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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, MD, 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 am. 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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On behalf of the Defendants  
PHS Deaconess Hospital and  
Paul A. Hudock, MD.

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PHILIP NOWICKI, MD., 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 one 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 is correct.

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?

5

1 A. Correct.

2 MR. SCOTT: You're about to be 50.

3 A. That's correct. Sad.

4 Q. Where do you work right now? Where are you  
5 employed?

6 A. I'm employed by the Department of Pediatrics at  
7 the Ohio State University College of Medicine.

8 In that capacity I am a professor of both  
9 physiology and pediatrics, pediatrics being my  
10 primary appointment.

11 As a member of the Department of Pediatrics,  
12 I am also a member of and employed by the  
13 pediatric practice plan which is called the  
14 Pediatric Academic Association, or PAA, and I  
15 receive compensation from both the Ohio State  
16 University on a monthly basis and from the PAA on  
17 a biweekly basis. And that's where my salary  
18 comes from.

19 Q. Okay. How much of your time, if you can tell me,  
20 is spent with the Department of Pediatrics and  
21 how much of your time is spent with the Pediatric  
22 Academic Association?

23 A. It's really coalesced. They really don't -- they  
24 merge together. As being a pediatric faculty  
25 member, I have responsibilities of teaching

6

1 medical students, but the teaching of medical  
2 students that I do primarily occurs during their  
3 clinical years, third and fourth years, and that  
4 usually occurs when I'm involved in the practice  
5 of medicine. Now, as a research based physician  
6 50 percent of my time is spent doing clinical  
7 work and 50 percent of my time involved in  
8 research and my teaching activities occurring  
9 when I'm involved in clinical research.

10 Q. Your areas of research are what as you state  
11 them?

12 A. I have for the past roughly 19 years been  
13 involved in the study of vascular biology, which  
14 is the biology of blood vessels as they pertain  
15 especially to the developmental changes that  
16 occur in the intestinal circulation of newborn  
17 infants as that would occur -- as that would  
18 pertain to their capacity to live after birth and  
19 begin to function after birth and absorb  
20 nutrients and such.

21 Q. I have a description of your research put out by  
22 Ohio State University. I'm going to show it to  
23 you and ask you if it accurately states your  
24 research interests.

25 MR. LEVIN: John, I pulled this off

7

1 the website.

2 A. That's correct. I wrote it. I know it's  
3 correct.

4 Q. Let me just read it into the record.

5 Developmental vascular biology on several  
6 organizational levels, including total organ,  
7 isolated microvessels, cell culture, vascular  
8 smooth muscle differentiation, integration of  
9 molecular differentiation, physiological outcome  
10 and endothelial cell biology, especially as  
11 regards nitric oxide and endothelin. Is that  
12 correct?

13 A. Correct.

14 Q. Now, part of this research is on humans and part  
15 is on animals, is that correct?

16 A. Almost all of it up to very recently has been on  
17 animals. We recently have commenced human work,  
18 or work using human tissue. It's just beginning.

19 Q. I see from your publications you do research on  
20 pigs?

21 A. Pigs.

22 Q. Okay. Have you ever done any research in  
23 hemophilia?

24 A. No, sir.

25 Q. Have you ever done any research with clotting

8

1 disorders or with coagulation issues?

2 A. No.

3 Q. Now, are you the primary care physician for any  
4 patients or are you someone who gets called in as  
5 a consultant?

6 A. My clinical responsibilities are primarily  
7 involved in the provision of intensive care to  
8 preterm and ill newborns. And I do all of my  
9 clinical work now at University Hospital, thus if  
10 a baby is born at University Hospital and is born  
11 preterm, or if born at term and after birth is  
12 ill, that child would come to the intensive care  
13 nursery where I would be the primary caretaker.

14 It's not primary care in the sense of being  
15 a family physician. It's specialized care.

16 However, as part of that, I also am responsible  
17 when we have -- as well as an intensive care  
18 nursery at University Hospital, we also have  
19 what's called a well infant nursery, which is  
20 where anticipate percent of the babies that are  
21 born there go.

22 In other words, you deliver a child at  
23 University Hospital. If they do not have a  
24 pediatrician, if the mother does not list a  
25 pediatrician when she comes in, it's mandated by

9

1 the State of Ohio that a pediatrician **see** the  
 2 child before discharge. The staff physicians,  
 3 which would be me, would do so.  
 4 So I'm providing care to well infants,  
 5 infants that are not **ill**, just to examine them,  
 6 perform circumcisions, provide counseling and  
 7 information to mothers, and referral of those  
 8 infants to pediatricians in the community.  
 9 Q. Let me ask this. Simpler question. Do you have  
 10 any patients that you follow when they leave the  
 11 hospital?  
 12 A. No.  
 13 Q. You deal only with neonates or do you also deal  
 14 with children who are older than neonates,  
 15 however you would characterize them?  
 16 A. We have --  
 17 Q. And by you, I mean you personally.  
 18 A. There is a follow-up program such that babies  
 19 that go through our intensive care nurseries are  
 20 followed by the physicians that saw them in the  
 21 intensive care nursery here as well as their  
 22 pediatricians on the outside. At this point in  
 23 my life I do not participate in that care at  
 24 all. So I do not follow any of the infants. The  
 25 only patients I see are newborn infants.

10

1 Q. How long has that been the case?  
 2 A. Since December of 1996.  
 3 Q. What percentage of -- strike that. I'm trying to  
 4 get some numbers here. You say you spend 50  
 5 percent of your time in research and 50 percent  
 6 of your time in clinical, is that correct?  
 7 A. Correct.  
 8 Q. And the clinical is divided between teaching and  
 9 rendering patient care, correct?  
 10 A. Correct.  
 11 Q. How would you divide that 50 percent clinical  
 12 between those **two**?  
 13 A. Oh, I would say 5 to 10 percent teaching, 40  
 14 percent clinical care. More -- you know, I don't  
 15 know how it's done in law school, but I mean  
 16 basically third and fourth year medical students  
 17 follow staff physicians around and watch them in  
 18 all their practices basically. So whenever I  
 19 provide care to a newborn at University Hospital,  
 20 invariably there is a third or fourth year  
 21 medical student right behind me in a white coat  
 22 watching what I **do**, and I'm talking to them and  
 23 teaching them. So it happens at the same time.  
 24 Q. Do you consider yourself -- let's **see** if we can  
 25 just go through in terms of what you consider.

11

1 You consider yourself an expert in pediatrics,  
 2 correct?  
 3 A. Yes.  
 4 Q. And you consider yourself an expert in  
 5 neonatology, correct?  
 6 A. Yes.  
 7 Q. By the way, do you have a rule of thumb as to  
 8 when neonatology ends and just being little kids  
 9 begins?  
 10 A. Technically, the neonatal period is define as the  
 11 first 28 days after birth. That is a very  
 12 romantic conception. It's based on ancient  
 13 history.  
 14 Q. What do you call it in your practice?  
 15 A. I think in my practice what I do is I'll take  
 16 care of a baby in the intensive care nursery  
 17 until that baby goes home. And if that baby  
 18 requires more than one month of hospitalization  
 19 as oftentimes is the case for very preterm  
 20 infants, then, you know, if the kid is in the  
 21 hospital for three months, then I'll take care of  
 22 it for three months.  
 23 Q. That's really developmental and able to thrive  
 24 more than just chronological?  
 25 A. Precisely.

