THE STATE OF OHIO,)
) SS: ROBERT E. FEIGHAN, J.
COUNTY OF CUYAHOGA:)

IN THE COURT OF COMMON PLEAS

(CIVIL DIVISION)

LAWSHADA WREN, ET AL.,)
)
Plaintiffs,)
)
vs.) Case No. 299143
)
UNIVERSITY HOSPITALS,)
ET. AL.,)
)
Defendants.)

--- o0o ---

EXCERPT OF PROCEEDINGS
(Cross-examination of Dr. Raff)

--- o0o ---

APPEARANCES:

On Behalf of the Plaintiffs:

By: WILLIAM JACOBSON, ESQ.
THOMAS MESTER, ESQ.
JEFFREY A . LEIKEN, ESQ.

On Behalf of the Defendant SAMUEL HORWITZ, M.D.:

By: TIMOTHY RISTAU, ESQ.

On Behalf of the Defendant University Hospital:

By: VICTORIA VANCE, ESQ.
EDWARD E. TABER, ESQ.

Thomas C. Walters
Official Court Reporter
Cuyahoga County, Ohio

THURSDAY MORNING SESSION, MARCH 5, 2001

* * * * *

MRS. VANCE: Thank you

CROSS-EXAMINATION OF MARTIN J. RAFF, M.D.

BY MRS. VANCE:

Q Doctor, good morning.

A How are you, ma'am?

Q Doctor, Mr. Jacobson asked you some questions about your background and I would like to start there as well.

Doctor, you do not have any publications that you have published in the literature concerning herpes simplex encephalitis?

A No, ma'am, I do not.

Q Have you done any of your professional work on the product or the drug Acyclovir in terms of published?

A I have not.

Q Mr. Jacobson asked you about some of your work in terms of lectures, giving talks, writing book chaptes, things of that nature.

Have any of those professional pursuits concerned herpes simplex encephalitis in children?

A I don't honestly recall. I have spoken in

institutions both in the United States as well as outside the United States on the management of patients with acute central nervous system infections and it has included herpes virus encephalitis, but the specificity with children, I don't recall.

Q Okay. In terms of an area of concentrating your professional work or professional publications, your professional research, has that ever included work on the drug Acyclovir in the management of herpes simplex encephalitis?

A No.

Q Either in adults or children?

A That's correct.

Q Do you have any publications or done professional work for your field in the pediatric emergency medicine?

A No, ma'am.

Q In terms of clinical research, I understand that the only clinical research you have done regarding herpes simplex encephalitis was the opportunity that you had to treat a colleague in Kentucky some years ago in the 70s, some 30 years ago?

A Yes, and several other patients with that Vidarabine.

Q So the jury is clear, the patient that you were referring to at that time back in the early 70s for which you prescribed the medication, that was not the drug Acyclovir --

A No.

Q -- was it?

A No, ma'am.

Q In your professional career as a physician I understand that you are often called upon as an infectious disease consultant?

A Yes.

Q Doctor, isn't it true that in your role as an infectious disease consultant you have been called upon to assist in the treatment or to consult on only four or five pediatric cases --

A That's correct.

Q -- involving herpes simplex encephalitis?

A Yes.

Q And those four or five pediatric cases cover the time period of 30 years of medical practice?

A That's correct.

Q If you thought back as to the last time that you were involved with serving as an ID consultant, pediatric case, herpes simplex encephalitis, we're talking about seven eight years ago, at least?

A Yes.

Q And just so we're clear, the facts in this case going back to the time period of 1989 when Lashawda was ten years old, that would, indeed, fall within the category of a pediatric case, and this would be a pediatric patient, is that right?

A Yes.

Q And you told us that in terms of your own practice you are board certified in internal medicine and infectious diseases?

A Yes.

Q Doctor, you are not board certified as a pediatrician?

A No.

Q And you are not board certified in pediatric infectious disease?

A I am not.

Q I think you indicated that at the time that you received your board certifications there wasn't a separate board in pediatric infectious diseases?

A That's correct.

Q Since then, however, the professional bodies that provide board certifications have, indeed, developed a subspecialty recognized as pedestric disease?

A Yes.

Q And they offer board certification and privileges in that field, is that right?

A Yes.

Q And you don't have that?

A No, ma'am.

Q In fact, it was in the 1990s, the mid-90s that is you stopped seeing pediatric patients at your university hospital where you practice?

A That's correct.

Q For the most part your pediatric practice has dramatically deminished over the years?

A Yes.

Q Back in 1989, the time period at issue here, your pediatric practice was already in a period of decline?

A Yes.

Q In fact, pediatric patients are not even seen at the hospital where you work. You say there's a new hospital that's been built in the Louisville area that receives the concentration of pediatric cases?

