligent?
A. There have been two instances that I know of where I have been sent records by somebody at Reminger & Reminger, and I called the lawyer and said I can't provide you with any defense assistance here because I don't feel that a defense is warranted. So there have been at least twice that I can remember.
Q. I want to ask you about the issue of protocols. We talked about it previously.
A. Uh-huh.
Q. There are -- I assume there are protocols in your practice here at Childrens and at University Hospital, is that correct?
A. That is correct.
Q. Are there protocols for reattempting a needle stick, one that covers that issue?
A. No. I have to look. I don't really know. That would be more of an issue that would be addressed by the clinical laboratories who draw most of our blood as opposed to anybody else. I'm really not sure, to be honest.
Q. You have clinical laboratories that draw blood

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because you are a large tertiary care center. Do you know whether places like Deaconess have such officials or employees, I guess, people who work in labs?
A. I have no idea.
Q. You would agree with me that as a general rule, the smaller the hospital, the more hats people might need to wear?
A. I don't know. I never worked in one.
Q. Okay. There is a protocol for circumcision here, correct?
A. Yes.
Q. In general at University Hospital who does the circumcisions? I know you said you do when you are a pediatrician. Here the obstetrician did it in this case. Do obstetricians do it at University Hospitals?
A. No.
Q. Is it exclusively pediatricians?
A. Yes.
Q. In your experience does that vary from hospital to hospital?
A. Yes.
Q. That is the only surgery you perform, is that fair?

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A. Outside of placing deep arterial and venous lines by cutdown, which is not really surgery, but that's the only other surgery I carry out, yes, that's correct.
Q. Can you tell me what the protocol is as you recall it for circumcision here in Columbus at the hospitals that you are at?
A. I would have to review the protocols specifically. In general -- what are you interested in knowing? I mean we basically --
Q. Not the doing of it so much as the follow-up afterwards.
A. Okay. After a baby has been circumcised, the penis is swaddled in a Vaseline-soaked gauze and then placed into a diaper. It is the responsibility of the nursing staff to look at the circumcision site at, I believe it's two hours, four hours and six hours after the circumcision. And then thereafter whenever the diaper is changed they will assess the circumcision and change the Vaseline gauze.
Q. I don't mean to cut you off, but does the checking every two hours by the nurse ever entail on these protocols some kind of duty to report anything significant back to the physician?

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A. I believe that if a nurse, when she checks a circumcision site, sees something that she feels is not normal, that she would call the physician and alert the physician, yes.
Q. Even if that was at two in the morning or four in the morning?
A. Absolutely.
Q. Okay. Go ahead. Were you done?
A. Sure. I mean basically that's the process until the child goes home. And of course, before the infant goes home, the parents are made aware of how to care for the circ site, to not bathe the baby. They are a given several packs of Vaseline gauze to swaddle the circumcision site for the first several days to ensure that it's cared for properly.
And they're also given a sheet of paper in the language relevant to the family, we have them in 25 different languages, that is written at the eighth grade level, and that details what to do for the circ site and when to call the doctor. And on that sheet is also a blank space which is -- on which the number is placed that a person can call if they have a question or concern, that we know that that phone will be answered 24 hours

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a day.
Q. Do you know specifically what instructions were given to Edna Stone with regard to the circumcision upon discharge?
A. No.
Q. Is there any discharge protocol at the hospital that you work at?
A. Yes.
Q. And in general, you are aware of its contents but probably couldn't state it exactly, would that be fair?
A. That's correct.
Q. Do you know, does it pertain as to under what circumstances the discharge should go forward, that is, under what conditions a patient is ready to be discharged?
A. I would have to look at it specifically.
MS. KMETZ: Objection.
A. Specifically, I don't know.
Q. Do you know if it discusses what kind of instructions should be given to a patient upon the discharge?
A. I would have to look at the document specifically.
Q. You're not planning on testifying as to that area

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at this point?
MR. SCOTT: Objection.
A. I would be --
MR. SCOTT: The doctor signed a written statement, and you have it, and he says that the nurses met ail applicable standards. Now, that's what he is going to testify to at trial.
Q. Well, in terms of standards, one place that one looks for standards would be the local standards governing the local hospitals for the standard protocols, correct?
A. No.
Q. No?
A. Standards are standards.
Q. But do you believe that in general doctors and caregivers should follow the protocols at their own hospital unless there is a compelling reason not to?
A. I think that you'll find that if you looked at a protocol for a particular situation, you would find that it would be in great unanimity from hospital to hospital to hospital. They wouldn't vary.
Q. Okay. And would you expect in general the