12

1 Q. Do you consider yourself an expert in hematology?  
 2 A. No.  
 3 Q. Do you consider yourself an expert in neurology?  
 4 A. No.  
 5 Q. Do you consider yourself an expert in  
 6 neurosurgery?  
 7 A. No.  
 8 Q. Do you consider yourself an expert in radiology?  
 9 A. No.  
 10 Q. And I assume that you do not consider yourself an  
 11 expert in the subfield of neuroradiology?  
 12 A. **No**.  
 13 Q. And do you consider yourself an expert on nursing  
 14 standards?  
 15 A. Nursing standards as they pertain to the normal  
 16 delivery and care of well infants, yes, I have  
 17 worked with nurses and worked in well baby  
 18 nurseries and intensive care nurseries for almost  
 19 20 years, and you know, nursing standards and  
 20 medical standards in that particular venue, walk  
 21 hand and hand. And so I would consider myself to  
 22 be very well-versed in what I would expect a  
 23 nurse in either a well baby nursery or an  
 24 intensive care nursery to be responsible for,  
 25 yes.

13

- 1 Q. Do you have a list of what you reviewed in this  
2 case?  
3 A. I have it right here in front of me. I reviewed  
4 the --  
5 MR. SCOTT: Actually, not to  
6 interrupt you, but I think there is a  
7 heading.  
8 MR. LEVIN: If we can read it into  
9 the record, it would be faster, if there is  
10 a list somewhere.  
11 MR. SCOTT: If that helps.  
12 A. Okay.  
13 Q. Can I see that front page?  
14 A. Sure.  
15 Q. Let me read this into the record. Doctor, you  
16 reviewed records from MetroHealth?  
17 A. That's correct.  
18 Q. And also neurological surgery at MetroHealth?  
19 A. Correct.  
20 Q. From Carol Crowe at MetroHealth?  
21 A. Correct.  
22 Q. And also five groups of records at University  
23 Hospitals, Shurin, correct?  
24 A. Correct.  
25 Q. Therapy records, physical therapy records?

14

- 1 A. Yes.  
2 Q. Some emergency department records?  
3 A. Yes.  
4 Q. An evaluation actually not from University but  
5 from Southwest, speech language?  
6 A. Yes.  
7 Q. And the records of Dr. Walker?  
8 A. Yes.  
9 Q. Have you reviewed anything else?  
10 A. I have had the opportunity to review the  
11 deposition of Dr. Go in this case that was given  
12 to me by Mr. Scott. And I have had the  
13 opportunity to review the expert witness reports  
14 from all of the witnesses in this case, both  
15 yours and Mr. -- Mr. Scott's. Pardon me. Brain  
16 failure.  
17 Q. And there were records of experts' reports from  
18 Dr. Go's side?  
19 A. Correct.  
20 Q. Have you reviewed those as well?  
21 A. Yes, I can give you that. For Dr. Go --  
22 Q. Okay. Let me ask you before we get to that.  
23 A. Sure.  
24 Q. Dr. Go had a two-part deposition that was, I  
25 believe, at least a month apart. Were you given

15

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

16

- 1 A. Correct.  
2 Q. You have no way of knowing, for instance, whether  
3 or not during all the hospital stays and hospital  
4 visits that this child has had, whether the  
5 records you were given are all the records? You  
6 would have no way of knowing that, would you?  
7 A. That's correct.  
8 Q. Okay. Do you have a list of the reports you  
9 have?  
10 A. Yes, I do.  
11 Q. May I see that, please?  
12 A. Okay.  
13 Q. So we have -- these records were sent to you on  
14 February 11, is that correct?  
15 A. That's correct.  
16 Q. And your report is dated?  
17 A. Much earlier than that. September of last year,  
18 I think.  
19 Q. So you did not have the benefit of these -- of  
20 any reports when you did -- strike that. At the  
21 time that you prepared your report, had you read  
22 anybody else's report?  
23 A. No.  
24 Q. At the time you had prepared your report, did you  
25 review Dr. Go's deposition?

17

- 1 A. Yes.
- 2 Q. At the time you had made your report, had you
- 3 reviewed all the records that you now have?
- 4 A. Correct. Just the medical records regarding this
- 5 case. Yes. But I reviewed-- the only
- 6 deposition that I reviewed was Dr. Go's. I had
- 7 not been given access to any of the reports. The
- 8 only reports that I have were given to me by Dr.
- 9 Scott and that was the 11th of this month.
- 10 Q. Mr. Scott. We don't want to promote him.
- 11 A. Mr. Scott. I'm not sure it's a promotion or
- 12 demotion, to be honest.
- 13 Q. My question is simpler. Did you receive any new
- 14 records after the initial set of records you got
- 15 --
- 16 A. No.
- 17 Q. -- before your report?
- 18 A. No.
- 19 Q. Doctor, let me read these in, just for the
- 20 record. You took a look at reports of
- 21 Dr. McClead, Dr. Neufeld, Dr. Goessler,
- 22 Dr. Rothner, Dr. Lanzieri, Dr. Miller,
- 23 Dr. Shurin, a Nurse Penny Buchholtz, a Nurse
- 24 Linda DePasquale, correct?
- 25 A. Correct.

18

- 1 Q. You were also sent another copy of your own
- 2 report?
- 3 A. Correct.
- 4 Q. Why was that?
- 5 A. I don't know.
- 6 Q. Has your review of these other expert reports
- 7 changed any of your opinions in any way at all?
- 8 A. No.
- 9 Q. I know I asked you this, and I can't remember.
- 10 Did you get Dr. Go's depo after your report?
- 11 A. No, I got it before.
- 12 Q. Okay. Have you ever taken a look at any films,
- 13 CAT scans or other radiological records with
- 14 regard to Forrest Stone?
- 15 A. No.
- 16 Q. Do you normally read those yourself?
- 17 A. No.
- 18 Q. Are you aware that Dr. Lanzieri as a
- 19 neuroradiologist read them and rendered an
- 20 opinion?
- 21 A. Yes.
- 22 Q. And would you agree with me that whatever the
- 23 validity of his reading, that neuroradiology is
- 24 not a field to which you hold yourself out as an
- 25 expert, correct?