A No. Let me see if I can explain that --

Q Is that true or if I misunderstood, just tell me?

A You did.

Q Doctor, it's true that the pediatric patients primarily go to another hospital, a local children's hospital?

A Yes, but it's a -- it's part of the university hospitals system, within a block of the university hospital.

Q But you don't go there and you don't see patients there?

A I do on occasion, yes.

Q You don't make treatment of pediatric patients. That is not your typical practice of medicine, isn't that right?

A It is.

Q In terms of the university setting?

A But not the university hospital with regularity.

Q Right?

A And, again, as I explained earlier --

Q Thank you, Doctor. The pediatric cases that you're seeing at some community hospitals in the greater Louisville area are the outlying communicates or counties of Kentucky?

A Yes, ma'am.

Q Doctor, you're board certified now or have you

ever been in emergency medicine?

A No.

Q Or in pediatric emergency medicine?

A No.

Q Have you ever pursued a pediatric emergency medicine training?

A No.

Q And yet you offer standard of care criticisms in this case regarding the pediatric emergency room management of Dr. Parrish, is that right?

A Yes.

Q Doctor, are you now or have you ever been a neurologist?

A No, ma'am.

Q Adult or child neurologist?

A No, ma'am.

Q And yet you offer criticism of the care of Dr. Horwitz the child neurologist who was caring for Lashawda Wren on February 19th, and who was responsible for her care that day. Isn't that what I heard you say?

A I don't think I ever mentioned Dr. Horwitz's name.

Q You didn't mention his name, but you are critical and just expressed criticism of the

management of this patient on the 19th and 20th during the first 24 hours of her admissions?

A Yes.

Q And isn't true that Dr. Horwitz was, in fact, the attending of record, and therefore responsible for this patient's care during that period of time?

A Yes.

Q Doctor, you have made a few comments about seizures, and your expectation about seizures, but it's true that in your practice you are primarily responsible for managing pediatric patients with new onset seizure disorder?

A Yes.

Q If a patient comes into the emergency room with a presentation, symptoms or history of a flu onset seizure disorder, chances are you're not the consultant who would be called on that case?

A That's correct.

Q Doctor, you mentioned your involvement with some medical/legal work, and in this particular case you were consulted and asked to review the medical records concerning Lashawda Wren's care at University Hospitals?

A Yes.

Q You did not look at any of the image films, CT

films or --

A No I did not.

Q And you also didn't look at EEGs because that would be something that you don't typically review, the actually tracings?

A That's correct.

Q Doctor, in connection with your work on this case, and reviewing material to formulate your opinions, it's true that you did not do any sort of a literature review or literature search in order to gather together any of the pertinent medical articles concerning the treatment of herpes simplex encephalitis in children, is that true?

A Specifically for the purposes of this case?

Q Correct.

A No, I did not do that.

Q In fact, you told us that you don't keep a file, kind of an active working file on herpes simplex encephalitis, but rather when you are confronted with a case involving that disease your practice is to go and do sort of a spot literature search or quick update at the time that you're involved with an active care, active management of a patient, right?

A That's correct.

Q And you said that the most recent occasion to do that was about a year ago with an adult, a young woman who presented with herpes simplex encephalitis?

A Yes.

Q And the literature you went to review, was that written by Dr. Whitley?

A That was one of the articles, yes.

Q You had acknowledge that Dr. Whitley does enjoy a reputation a having knowledge and expertise in herpes simplex encephalitis, isn't that right?

A In the accumulation of data, yes.

Q Doctor, Mr. Jacobson asked to you acknowledge that you did at least spend part of your time involved with medical/legal work.

You have handled three or four other cases for his law firm in the past, is that true?

A I have examined the records of about three or four patients from their law firm.

Q You generally get about 11 case assignments a year from all lawyers -- not saying from Mr. Jacobson's firm --

A That's correct?

Q 75/80 percent of your medical/legal consulting work is for the plaintiffs in medical/legal litigation?

A That is also correct.

Q Okay. In terms of your your collaboration with plaintiffs' counsel, besides reviewing medical/legal cases for plaintiffs upon request, you actually have gotten involved in some publications in collaboration with a plaintiff's attorney, didn't you?

A Yes.

Q In fact, you yourself are a lawyer. You're a licensed member of the Kentucky bar?

A Yes.

Q You keep up your law license, I should say?

A That is also correct.

Q Going back to the year 1989, specifically May 19th you published an article that appeared in a trial magazine devoted to plaintiffs' attorneys on the subject of expert medical witnesses?

A Yes, ma'am.