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medical providers, both nurses and doctors, would follow those protocols or would act in accordance with them as a general rule?
A. Oh, yes.
Q. Okay. Are there any protocols at University Hospital or at Childrens Hospital that cover the area of tests ordered but not completed?
MS. KMETZ Objection.
A. To the best of my knowledge, no.
Q. I've only got one page so it's not as bad as it looks.
Okay. You said earlier that you had five to six patients in the last ten years who were neonates who have had hemophilia. Who made the diagnosis?
A. In I believe at least three of the cases the diagnosis was actually made antenatally because of a previous child that had been born, the mother had been karyotyped and diagnosis of the mother being a carrier had been made. Fetal chromosomes had been drawn, fetal blood tests had been obtained and diagnosis of the factor VIII deficiency was made antenatally so that we could prepare for the birthing process.
In one case I remember vividly as a resident

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a child that had gone home -- it was a child of a very orthodox Jewish family in Boston. And the rabbi had done Bris, and the baby did not stop bleeding for five days. Brought the child into the hospital, and the child was of Russian descent, and had classic hemophilia.
Another case was a premature infant where we -- normally, preterm infants have a prolonged PTT. And that baby had a very, very prolonged PTT, well over a hundred seconds, which is very unusual. So we got hematology involved, did a factor VIII analysis, and the kid did have classic hemophilia.
Q. My question. Were all five or six times, whatever you stated, were all those times cases where the diagnosis was actually made by a hematologist?
A. I would say yes.
Q. Okay. And on the three that were made prior to birth, do you know whether the factor VIII was given almost immediately after birth?
A. I don't recall.
Q. Okay. Again, that would be hematology's decision?
A. Yeah. I don't recall. We have a very aggressive

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program over at University for fetal treatment. And as a consequence, you know, I heard about the case because it was presented at a conference.
Q. Now, let me ask you a question with a long premises. Assuming --well, let's start. You would agree with me this was a full-term baby?
A. Yes.
Q. Okay. For full-term babies who are not on any medication, what does a prolonged PTT indicate other than clotting disorder, if anything?
A. Nothing.
Q. Okay. Do you have any information as to when the nursery was closed at Deaconess?
A. No.
Q. Do you know if in fact whether or not it was closed some time shortly after the discharge of Forrest Stone?
A. No.
Q. Again, this is at the risk incurring the wrath of your lawyer who retained you, but would you agree with me that there was increased bleeding noted on the chart on the day of discharge for Forrest Stone?
MR. SCOTT: Objection.
A. It was my recollection that the baby was noticed

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to have had -- the circumcision site was still bleeding.
Q. Let me show you a record that I think you have.
A. Okay.
Q. It's a record that's in several places. It is Exhibit 8.
MR. LEVIN: Did you bring the exhibits?
MR. SCOTT: I don't have them.
Q. 111 show it to you. It's got some highlighting and some of my writing on it.
MS. KMETZ: Do you have where it's from?
Q. I'm not going to characterize it further. And it's also found, I believe, in at least two other places in the chart. I believe it's in Dr. Go's records and maybe some hospital records and the neonatal records. Several places.
First of all, doctor, I believe you have seen this.
MR. LEVIN: And John can tell me, you would have given him this?
MR. SCOTT: Right.
Q. Okay. Does that record, Exhibit 8, indicate to you that it is noted there is increased bleeding

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on the day of 3-27 which is the date of discharge?
A. That's what it says.
Q. And can you tell from your analysis of the records and from what you know about the case what Exhibit 8 is?
A. It's a postpartal referral form to the Home Health Services of Northeast Ohio as evidenced by the title on the top of the page.
Q. Can you tell from this note who made the observation that there was increased bleeding?
A. It is signed by Dr. Go.
MR. LEVIN: I have no further questions. Thank you, doctor.
MR. SCOTT: Any questions?
MS. KMETZ: No, no questions.
MR. SCOTT: We'll not waive. And could you send iiie -- i'ii order a copy. Send that directly to me.

PHILIP NOWICK , ...D.

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CERTIFICATE

The State of Ohio ) SS:
County of Cuyahdga.)

I, Sandra L. Mazzola, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named PHILIP NOWICKI, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 2002.

_____
Sandra L. Mazzola, Notary Public, State o io
14237 Detroit Avenue, Cleveland, Ohio 461%
My commission expires February 4,2007

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## D



## E

## Q



## R



## S

## T