19

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

20

- 1 Dr. Likavec, Penny Buchholtz or anybody else?
- 2 A. No.
- 3 Q. Do you know Susan Shurin?
- 4 A. No.
- 5 Q. You understand that Susan Shurin does pediatric
- 6 hematology?
- 7 A. That's what I understand from reading her report.
- 8 Q. Okay. Do you use-- do you ever bring in
- 9 pediatric hematologists to assist you in the care
- 10 of treatment of your patients?
- 11 A. Yes.
- 12 Q. Under what circumstance or under what
- 13 circumstances?
- 14 A. Primarily when we have concerns regarding
- 15 bleeding disorders when we are not able to
- 16 ourselves determine what the problem is causing the
- 17 bleeding diathesis. We also have done it on
- 18 occasion when we are giving hormones to stimulate
- 19 the production of either red blood cells or white
- 20 blood cells. We have occasionally done it in
- 21 instances where we were concerned about the
- 22 presence of a congenital malignancy of the blood
- 23 cells.
- 24 Q. Doctor, will you agree with me that the Childrens
- 25 Hospital and University Hospitals that you're

21

1 associated with are tertiary care centers as that  
 2 term is used?  
 3 A. Yes.  
 4 Q. Okay. And University Hospitals, just for the  
 5 record, since we are in Cleveland is University  
 6 Hospital of Columbus, not University Hospital of  
 7 Cleveland, which the jury may know as a separate  
 8 institution?  
 9 A. That is correct.  
 10 Q. They're not affiliated?  
 11 A. No, they are not.  
 12 Q. Okay. Now, there are primary care centers, there  
 13 are secondary care centers and the tertiary care  
 14 centers, sometimes they are called level I, II  
 15 and III, correct?  
 16 A. Correct.  
 17 Q. What is the difference between a primary and a  
 18 secondary and a tertiary, if you could just  
 19 explain briefly?  
 20 A. Secondary is kind of an -- I'm not sure I can  
 21 identify a secondary care center. There is  
 22 really more primary and tertiary.  
 23 Q. Secondary being squeezed at both ends?  
 24 A. Right. A primary care center is a smaller  
 25 institution, a smaller hospital, whose patient

22

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

23

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

24

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

25

1 hospital.

2 By contrast, somebody comes into a level I  
3 hospital in massive chest pain, an adult, an ER  
4 physician or primary care physician diagnoses a  
5 massive myocardial infarction. That patient is  
6 going to require catheterization and probably  
7 stent placement. That's not done at the level I  
8 hospital. Then you immediately move the  
9 patient.

10 So it's really a function of the patient's  
11 condition and what has to be done to that  
12 patient.

13 Relevant to this case, which is what you are  
14 getting at --

15 Q. Doctor, I appreciate actually your giving me long  
16 answers and I'm learning a lot. I don't know if  
17 we're going to get through the deposition that  
18 way. And I will not cut you off again. When you  
19 say relevant to this case, I just want to get  
20 through --

21 A. Okay.

22 Q. I appreciate your candor. I really do. You are  
23 giving me very long answers and I have a lot of  
24 short questions I've got to get through today.

25 A. Okay.

26

1 Q. If you want to continue, go ahead. I don't want  
2 to cut you off.

3 A. No. I give you long answers when long answers  
4 are mandated, and there is no short answer to the  
5 question you gave me, and the fact is it's a  
6 function of what the situation dictates at the  
7 time, what the patient would require.

8 Q. Is hemophilia normally able to be treated at  
9 primary care hospitals?

10 A. It can be diagnosed and treated in primary care  
11 hospitals very easily, yes.

12 Q. Okay. And to **treat it, it would require** a factor  
13 VIII or factor IX, is that correct, in general?

14 A. That is correct.

15 Q. Do you know whether factor VIII or factor IX is  
16 available at Deaconess Hospital?

17 A. I'm absolutely certain that it was.

18 Q. **What do you base that on?**

19 A. Every hospital in this country is going to have  
20 access to fibrin --

21 Q. Access meaning on site?

22 A. On site, yes. I mean it's --

23 Q. That is my only question.

24 A. Yes, they do. They have it. Guaranteed.

25 Q. Again, I'm not trying to cut you off, doctor.

27

1 A. Okay. Go ahead.

2 Q. What duties -- you said that the hospital owes  
3 certain duties to the patient other than what the  
4 doctors owe. What duties do the hospital owe the  
5 patients?

6 A. And if you want short answers, start making  
7 relevant intelligent questions. I'm serious.  
8 That's a ridiculous question. Okay?

9 A hospital has a responsibility to provide  
10 care for the patient, to provide an environment  
11 in which the patient can be properly cared for,  
12 to provide staff that are intelligent,  
13 well-trained and know what to do with the  
14 patient.

15 Now, I'm not a hospital administrator. I'm  
16 not an administrator in any capacity, way, shape  
17 or form. So outside of an obvious answer, that's  
18 the best I can tell you. That's what the  
19 hospital's responsibility is.

20 Q. Do you have an opinion about the appropriateness  
21 or need for protocols for nursing in hospitals?

22 A. Virtually all hospitals that I have ever --  
23 actually every hospital that I have ever worked  
24 in has protocols, not only for nursing care but  
25 for medical care. Especially nurseries. And

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1 that is done because it is imperative that the  
2 most up to date, most appropriate care be given  
3 to every patient, that the care not be altered by  
4 an individual caregiver's level of experience.

5 So for example, when a patient in a nursery  
6 has -- a newborn infant has a problem, say he's  
7 breathing too fast, there will be a book in that  
8 room that tells the nurse, tells the doctor what  
9 exactly they should be thinking about. That  
10 happens everywhere in the world, or in this  
11 country that I'm aware of.

12 Q. **Have you seen?** protocols or procedures **for**  
13 Deaconess Hospital in this case?

14 A. No.

15 Q. Did you ask for those?

16 A. No.

17 Q. Do you have any opinion as to whether the  
18 procedures and protocols that were in place at  
19 Deaconess were reasonable? Do you have any  
20 opinion on that?

21 A. I haven't seen them, so I have no opinion.

22 Q. And do you have any opinion as well as to whether  
23 they were followed?

24 A. I haven't seen them, so I have no opinion.

25 Q. Have you asked Mr. Scott for any additional

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

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

30

- 1 A. That's correct.  
 2 Q. Do you know how Mr. Scott found you?  
 3 A. I have done reviews for Reminger & Reminger for  
 4 several years now. I suspect that my name is on  
 5 their Rolodex.  
 6 Q. Have you ever testified before?  
 7 A. Yes.  
 8 Q. How many times have you testified -- I'm going to  
 9 ask you first how many times have you testified  
 10 in the courtroom?  
 11 A. Twice.  
 12 Q. Both for Reminger?  
 13 A. Yes.  
 14 Q. And in what cities, Cleveland, Columbus?  
 15 A. One in Cleveland and one in a town outside of  
 16 Cleveland, south and west, and I can't remember  
 17 its name. That was the first one I ever  
 18 testified in, And I don't recall.  
 19 Q. Medina?  
 20 A. No, it wasn't Medina.  
 21 Q. Elyria?  
 22 A. It was a small town. Elyria, no.  
 23 Q. Ashland, Mansfield?  
 24 A. No. it wasn't Mansfield or Ashland.  
 25 Q. I'm going to run out of county seats, so let me