Q And that is an article that you wrote and published in the Legal Press for plaintiff's counsel with a fellow author who was a personal injury lawyer from Kentucky?

A He's in and out -- now a defense lawyer from Kentucky.

Q He was then a personal injury trial lawyer from

Louisville?

A Yes.

Q Now, your article concerned expert medical witnesses, and specifically your thought that expert medical witnesses need careful coaching and gentle handling?

A Yes.

Q And as I understand it, this six or seven page article that you wrote is directed to plaintiffs' attorneys suggesting to them how they might best go about finding expert witnesses, preparing expert witnesses for testimony, and using their testimony at trial?

A That's correct.

Q Okay. When you talk about the selection of expert witnesses you suggested that it would be best to find a medical expert who has experience with the issues in question in the litigation, is that right?

A Correct.

Q Because if you found a doctor who has never practiced or has had no experience with the issues in question, that person is seldom credible?

A That is also correct.

MR. JACOBSON: Can we have a copy

of the article, please?

MRS. VANCE: I only have one copy. I'm sure the doctor provided you one.

Q You also suggested in terms of selection of experts, said a good place to start to examine the literature and major texts concerning the topic or medical issue in question, and look for authors who have written contemporary articles and chapters pertaining to litigation?

A Yes.

Q Now, Doctor, have you ever authored any major texts or literature on topics pertaining to the litigation that is at issue in this case?

A No, ma'am, but I have a great deal of experience.

Q Doctor, you also suggested that in selecting experts, plaintiff's counsel should be concerned because some experts may only choose to accept the assignments in order to simply supplement their income. Didn't you offer that caveat or caution?

A Yes.

Q Now, you also went onto tell these lawyers that once they have an expert witness or a doctor who is willing to serve and work with them, that it

would be behove the plaintiff's lawyer to spend a little bit of time with that witness and talk to them about some of the important legal terms that have to be considered in the litigation?

A Yes.

Q You suggested it would be good for the plaintiff's lawyer to instruct their expert or talk to them about a phrase such as what it means to have a duty or standard of care?

A Yes.

Q In fact, you said that the standard of care term is a term that should be explained to the expert as referring to expectations of minimally accepted care by comparable physicians in the same field of practice?

A That's correct.

Q In other words, the standard of care is looked upon as that level of care that is practiced by comparable physicians in the same field of practice as the defendants or the doctors who are being accused of a malpractice?

A That's correct.

Q And you went onto say that in understanding and being able to speak to the standard of care, that the expert witness should be bear in mind

that it's not their own standard or what they practice in their field of medicine that is important, but it's the field of medicine of the doctors who are standing accused of malpractice?

A Yes.

Q Again, in this case, Doctor, you are not a pediatric neurologist, correct?

A Yes.

Q You are not a pediatrician, correct?

A Correct.

Q And you are not an emergency room physician?

A That is also correct.

Q You went onto say in your article that the expert should be instructed about the notion of causation and how that factors in an expert's testimony, right?

A Correct.

Q And you said that the experts need to understand that even if there might be some thought of criticism about medical care, it's important and necessary that that care be proved to be a cause of the alleged harm, correct?

A Proved -- I don't remember saying proved, but --

Q Well, the doctors would not be found liable

under the law unless it's proved that the patient was harmed as a result?

A Well, proved by legal standard, yes.

Q Sure. In other words, there's got to be linkage between --

A Yes.

Q -- between critical care and the end result?

A Yes.

Q And absent linkage, absent causation, there is no successful proof and the proof fails?

A I would agree.

Q Okay. You also made a comment that it's important that physicians testify or make the point that physicians -- when medicine is practiced, rather, it's not practiced in fragments. Remember saying that?

A Yes.

Q And that you suggested an analogy to a jigsaw puzzle and that inappropriate fitting of any piece of a puzzle could have a potential to confuse the picture?

A Yes. And I explained that here today.

THE COURT: Yes.

Q Okay. Now, Doctor, you also went on to talk about when experts do their review what they should

the other day, the patient we were saying had had malaria in the past. I asked him, do you have documentation for that, that it was anecdotal? In fact, the patient never had malaria.

Q Anecdotal is if you run into one of your medical colleagues from another discipline and he starts talking to you about one of his cases or an interesting patient, and you pickup information about a case, because you don't have any personal information about it. It's just something that you

heard about and that's referred to as shomewaht of an anecdotal bit of information?

A That is not quite anecdotal, because that --

THE COURT: No.

A No.

Q All right. Doctor, you also suggested that once these experts get retained that the lawyer ought to spend a little bit of time with them preparing them with their testimony?

A Yes.

Q Suggested that the experts should be prepared for cross-examination and also for their direct testimony in the courtroom.

A Yes.

Q You suggested that review and rehearsing the doctor's testimony if at all possible?

A Yes.

THE COURT: Excuse me. Stand in recess, ten minutes to 11:00.

(Thereupon, a recess was had.)

THE COURT: Miss Vance?

MRS. VANCE: Thank you, your Honor.

Q Doctor, I now would like to turn to the opinions that you have expressed here this morning.

I understand that your opinion essentially is that you think that the standard of care was not met when the patient came into the emergency room at midnight on February 18th and was receiving treatment during the morning hours of February 19, 1989, is that right?

A That's correct.

Q And I believe I heard you say that your concern, one of your concerns was with the sufficiency of the history that Dr. Parrish took from the patient and her mother that evening, is that right?

A Yes.

Q You felt that the history needed to be expanded upon or that more needed to be learned or obtained from the parent of this child, is that right?

A That's correct.

Q Doctor, are you aware that Dr. Korobkin, a pediatric neurological physician from San Francisco testified yesterday that, in her opinion, the standard of care was met on February 18th and February 19th, 1989 for that matter.

Are you aware of that?

A No.

Q All right. Doctor, are you aware that a Dr. Baker, emergency medicine physician practicing in Chicago retained by the plaintiffs in this case has given trial testimony indicating that, in his opinion, the standard of care was met in terms of the history and the physical that Dr. Parrish took.

Are you aware of that?

A No.

Q Your concern is that Dr. Parrish did not do an adequate history and physical examination?

A That's correct.

Q You're not aware that Dr. Baker, an emergency medicine board certified physician, at least in his opinion, who reviewed the same case for the plaintiffs is of the opinion that the standard -- the history and the examination taken, the laboratory work that she did, complied with the standard of care?

A Not aware of that.

Q Okay. And that, specifically, when referring to the history and the physical exam said, I think it's as good as she's going to get in terms of what Dr. Parrish is able to obtain.

Were you aware of that?

A No, ma'am.

Q In terms of the history that you say was deficient in your judgment, you don't know of any specific item of medical history that was not obtained or was overlooked by the caregivers taking care of Lashawda Wren, isn't that right?

A I mean I can't know what was overlooked if it wasn't done.

THE COURT: When these questions are asked, if you can answer them yes or no, or I don't know, or I don understand the question, please try and do it that way. All right?

THE WITNESS: Thank you, your Honor.

THE COURT: Thank you.

Q Doctor, you have looked at the entirety of Lashawda's medical records, correct?

A Yes.

Q You have looked at all, at least many of the depositions that have been accumulated in this case, is that also true?

A Yes.

Q As a physician coming into court to give testimony critical in a medical/legal setting, you

want to be sure that you have looked at everything and considered all available data, correct?

A As a general rule.

Q And based on all the information that is available to you, historically, about this young girl and subsequently information that the parents have been able to provide and a host of different kinds of medical records and available records, you know of no specific item of medical information that was not obtained or that was overlooked by the caregivers, isn't that true?

A I don't recall.

Q Okay. Now, when Lashawda came back into the hospital on the 19th, the morning of the 19th you talked a little bit here this morning about things that you believe should have been done differently.

And if I heard you correctly, I understood you to say that I would have, speaking of yourself, I would have done things differently. I would have done a lumbar puncture. I would have done a CT scan, isn't that true?

A Yes.

Q That is how you testified this morning?

A Yes.

Q You agree that when Lashawda Wren came back

in on Sunday morning for the second emergency room visit there did not appear to be any -- no focal neurologic deficits that morning, isn't that true?

A That's correct.

Q In terms of evaluation of Lashawda's mental status, isn't it true that the alterations of consciousness which is a factor that one considers in the diagnosis of herpes, that the alterations of consciousness associated with herpes can be difficult to distinguish from the type of post-ictal state as you see following seizure?

A Yes.

Q And your judgment is that, post-ictally, it would be unusual if a patient had a significant memory impairment, correct?

A Yes.

Q And we know from a review of this record that this patient never had a significant memory impairment when she came back in on the morning of the 19th, isn't that right?

A I don't recall.

Q Doctor, are you aware Dr. Korobkin came into court yesterday and shared with us the notes of her review in this case in which, among others things,

she noted that there was a minimal memory difficulty for this child upon readmission.

Do you share that opinion? Do you share that observation based on your review of the record?

A I frankly don't recall.

Q Okay. But it's the significant memory impairment that might be one of those tip-off signs about distinguishing alterations of consciousness associated with herpes and the post-ictal damage state one might see after seizure. It's at least one factor, correct?

A Yes.

Q Okay. As seen in these emergency room records, Doctor, you agree that this child's mental condition, as observed in the emergency room, is not incompatable with a post-ictal state?