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- 1 go on. Do you recall the captions of either of  
 2 those cases?  
 3 A. No.  
 4 Q. Do you recall who the plaintiff's lawyer was in  
 5 either of those cases?  
 6 A. The plaintiff's lawyer for the first case, it was  
 7 a woman. Her husband is also a lawyer. She  
 8 works in the Cleveland area.  
 9 Q. Claudia Eklund?  
 10 A. Yes. Claudia Eklund. Thank you.  
 11 Q. You are welcome.  
 12 A. Yes.  
 13 Q. Small community. Do you know who the plaintiff's  
 14 lawyer was in the other case?  
 15 A. No, I don't remember.  
 16 Q. How many times have you testified in depositions?  
 17 A. I don't have an accurate record. I would say  
 18 probably about 25.  
 19 Q. And that would include also giving depositions in  
 20 the two cases that you ended up trying, is that  
 21 correct?  
 22 A. Yes.  
 23 Q. How many of those 25 were for Reminger &  
 24 Reminger?  
 25 A. 15.

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



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

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

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

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

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

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

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

19 A. Correct.

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

22 A. Correct.

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

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1 complications?

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

4 Q. I'm sorry. At University Hospital.

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

7 Q. Well, in the last three years.

8 A. Last three years, 24 to 36 hours.

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

15 A. No.

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

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

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

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

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1 Q. Yes.

2 A. Yes.

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

5 A. Correct.

6 Q. So how many?

7 MR. SCOTT: I object to this.

8 Q. How many hours?

9 MR. SCOTT: He asked two questions.

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

12 A. I have to look that up.

13 Q. Why don't you look it up?

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

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

19 MR. SCOTT: You're testing his  
20 recollection.

21 MR. LEVIN: Correct.

22 A. Looks like he was born on 3-25 at 8:08 in the  
23 morning. And let's see when he was discharged.

24 It's in my report, I believe.

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

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

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

11 A. That's fine.

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

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

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

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

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

24 A. Careful.

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

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1 case to give opinions and I can address -- I can  
 2 test your opinions, doctor.  
 3 MR. SCOTT: You need to be courteous  
 4 and professional to everybody.  
 5 A. You need to be a professional person because it's  
 6 going to get ugly.  
 7 Q. Get as ugly as you want, doctor. I need to know.  
 8 A. I don't have a precise time as to when the child  
 9 was discharged. Now, if you want to sit there  
 10 and wait until I find it --  
 11 Q. I was waiting until your counsel --  
 12 A. -- it's your --  
 13 MR. SCOTT: That's fine. But what's  
 14 the purpose, Joel? Why don't you give him  
 15 the pertinent times and dates which are  
 16 contained in the record?  
 17 A. He was discharged when, John, on that following  
 18 --  
 19 MR. SCOTT: Is that okay with you,  
 20 Joel, that we disclose when he was  
 21 discharged?  
 22 MR. LEVIN: No. I think he's either  
 23 competent to find it in the record or he is  
 24 not, and I'm allowed to test that.  
 25 MR. SCOTT: Why don't we just go

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1 through the records and you can take all the  
 2 time you want then.  
 3 MR. LEVIN: I don't believe you can  
 4 help him find it in the records, John.  
 5 MR. SCOTT: Well, I don't think  
 6 that's accurate. As a matter of fact, I can  
 7 do anything I wish in terms of what's  
 8 contained in the records.  
 9 MR. LEVIN: Let the record show that  
 10 John Scott is showing the doctor how to find  
 11 records because the doctor seems unable,  
 12 without assistance, to understand the chart,  
 13 MR. SCOTT: I object. And I move to  
 14 strike. And you are really asking for a lot  
 15 of headache in this case and I'm going to  
 16 give it to you.  
 17 MR. LEVIN: I'm very worried, John.  
 18 A. He was discharged to home, counsel --  
 19 MR. SCOTT: And this is silly.  
 20 A. -- on 3-27-99 at 8:30 in the morning, the order  
 21 was written.  
 22 Q. Is that when he left the hospital?  
 23 A. I don't know when he left the hospital.  
 24 MR. SCOTT: Is that your next  
 25 question?

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1 A. Counsel.  
 2 MR. SCOTT: Is that your next  
 3 question?  
 4 A. I wasn't there.  
 5 MR. SCOTT: All of this was  
 6 unnecessary, Joel.  
 7 MR. LEVIN: Can I ask questions,  
 8 John?  
 9 MR. SCOTT: Go right ahead.  
 10 A. Ask questions.  
 11 MR. LEVIN: Let the record reflect  
 12 that the doctor is yelling.  
 13 MR. SCOTT: I object to that. The  
 14 doctor is not yelling.  
 15 A. I'm not yelling, sir.  
 16 Q. Doctor --  
 17 MR. SCOTT: You're the one playing  
 18 games here.  
 19 Q. My question to you -- perhaps you lost it -- is  
 20 when was the circumcision done?  
 21 MR. SCOTT: Do you want him to look  
 22 at the records?  
 23 MR. LEVIN: Yes.  
 24 MR. SCOTT: I presume so. Look at  
 25 the records.

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1 A. I have that here actually. He was circumcised --  
 2 he was born on March 25, 1999 at 808 am. He  
 3 was circumcised by Dr. Hudock in the afternoon of  
 4 the next day without difficulty, which would have  
 5 been March 26, 1999.  
 6 MR. SCOTT: Now, what was the  
 7 purpose of that, Joel?  
 8 A. That evening, and again, in the morning his circ  
 9 site was noted to be bleeding. Dr. Go and  
 10 Dr. Hudock examined the infant and applied a  
 11 topical procoagulant, and he was discharged on  
 12 the next day.  
 13 MR. SCOTT: Next question.  
 14 Q. How many hours to your understanding was there  
 15 between the circumcision and discharge, doctor?  
 16 A. I don't have any way of knowing exactly how many  
 17 hours. If he was circumcised on the afternoon of  
 18 his -- the day after he was born and he was  
 19 discharged the next day, I would estimate that  
 20 there would have been approximately 24 hours,  
 21 possibly a little bit less. Possibly a little  
 22 bit more.  
 23 I should note, counsel, that it is never  
 24 written in a medical record when the patient  
 25 actually exits the hospital. The patient's exit

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1 from the hospital is based on when the discharge  
 2 order was written. You should know that.  
 3 MR. SCOTT: Next question, counsel.  
 4 MR. LEVIN: Don't interrupt.  
 5 MR. SCOTT: What goes around comes  
 6 around, counsel. Next question.  
 7 MR. LEVIN: John, you know the local  
 8 rule says you are forbidden from talking--  
 9 MR. SCOTT: Baloney.  
 10 MR. LEVIN: I don't want to take it  
 11 to court.  
 12 MR. SCOTT: Take it to court. Take  
 13 it, Joel.  
 14 A. Let's go.  
 15 MR. SCOTT: I'm really upset that  
 16 you take that kind of line of questioning  
 17 and that attitude towards the witness, and  
 18 you ought not to do that. What's the  
 19 purpose?  
 20 MR. LEVIN: To test his knowledge of  
 21 this case.  
 22 MR. SCOTT: Recollection. It's not  
 23 knowledge. Go ahead. Go.  
 24 Q. Do you have any estimate as to how much of the  
 25 time between the circumcision and the discharge