A That is correct.

Q And you talked a moment this morning about performing -- that you wanted to get a lumbar puncture on this child earlier than it was, in fact, obtained?

A Yes.

Q I believe you said you would get the lumbar puncture, and when you get the results, then you

would start treating with Acyclovir?

A That's correct.

Q All right. So if I understand correctly, your practice would be that you would do the CAT scan for the child and check the brain, correct?

A If I felt --

THE COURT: Correct?

A I can't answer the question as asked.

Q In any event, when it comes to the lumbar puncture and the starting of a Acyclovir, is it your practice to get the lumbar puncture results back and then make your judgments and decisions about what medications to administer to the patient?

A Depends upon the circumstances.

Q And in this case you would have waited for the lumbar puncture results and then start the Acyclovir, correct?

A Yes.

Q In this case, Doctor, the physicians who were caring for Lashawda began on the 20th, a combination of medications. They administered both Ceftriaxone, an antibiotic, and Acyclovir, an antiviral --

A Yes.

Q I believe you said on direct examination that doing that sort of dual track treatment, covering for

the bacteria possibility; covering for the viral possibility, is good medical practice?

A It is reasonable medical practice.

MR. JACOBSON: Your Honor, may we approach for just one moment?

(Thereupon, a discussion was had between Court and counsel off the record at the bench, after which the following further proceedings were had in open court:)

Q Doctor, I want to ask a couple questions based on testimony that you gave under oath a few months ago at your deposition.

Do you remember giving a deposition in this case?

A Yes, ma'am.

Q Okay. And a couple statements you said -- I want to just follow up?

A May I have a copy, please?

Q Be happy to. In fact, this is the original of your deposition. Do you recall that?

A Can you direct me to the page?

Q I will. We are having some conversation

about the history or the information that was available to the caregivers about Lashawda's condition from the time she first left the emergency room about 2:00 in the morning until she returned at about 6:25, 6:30 in the morning?

A Yes.

Q Just so set the stage, we are talking about information concerning that interval.

You made the comment at your deposition at page 64 that when she returned to the emergency room --

THE COURT: Line please?

MRS. VANCE: I think the answer began at the bottom of page 63, continued to the top of page 64.

A Could you give me just a second?

Q Sure.

A Thank you. Yes.

Q We were talking about what had occurred in the interval between the first discharge and the return visit. You made a statement in there that I just want to see indeed is accurate.

We are talking about what Lashawda had experienced that morning and what prompted her to be returned to the hospital, and you made a

comment on the top of page 64, a long answer, but around line three, made the very blanket statement --

"That there is absolutely no indication in this medical record of what may have transpired between the time at which she was discharged on the 18h and readmitted on the 19th. There is absolutely no indication in this medical record."

Doctor, that is not exactly true. Some information was recorded in this medical record about the interval of events when she saw Dr. Parrish again on the morning of the 19th.

We do have information in some detail about her -- Lashawda's second onset of seizure, exactly how that occurred and what the circumstances were for that.

She had been sleeping in bed with her 14 year old cousin and the cousin felt kicking, scratching, pulling, the bed shaking, called the patient's dad who saw all extremities trembling; eyes rolling back, so we do have a description of information that occurred in that interval, do we not, Doctor?

A I think what I was referring to --

THE COURT: Wait a minute. Can you answer that yes or no?

THE WITNESS: No.

Q You made a very blanket statement, a very broad statement -- "That there is absolutely no indication in this medical record of what may have transpired between the time at which she was discharged on the 18th and readmitted on the 19th."

And isn't that some information that refutes the testimony that you gave at your deposition?

A No.

Q Further, the physician who was seeing the patient that morning Dr. Beguin, also includes information in his note about the interval, history between the two discharges?

A Not the record to which I was referring.

Q But that is a statement that you made at your deposition, and this is at least some information in the medical records to refute that statement, isn't that true?

A In that note, yes.

Q Okay. And, Doctor, turning now to some of the medical treatment that you are opining about here today in terms of the use of Acyclovir --

A Yes.

Q -- it's true that you have administered

Acyclovir to pediatric patients just four or five times in your career, correct?

A No.

Q You have not. It's not correct to say you have administered to Acyclovir to pediatric patients just four -- with respect to a concern for herpes simplex encephalitis?

A Yes, that's correct.

Q Thank you. In your opinion, you start to give Acyclovir when you know you have an encephalitis, is that right?

A Yes.

Q Okay. Now, again the your deposition, in making your point about the usefulness or the timing of Acyclovir, I believe you said at the deposition that you thought in your review of this record that Dr. Horwitz had insisted upon the administration of Acyclovir on the evening of Sunday the 19th?

A Can I read the record, the page to which you are referring?

Q Let me -- I believe it may be in the vicinity of page 79, lines -- the answer begins at line 17?

A Will you give me just a second?

Q Sure.

A Thank you. You're on 79?

Q Page 79, line 23. We were talking about your opinion about the time to give Acyclovir, and your answer included the statement, and I believe that Dr. Horwitz, even in his deposition, indicated that he felt that therapy should be instituted at that time, and we were referring to the evening of the 19th after the lumbar puncture results came back.

A Yes.

Q Certainly after he was aware of the results, she should have been treated immediately?

A Yes.

Q So your take on Dr. Horwitz's testimony that you reviewed in preparation for giving testimony under oath was that Dr. Horwitz thought Acyclovir needed to be administered to this child that evening, correct?

A That may have been the impression I got. Yes.

Q In fact, Doctor, are you aware in looking at Dr. Horwitz's testimony, the deposition that you would have had available when you gave your own testimony, Dr. Horwitz simply said, "That I probably would have considered the use of Acyclovir earlier, but without great conviction."

Isn't that, in fact, what Dr. Horwitz

said at his deposition?

A I don't have the deposition in front of me.

Q Are you aware that Dr. Horwitz testified in this courtroom though, that he would have considered Acyclovir -- considered using it.

He would have not have started it that evening, Sunday, because he felt that the indications for starting it in this case were lacking.

Are you aware of that?

A No.

Q Now, Doctor, you have talked a lot about or we spent some time about lumbar puncture results.

The lumbar puncture that was done on Lashawda on the 19th, that Sunday, returned certain results in terms of white blood cells, red blood cells, protein and glucose, and you would agree that the results, as available that evening, showed or were consistent with an encephalitis, but of undetermined cause?

A Yes.

Q So as of the 19th, based on the lumbar puncture the doctors know that they may be dealing with an encephalitis, but of undetermined cause, correct?

A Correct.

Q And that the encephalitis may be viral in

origin and you could not exclude bacterial causes at that time?

A That is also correct.

Q Because occasionally you might see bacterial, just a meningitis present in a very similar fashion as in Lashawda's case?

A That is conceivable.

Q Lumbar puncture results do not necessarily clearly establish the diagnosis?

A That's correct.

Q We spoke a moment this morning about the red blood cell content of that first LP, and the fact that she had a red blood cell level that you felt was elevated?

A Yes.

Q You also, just so the jury is clear, we do know that the lumbar puncture that was performed on that day was what is known as a traumatic tap or traumatic spinal tap?

A We don't know that.

Q Don't we know from the physicians entry that described the lumbar puncture that a little bit of blood was obtained when she initially inserted the needle in the lumbar puncture?

A That may be correct, but that doesn't mean

necessarily that the fluid has red blood cells in it.

It's not uncommon to put a needle into the spinal fluid and get clear cerebral spinal fluid with no red blood cells seen on the smear and yet have a drop of blood at the site of puncture. That is not at all uncommon.

Q The red blood cell level that was obtained would be consistent, not just with viral encephalitis, but it could be consistent with any number of other types of encephalitises?

A Yes.

Q Mr. Jacobson took you through some possible diagnoses for both viral and bacterial causes of encephalitis. I want to approach the same issue, but just a little bit differently.

The lumbar puncture result on the 19th tells us that we are dealing with an encephalitis, fair enough?

A No.

Q Is it consistent with an encephalitis?

A No.

Q Is it telling us that she has herpes?

A No.

Q Didn't you just tell me a moment ago that the results would show we have an encephalitis of

undertimed etiology?

A Yes.

Q But the lumbar puncture results don't tell us that it's even an encephalitis?

A No.

Q Okay. But assuming that you know or suspect that you're dealing with an encephalitis, Doctor, can we agree that encephalitises may be of bacterial origin or viral origin?

A Encephalitis is rarely of bacterial origin.

Q But some may be?

A It's conceivable.

Q Okay. So you might have a bacteria -- do you think more often viral, is that right?

A Depends on the particular clinical circumstances.

Q Can we agree that viral may be a cause of encephalitis?

A Absolutely.

Q And within the universe of viral causes of encephalitis some of those causes are known and some are unknown, correct?

A Absolutely.

Q So even if you understand the viral, you're going to have those which are known, known viruses,

identified viruses, and some are unknown viruses, isn't that right?

A May I ask a clarification question?

THE COURT: Yes.

Q Sure.

A Are you referring now to the time at which you see the patient?

Q I'm referring to right now, the date of February 19th of 1989 when a physician has a concern of an encephalitis. This is just a general discussion about --

A You will never be certain what virus is producing the infection at that point in time.