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1 this child was bleeding from the circumcision  
 2 site?  
 3 A. In my reading of the medical record, my  
 4 understanding is that the child bled between the  
 5 time of the circumcision, which was done on the  
 6 26th, and the time when the doctors were rounding  
 7 in the hospital on the next day, the 27th. Both  
 8 of the doctors were in the hospital when the  
 9 nurse took the infant's diaper off on that day  
 10 noticing that there had been blood present in the  
 11 diaper. And both of the doctors, Dr. Hudock and  
 12 Dr. Go, in the medical records it's stated that  
 13 they examined the child.  
 14 So that there was bleeding that was  
 15 occurring or that had occurred at the time of --  
 16 between the time of the circumcision and the  
 17 examination of the child on the next day.  
 18 Q. At that time, at that time. At that time when  
 19 they noticed that, do you believe there was any  
 20 concern for hemophilia?  
 21 A. There had to be.  
 22 MS. METZ Objection.  
 23 A. Because Dr. Go in her orders ordered blood tests  
 24 to be done. That would have been the initial  
 25 screening evaluation looking for coagulation

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1 disorders.  
 2 Q. That would include a PTT, correct?  
 3 A. That's correct.  
 4 Q. And is the PTT a dispositive test for hemophilia?  
 5 A. No.  
 6 Q. What is?  
 7 A. The only way to diagnose hemophilia completely is  
 8 to actually measure the percentage of the  
 9 clotting factor's activity. You actually do a  
 10 factor VIII percentage level.  
 11 Q. The initial test is PTT is to see whether further  
 12 tests should be done, is that fair?  
 13 A. That is correct.  
 14 Q. So do you believe that Dr. Go acted appropriately  
 15 in being concerned that there may be a clotting  
 16 disorder in ordering a PTT?  
 17 A. To be honest, I thought at that time it was  
 18 overkill. I would not have. I've done well over  
 19 2,000 circs in my career and I would say that a  
 20 full 15 percent of them are bleeding 24 hours  
 21 later. It's purely a function of how the Gomco  
 22 clamp was placed with respect to the anatomy of  
 23 the child's penis, and when you take into  
 24 consideration the number of circs that bleed 24  
 25 to 48 hours after the procedure versus the

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1 percentage of hemophilia in the community at  
 2 large, it's a vast difference.  
 3 So I would -- personally, if the house  
 4 officer had called me or I had seen the  
 5 circumcision that was bleeding at 24 hours, I  
 6 would probably not have ordered a PT and a PTT  
 7 and a platelet count.  
 8 Q. Was there any bruising on this child?  
 9 A. There was some bruising, yes.  
 10 Q. Where was the bruising?  
 11 A. I believe it was on the face with petechiae on  
 12 the face and some bruising on the limbs as I  
 13 recall.  
 14 Q. Are either of those indication of possible  
 15 hemophilia or clotting disorder?  
 16 A. Once again, they certainly would be a harbinger  
 17 of undercoagulation disorder. However, at least  
 18 35 percent of infants that are born through the  
 19 birth canal will have some degree of bruising.  
 20 The degree of bruising is the function of how  
 21 long the labor was, how precipitous it was, what  
 22 the configurations of the woman's pelvis were.  
 23 If it was small and pointed with the issue of  
 24 tuberosity in close proximity, then the bumping  
 25 of its head would be somewhat more substantial

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

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

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

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1 rupture. It's very common to see petechiae,  
 2 especially on the face and head of newborn  
 3 infants. I would say at least 50 percent of  
 4 newborn infants have some petechiae at birth.  
 5 Q. My question was is it your testimony that  
 6 evidence of petechiae that is higher than normal  
 7 is a possible sign of a clotting disorder?  
 8 A. Higher than normal is the hard part. If you have  
 9 a child that's covered with petechiae, then I  
 10 would say that a coagulopathy should certainly be  
 11 considered.  
 12 Q. One of the obvious symptoms of petechiae is  
 13 redness of the face, that's one thing clinically  
 14 that presents, correct?  
 15 A. No. A petechiae is a small, bright red mark  
 16 which indicates that a capillary or arteriole in  
 17 the dermis of the face is ruptured. It's a very  
 18 small red dot.  
 19 Q. Is it sometimes multiple?  
 20 A. Almost invariably multiple.  
 21 Q. If the child's face is extremely red, is that  
 22 something that is indicative of potentially  
 23 higher than normal petechiae?  
 24 A. No.  
 25 Q. Is that -- is that a concern for any possible

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1 disorder?

2 A. No.

3 Q. Do you know whose decision it was not to repeat  
4 the PTT?

5 A. I assumed that it was Dr. Go's. I assume that  
6 the nursing staff called Dr. Go with the fact

7 that the PT and PTT could not be obtained and  
8 that it was her decision not to proceed further.

9 Q. You say could not be obtained. Would it be fair  
10 to say that it was not obtained the first time  
11 and it would require a reinjection?

12 A. Correct.

13 Q. Do you know who made the first injection, whether  
14 it was the nursing staff or whether it was a  
15 physician?

16 A. I don't believe it was the physician. It would  
17 have been probably somebody from the lab staff  
18 actually.

19 Q. Do you know whether the lab staff had the  
20 authority to reinject?

21 A. No, they do not. If a sample cannot be drawn in  
22 a normal onetime pass, then especially in a  
23 child, the lab staff backs off or the nursing  
24 staff backs off and calls the doctor. That's  
25 very, very important. Parents become extremely

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1 upset when their child is repeatedly punctured.

2 Q. Are you going to offer an opinion on the  
3 prognosis of this child?

4 A. No.

5 Q. Are you going to offer an opinion about the need  
6 for neurosurgery of this child?

7 A. No.

8 Q. Are you going to offer an opinion as to whether  
9 or not earlier neurosurgery would have given a  
10 better prognosis?

11 A. No.

12 Q. We can agree from what you have said in your  
13 report that -- strike that. Let me start from  
14 the beginning. It is your opinion that the  
15 bleeding began at birth, correct, that's the  
16 subdural hematoma?

17 A. Correct.

18 Q. And in the normal course of a subdural hematoma  
19 that is not resolved, there is going to be  
20 swelling or edema, correct, typically?

21 A. Of what?

22 Q. Some part of the neural cavity, some part of the  
23 brain.

24 A. No.

25 Q. Is there going to be any edema or swelling?

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1 A. A subdural hematoma or hemorrhage is -- occurs  
2 when the veins that traverse the dural membranes  
3 from both the calvarium bone and from the brain  
4 cell stems are sheared and thus becomes  
5 disrupted, you get bleeding between the bone and  
6 the subdural membrane.

7 Q. Is there any edema here in this boy's head?

8 MR. SCOTT: When?

9 Q. Ever.

0 A. I believe that on one of the CT scans there was a  
1 discussion of edema. I was getting to that. The  
2 hemorrhage gets bigger because it's -- it is not  
3 tamponaded. The baby's brain or the baby's  
4 calvarium, unlike yours, is not fused. The bones  
5 are not fixed.

6 And as a consequence, there is no pressure  
7 that stops the bleeding initially. Over the  
8 course of time as the pressure does build up,  
9 then there will be a pressure delivered to the  
10 brain substance below the dura. And when this  
11 occurs, the brain substance certainly can become  
12 injured and become edematous. The dura itself  
13 does not become edematous. The brain space  
14 becomes edematous. The edema which is an  
15 excessive amount of water outside the vascular

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1 space occurs to brain tissue.

2 Q. Do you know when the pressure, as you put it,  
3 began? Or is that something that's outside your  
4 expertise with regard to this point? I don't  
5 know what you mean by pressure.

6 A. This baby's hemorrhage occurred at the time of  
7 the delivery. There is no other time it could  
8 have occurred. A subdural hematoma or hemorrhage  
9 just doesn't happen. It's not like a stroke.  
0 You have to have trauma to the head, sort of a  
1 sheering process to occur. And the only time  
2 this baby would have experienced trauma to his  
3 head was at the time of delivery. So the  
4 hemorrhage began then.

5 Now, we know now that he had hemophilia so  
6 that his ability to stop that hemorrhage would  
7 have been -- would have been somewhat decreased.  
8 Over the course of days the bleeding continued,  
9 and as the bleeding continued, the space between  
10 the bone plates and the brain became more and  
11 more compromised so that pressure eventually  
12 developed such that the brain tissue was being  
13 pushed down by the dura.

14 Q. My question is --

15 A. When did it start. The child became clinically

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

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

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

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

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

22 A. Yes.

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

25 A. No.

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

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

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

10 A. No.

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

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

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

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

25 I would further go on to say that even if

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

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

9 A. That's correct.

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

12 A. Yes.

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

18 A. Maybe you did. Let's see.

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

21 MR. LEVIN: Correct.

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

25 MR. LEVIN: That's false. You know

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

3 MR. SCOTT: All right.

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

6 MR. SCOTT: Okay. He's answered.

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

10 MR. SCOTT: Okay.

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

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

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1 and that's what this fax shows.  
 2 MR. SCOTT: You know, you become too  
 3 excited about too much. We can talk back  
 4 and forth without each other getting  
 5 excited.  
 6 MR. LEVIN: I did not sit on the  
 7 report.  
 8 MR. SCOTT: I'm not saying you did.  
 9 MR. LEVIN: I got sent it to you  
 10 within minutes of when I got it.  
 11 MR. SCOTT: Okay. I'm happy to hear  
 12 that.  
 13 MR. LEVIN: I don't care if you're  
 14 happy or not.  
 15 MR. SCOTT: Go ahead. Now the  
 16 doctor answered the question. Be calm. Do  
 17 you want me to saying anything more? Go  
 18 ahead.  
 19 Q. Doctor, if the PTT comes back and reveals a  
 20 possible bleeding disorder, would it be fair to  
 21 say that the treatment issues would be handled by  
 22 a hematologist?  
 23 A. Yes.  
 24 Q. And would it also be fair to say that in general,  
 25 without talking about this case, there are

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

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

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



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

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

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

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

23 A. Yes.

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

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1 A. Yes.

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

7 A. No.

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

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

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

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

23 MR. SCOTT: Objection.

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

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

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

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

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

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

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

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

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

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

13 A. I do not have an understanding, no.

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

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

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

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

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

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

20 A. Much less likely hemophilia.

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

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1 A. No.

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

4 A. No.

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

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

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

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

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

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

12 MR. SCOTT: Object.

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

18 Q. Which would include hemophilia?

19 A. Yes.

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

25 A. No. Not really. Babies get vitamin K

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

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

10 A. Yes.

11 Q. And I believe you said the petechiae was about a  
12 50 percent chance?

13 A. Yes, that's correct.

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

16 A. Correct.

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

19 MR. SCOTT: Object.

20 A. I would say one in 25.

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

24 A. Phrased that again.

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

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

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1 expertise as a professor of medicine, correct?  
 2 A. Correct.  
 3 Q. And so sometimes one gets an odd collection of  
 4 clinical signs and symptoms and one has to sort  
 5 of be a medical Sherlock Holmes, put it together  
 6 and see what it is, correct?  
 7 A. Correct,  
 8 Q. And one thing one wants to worry about is  
 9 coincidence versus something that is related,  
 10 right? I mean one wants to look at that?  
 11 A. Correct.  
 12 Q. Would **you agree with me the only thing that would**  
 13 **not be coincidence, but would link the following**  
 14 **symptoms, in the abstract, prolonged bleeding**  
 15 **from the circ site, facial bruising, bruises and**  
 16 **lumps from the injection site, and greater than**  
 17 **normal petechiae, would be some kind of blood**  
 18 **disorder? Any other collection of that in the**  
 19 **same patient would be coincidental?**  
 20 A. No, I don't.  
 21 Q. What other reason other than a blood disorder  
 22 would link those other than coincidentally?  
 23 A. If the child had just been born and gone through  
 24 the birthing canal, and in the process of doing  
 25 that, had exposure to shear stresses and

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

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

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

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

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1 MR. LEVIN: I asked a yes or no  
 2 question. If he wants to volunteer life,  
 3 then I'm allowed to follow up.  
 4 MR. SCOTT: Go on, Joel. Baloney.  
 5 Go on.  
 6 MR. LEVIN: How are you going to  
 7 protect him from all this at trial, John, if  
 8 you jump up every second?  
 9 MR. SCOTT: Believe me, it won't be  
 10 a problem.  
 11 A. No, it won't be a problem. No, it won't. I  
 12 suggest strongly that you read my trial  
 13 testimony.  
 14 Q. I'm sure you're very proud of it, doctor.  
 15 A. I am very proud.  
 16 MR. SCOTT: We are not going to do  
 17 that. You either ask a legitimate question  
 18 --  
 19 MR. LEVIN: Why does he think I want  
 20 to be in his shoes?  
 21 MR. SCOTT: Stop, Joel. I expect  
 22 more from you. Come on.  
 23 MR. LEVIN: I'm just asking  
 24 questions. I didn't raise my voice, I  
 25 didn't insult anybody. I'm asking