Q Okay. All right. Then let's take more of a step backwards and just have a general discussion since we can't know on that day, February 19th of the cause, injuries in general, what physicians know about viral causes of encephalitis.

You know that of the viruses that may be responsible for an encephalitis some of the viruses are known. They have been identified and they have been given names?

A Yes.

Q And we also know that there's a number of viral causes for which we have haven't been

able to identify specifically the agent or the mechanism?

A We suspect that may be the case.

Q And, in fact, the universe of unknown causes of viral encephalitis is actually more than 50 percent, isn't that right?

A No, I don't believe that. I think that --

THE COURT: No, is that right?

THE WITNESS: No.

THE COURT: Thank you.

Q Doctor, we had a discussion about this at your deposition. I refer you to page 93; line 6.

"Doctor, of the viral encephalopathies of unknown etiology, isn't it true that many of those are capable of producing the same kind of profound encephalopathy in this patient?"

A Yes.

Q We talked about that?

A Yes.

Q And didn't we also talk about the fact that the -- didn't we also talk about the fact that -- referring back to page 83, line 15, Doctor;

"Isn't it true that the majority, in excess of 50 percent of encephalopathies are of unknown origin?" "Yes."

A Yes, but that is not the question that --

Q Were we not discussing viral causes of encephalopathy?

A Yes.

Q And isn't it true that the majority of the viral causes are of unknown etiology?

A Yes.

Q All right.

A But you asked if they were due to different viruses.

Q Of those viral causes that are known, there are several, are there not?

A Yes.

Q Herpes being just one of those?

A Yes.

Q Okay. And, again of the viral encephalopathies of unknown etiology, isn't it true that many of those are capable of producing the same kind of profound encephalopathy that we see in this case?

A Yes.

Q So whereas herpes is one of our known viral causes, the presentation we have here and the course we have here, at least in terms of a profound encephalopathy, can also be produced by any of the unknown viral causes that are in existence, isn't

that true?

A I can't answer your question.

Q Well, Doctor, we at least know that in this case the doctors who were caring for Miss Wren in 1989 were, in fact, exploring -- searchong for a number of potential causes for the viral encephalopathy that they believed she had?

A Absolutely.

Q And they were, in fact, checking for the mycroplasma, EBV --

A Yes.

Q -- and enteroviruses. They were looking for other kinds of known viruses beyond just herpes?

A Yes.

Q And that is good medical practice, isn't it, Doctor?

A After instituting therapy.

Q And that is when they were doing nd sending off many of these tests, after they had instituted therapy?

A Yes.

Q Now, Doctor, let's talk about the clinical picture, not just the clinical picture of what was, in fact, known in this case and as it relates to herpes.

Doctor, you agree with me that CAT scans can have a characteristic pattern when they they are obtained on a patient with a herpes simplex encephalitis?

A True.

Q And, in fact, for patients with a herpes simplex encephalitis the CAT scan characteristically will show a very specific temporal lobe lesion, true?

A Yes.

Q And you have seen the CAT scan reports in this case, if not if films, isn't that true?

A Yes.

Q Do any of the scans or the films show scarred tissue, specifically temporal lobe lesions on any of those taken on Lashawda?

A No.

Q As I recall, the MRIs done on Lashawda, there is a characteristic pattern one would see for herpes simplex encephalitis, isn't that true?

A May see.

Q Do see we any of the characteristic findings on the MRIs obtained in this case?

A No.

Q We have spoken about EEGs. Those, too, have a

characteristic pattern when obtained in patients with a herpes simplex encephalitis, isn't that true?

A On occasion.

Q Okay.

A Have a characteristic --

Q But we don't see that in this case either, do we, Doctor?

A No.

Q In fact, characteristically, the EEGs, if they're going to show a characteristic pattern it's going to be a temporal lobe, focality, correct?

A Superimposed on slow wave activity.

Q My focus though is on the location. The temporal lobe is where you would expect to see the EEG activity in a patient with herpes simplex encephalitis?

A On many occasions.

Q In this case though, Doctor, there was never a temporal lobe focality, was there, Doctor?

A Not to to my knowledge, no.

Q And even in the infectious disease consult note Mr. Jacobson showed you where they talk about EEG findings, the description even here is EEG right frontal and left frontal. Now the frontal lobe is not the temporal lobe?

A That's correct.

Q And frontal lobe lobby is not where you would be expecting to see EEG emissions or the electrical activity characteristic of herpes?

A It may well be the frontal lobe. With herpes it occurs with some frequency.

Q But that is not the characteristic pattern, is that, Doctor?

A I don't know what you mean by characteristic pattern.