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1 questions.  
 2 MR. SCOTT: The content of the  
 3 question is precisely --  
 4 A. Go ahead now.  
 5 MR. LEVIN: Let's take a break.  
 6  
 7 (Thereupon, a recess was had.)  
 8 - - - -  
 9 Q. Doctor, you said there was -- I'll try to get  
 10 your language as my colleague wrote it down as  
 11 closely as possible -- that there were a standard  
 12 battery of tests for diagnosing bleeding  
 13 disorders?  
 14 A. Correct.  
 15 Q. What would they be?  
 16 A. A PTT, a PT and a platelet count.  
 17 Q. Doctor, you work in the NICU, in the neonatal  
 18 intensive care unit, is that right?  
 19 A. I work in both the NICU and the well baby  
 20 nursery.  
 21 Q. Is critical care the same at Ohio State as  
 22 intensive care? Are those terms used  
 23 interchangeably here?  
 24 A. Yes.  
 25 Q. Now, is there a group at Ohio State that's the

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1 critical care group for pediatrics?  
 2 A. There is a group, a division of neonatology  
 3 within the department of pediatrics at the Ohio  
 4 State University. We provide the newborn  
 5 intensive care and well infant care at University  
 6 Hospital, Childrens Hospital and Mt. Carmel East  
 7 Hospital.  
 8 Q. You are part of the critical care group?  
 9 A. Correct.  
 10 Q. Are you part of the neonatology group?  
 11 A. Same thing, same group.  
 12 Q. Are there different divisions within this group?  
 13 A. No.  
 14 Q. Is there an adolescent health medicine division?  
 15 A. I think so.  
 16 Q. And there is an ambulatory services division?  
 17 A. I think so.  
 18 Q. And I won't go through all this whole long list.  
 19 You are not part of the adolescent health group?  
 20 A. No.  
 21 Q. And you are not part of the ambulatory services  
 22 group?  
 23 A. Correct.  
 24 Q. I may go through this list. There is a  
 25 behavioral pediatrics group. Are you part of that

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1 group?  
 2 A. No.  
 3 Q. The cardiology group, are you part of the  
 4 cardiology group?  
 5 A. No.  
 6 Q. There is a cardiothoracic surgery group. Are you  
 7 part of that?  
 8 A. No.  
 9 Q. There is a critical care group. Are you part of  
 10 that?  
 11 A. They are the ones that take care of pediatric  
 12 older patients in critical care. No; I'm not.  
 13 Q. There is emergency medicine. You are not part of  
 14 that?  
 15 A. No.  
 16 Q. And there is endocrinology. Are you part of  
 17 that?  
 18 A. Nope.  
 19 Q. And there's gastroenterology. You are not part  
 20 of that?  
 21 A. No.  
 22 Q. There is hematology oncology. You are not part  
 23 of that, correct?  
 24 A. No.  
 25 Q. That would be the group that you would refer a

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1 patient who you had some strong suspicion of  
 2 hemophilia to, correct?  
 3 A. Yes.  
 4 Q. There's the human and molecular genetics group.  
 5 Are you part of that group?  
 6 A. No.  
 7 Q. The infectious disease group, are you part of  
 8 that?  
 9 A. No.  
 10 Q. There is the metabolism group. Are you part of  
 11 that?  
 12 A. No.  
 13 Q. There is the neonatology group. Are you part of  
 14 that?  
 15 A. Yes.  
 16 Q. There's the molecular medicine group. Are you  
 17 part of that?  
 18 A. No.  
 19 Q. Doctor, I downloaded this from your website. A  
 20 very good likeness of you, I believe, on the  
 21 picture.  
 22 A. Ugly guy.  
 23 Q. I warn you, doctor, you are under oath.  
 24 A. I'm still ugly.  
 25 MR. LEVIN: Let me just point out,

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1 and I **don't** want to keep this from you,  
 2 John.  
 3 MR. SCOTT: Oh, go ahead. Keep it  
 4 from me.  
 5 MR. LEVIN: I've had it for some  
 6 long time.  
 7 Q. You are listed under molecular medicine and you  
 8 are not listed under neonatology.  
 9 A. Yes.  
 10 Q. What is the explanation for that?  
 11 A. In December of 1996 the former director of the  
 12 division of neonatology and I had a falling out.  
 13 He and I were both at about the same level as far  
 14 as seniority. We were both the two most senior  
 15 people. I went to.  
 16 My chairman and said that I could no longer  
 17 work in the situation where that individual was  
 18 providing my schedule and my call schedule. My  
 19 chairman, feeling that I was an extremely  
 20 valuable member of this department, said, Fine,  
 21 no problem. We will shift you over to a  
 22 different division. You will still conduct your  
 23 practice in neonatology, and I will have Dr. Dave  
 24 Fisher, who is the academic director, coordinate  
 25 scheduling for you on your clinical practice in

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1 neonatology.  
 2 That went on until July of this year when  
 3 the individual that was a problem was removed  
 4 from his position and has now been replaced by  
 5 Dr. Steve Welty, who is now the division  
 6 director. And Dr. Steve Welty is now the  
 7 division director in neonatology, and I have been  
 8 -- as of July, I was moved back into the  
 9 division of neonatology.  
 10 But that's purely a matter of where my name  
 11 appears on a website. I was still conducting or  
 12 carrying out my clinical work in the division of  
 13 neonatology.  
 14 Q. This download suggests that it was downloaded on  
 15 2-8-02. Do you have any reason to think that's  
 16 false?  
 17 A. No, it just hasn't been updated.  
 18 Q. You believe that you were in molecular medicine  
 19 until what date?  
 20 A. July of 2002.  
 21 Q. What is molecular medicine?  
 22 A. It's a -- it's a division that is constructed of  
 23 people who have an interest in research activity  
 24 that involves molecular genetic techniques, which  
 25 I do. People that work in this building here,

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

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

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

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1 because you are a large tertiary care center. Do  
 2 you know whether places like Deaconess have such  
 3 officials or employees, I guess, people who work  
 4 in labs?  
 5 A. I have no idea.  
 6 Q. You would agree with me that as a general rule,  
 7 the smaller the hospital, the more hats people  
 8 might need to wear?  
 9 A. I don't know. I never worked in one.  
 10 Q. Okay. There is a protocol for circumcision here,  
 11 correct?  
 12 A. Yes.  
 13 Q. In general at University Hospital who does the  
 14 circumcisions? I know you said you do when you  
 15 are a pediatrician. Here the obstetrician did it  
 16 in this case. Do obstetricians do it at  
 17 University Hospitals?  
 18 A. No.  
 19 Q. Is it exclusively pediatricians?  
 20 A. Yes.  
 21 Q. In your experience does that vary from hospital  
 22 to hospital?  
 23 A. Yes.  
 24 Q. That is the only surgery you perform, is that  
 25 fair?

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

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

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1 a day.  
 2 Q. Do you know specifically what instructions were  
 3 given to Edna Stone with regard to the  
 4 circumcision upon discharge?  
 5 A. No.  
 6 Q. Is there any discharge protocol at the hospital  
 7 that you work at?  
 8 A. Yes.  
 9 Q. And in general, you are aware of its contents but  
 10 probably couldn't state it exactly, would that be  
 11 fair?  
 12 A. That's correct.  
 13 Q. Do you know, does it pertain as to under what  
 14 circumstances the discharge should go forward,  
 15 that is, under what conditions a patient is ready  
 16 to be discharged?  
 17 A. I would have to look at it specifically.  
 18 MS. KMETZ: Objection.  
 19 A. Specifically, I don't know.  
 20 Q. Do you know if it discusses what kind of  
 21 instructions should be given to a patient upon  
 22 the discharge?  
 23 A. I would have to look at the document  
 24 specifically.  
 25 Q. You're not planning on testifying as to that area

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1 at this point?

2 MR. SCOTT: Objection.

3 A. I would be --

4 MR. SCOTT: The doctor signed a

5 written statement, and you have it, and he

6 says that the nurses met all applicable

7 standards. Now, that's what he is going to

8 testify to at trial.

9 Q. Well, in terms of standards, one place that one

10 looks for standards would be the local standards

11 governing the local hospitals for the standard

12 protocols, correct?

13 A. No.

14 Q. No?

15 A. Standards are standards.

16 Q. But do you believe that in general doctors and

17 caregivers should follow the protocols at their

18 own hospital unless there is a compelling reason

19 not to?

20 A. I think that you'll find that if you looked at a

21 protocol for a particular situation, you would

22 find that it would be in great unanimity from

23 hospital to hospital to hospital. They wouldn't

24 vary.

25 Q. Okay. And would you expect in general the

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1 medical providers, both nurses and doctors, would

2 follow those protocols or would act in accordance

3 with them as a general rule?

4 A. Oh, yes.

5 Q. Okay. Are there any protocols at University

6 Hospital or at Childrens Hospital that cover the

7 area of tests ordered but not completed?

8 MS. KMETZ: Objection.

9 A. To the best of my knowledge, no.

10 Q. I've only got one page so it's not as bad as it

11 looks.

12 Okay. You said earlier that you had five to

13 six patients in the last ten years who were

14 neonates who have had hemophilia. Who made the

15 diagnosis?

16 A. In I believe at least three of the cases the

17 diagnosis was actually made antenatally because

18 of a previous child that had been born, the

19 mother had been karyotyped and diagnosis of the

20 mother being a carrier had been made. Fetal

21 chromosomes had been drawn, fetal blood tests had

22 been obtained and diagnosis of the factor VIII

23 deficiency was made antenatally so that we could

24 prepare for the birthing process.

25 In one case I remember vividly as a resident

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1 a child that had gone home -- it was a child of a

2 very orthodox Jewish family in Boston. And the

3 rabbi had done Bris, and the baby did not stop

4 bleeding for five days. Brought the child into

5 the hospital, and the child was of Russian

6 descent, and had classic hemophilia.

7 Another case was a premature infant where we

8 -- normally, preterm infants have a prolonged

9 PTT. And that baby had a very, very prolonged

10 PTT, well over a hundred seconds, which is very

11 unusual. So we got hematology involved, did a

12 factor VIII analysis, and the kid did have

13 classic hemophilia.

14 Q. My question. Were all five or six times,

15 whatever you stated, were all those times cases

16 where the diagnosis was actually made by a

17 hematologist?

18 A. I would say yes.

19 Q. Okay. And on the three that were made prior to

20 birth, do you know whether the factor VIII was

21 given almost immediately after birth?

22 A. I don't recall.

23 Q. Okay. Again, that would be hematology's

24 decision?

25 A. Yeah. I don't recall. We have a very aggressive

96

1 program over at University for fetal treatment.

2 And as a consequence, you know, I heard about the

3 case because it was presented at a conference.

4 Q. Now, let me ask you a question with a long

5 premises. Assuming -- well, let's start. You

6 would agree with me this was a full-term baby?

7 A. Yes.

8 Q. Okay. For full-term babies who are not on any

9 medication, what does a prolonged PTT indicate

10 other than clotting disorder, if anything?

11 A. Nothing.

12 Q. Okay. Do you have any information as to when the

13 nursery was closed at Deaconess?

14 A. No.

15 Q. Do you know if in fact whether or not it was

16 closed some time shortly after the discharge of

17 Forrest Stone?

18 A. No.

19 Q. Again, this is at the risk incurring the wrath of

20 your lawyer who retained you, but would you agree

21 with me that there was increased bleeding noted

22 on the chart on the day of discharge for Forrest

23 Stone?

24 MR. SCOTT: Objection.

25 A. It was my recollection that the baby was noticed



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1 to have had-- the circumcision site was still  
 2 bleeding.  
 3 Q. Let me show you a record that I think you have.  
 4 A. Okay.  
 5 Q. It's a record that's in several places. It is  
 6 Exhibit 8.  
 7 MR. LEVIN: Did you bring the  
 8 exhibits?  
 9 MR. SCOTT: I don't have them.  
 10 Q. I'll show it to you. It's got some highlighting  
 11 and some of my writing on it.  
 12 MS. KMETZ: Do you have where it's  
 13 from?  
 14 Q. I'm not going to characterize it further. And  
 15 it's also found, I believe, in at least two other  
 16 places in the chart. I believe it's in Dr. Go's  
 17 records and maybe some hospital records and the  
 18 neonatal records. Several places.  
 19 First of all, doctor, I believe you have  
 20 seen this.  
 21 MR. LEVIN: And John can tell me,  
 22 you would have given him this?  
 23 MR. SCOTT: Right.  
 24 Q. Okay. Does that record, Exhibit 8, indicate to  
 25 you that it is noted there is increased bleeding

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

21 PHILIP NOWICKI, M.D., \_\_\_\_\_  
 22  
 23  
 24  
 25

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## CERTIFICATE

1  
 2  
 3  
 4  
 5 The State of Ohio ) SS:  
 6 County of Cuyahoga.)

7 I, Sandra L. Mazzola, a Notary Public  
 8 within and for the State of Ohio, authorized to  
 9 administer oaths and to take and certify  
 10 depositions, do hereby certify that the  
 11 above-named PHILIP NOWICKI, M.D., was by me,  
 12 before the giving of his deposition, first duly  
 13 sworn to testify the truth, the whole truth, and  
 14 nothing but the truth; that the deposition as  
 15 above-set forth was reduced to writing by me by  
 16 means of stenotypy, and was later transcribed  
 17 into typewriting under my direction; that this is  
 18 a true record of the testimony given by the  
 19 witness, and was subscribed by said witness in my  
 20 presence; that said deposition was taken at the  
 21 aforementioned time, date and place, pursuant to  
 22 notice or stipulations of counsel; that I am not  
 23 a relative or employee or attorney of any of the  
 24 parties, or a relative or employee of such  
 25 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 of Ohio  
 14237 Detroit Avenue, Cleveland, Ohio 44101  
 My commission expires February 4, 2007

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