Q You don't. In terms of the lumbar punctures that we know were done over a period of the months that Miss Wren was in the hospital there were four of them.

Doctor, would you agree with me that this series of the lumbar puncture results returned to normal after February 19th in terms of the protein counts and the glucose levels?

A Yes, after Acyclovir was instituted.

Q And that was after Acyclovir was instituted. And that normal pattern would not be characteristic of a herpes simplex encephalitis, isn't that also true?

A I don't think that there's any single factor that is absolutely characteristic.

Q No, there may not be any one single -- I'm asking you for a number of tests, the number of the findings both clinically as well as laboratory, as well as imaging -- even when taken together each contribute information about whether or not we have a diagnosis of herpes?

A That's correct.

Q Even the seizure pattern, are you -- you're not qualified by your own admission to comment on the seizure pattern that Miss Wren experienced?

A That is correct.

Q Okay. And, Doctor, we know that Miss Wren has suffered a cortical blindness. Would you agree that that, too, is not the kind of neurologic impairment that is characteristic of a herpes?

A Not usually.

Q Okay. And, in fact, Doctor, isn't it true that you cannot point to any aspect of Lashawda's symptomatology or any aspect of the findings that you would say are characteristic of herpes simplex encephalitis, isn't that true?

A My answer to that would be I cannot. Well, I'll say no.

Q Well, Doctor, let's not be uncertain about this. I asked you at your deposition, page 8, line

13. I'll give you a moment to find it. Do you have it there, Doctor?

A Yes.

Q Can you point to my question? My question to you was, "Can you point to any aspect of her symptomatology or findings in this case that you would say are characteristic of herpes?"

"Answer; No, ma'am."

A Yeah, but you're taking that out of context. If you will read the paragraph --

THE COURT: Just a moment.

Q Can you point to any of the host of factors, symptoms, findings, anything about her symptoms over two months; anything about her findings over two months that you say is characteristic of herpes?

A No.

Q Doctor, you said here this morning that you thought there was some transient improvement that Miss Wren experienced after the Acyclovir was delivered --

A That's correct.

Q -- or administered to her?

A That's correct.

Q Well, Doctor, do you recall that when I took your deposition we had a little discussion about that

same subject as to whether or not you thought that was, indeed, the case; that there was any transient improvement. Do you remember that in your deposition?

A No.

Q Let me refer you to it. Page 91, Doctor, starting -- actually page 90, starting at line two.

A Yeah.

Q Okay. We were having a discussion at your deposition on this very same topic, whether or not you thought Acyclovir gave this patient any improvement after it was given to her and the significance of any improvement or how that may be demonstrated?

A Yes.

Q You just reviewed the deposition. My only point is very simple for purposes of today's examination.

At the time of the deposition when I asked -- when we got onto this topic, and I asked you to be specific; "Tell me, Doctor, how it is that you think Acyclovir gave any kind of a transient improvement?"

You said at the time, at line five, page 90; "I don't recall specifically. I would have

to go back and reread the chart. I just -- I recall at the time that the child improved. I don't remember exactly what the parameters were."

Isn't that what you said?

A Yes.

Q And we have a little discussion at that time and I said, "That's fair. It's a buying medical record. There's a lot of information in it, and you may not be able to put your finger on it at this spot."

I went onto to ask you, if you will, on the record, and you were under oath, "Whether or not you would do me the courtesy of reviewing the records at your leisure after the deposition and find that information." And you said that you would do that, right?

A Yes.

Q In fact, on page 91, around line four we talked about how you might best communicate that information to me. You knew you were going to read the deposition after it was taken, correct?

A Yes.

Q You are a lawyer so you know the importance --

MR. JACOBSON: I'll object. He has no obligation to communicate with her.

THE COURT: Overruled.

Q You knew the portion of reading the deposition correcting for errors?

A Yes.

Q In fact, it was your suggestion that you would make any notation of this opinion of yours in the correction sheet that accompanies the deposition?

A If I had found it.

Q And you did, in fact, read your deposition after it was taken, correct?

A I believe I did.

Q In fact, the copy that I handed you is the original deposition, and if you look in the back your original correction sheet is attached?

A Yes. Okay.

Q You have it there?

A Yes.

Q Does that original correction sheet have your signature?

A Yes.

Q Is your signature notarized, Doctor?

A Yes.

Q Did you, in fact, take the opportunity afforded you and review this transcript?

MR. JACOBSON: I object. That is

not what the correction sheet is for.

THE COURT: Overruled.

Q Doctor, did you, in fact, review this deposition and note corrections to the deposition?

A Yes.

Q And it was the corrections sheet that you would use to communicate back to us your opinion and the specifics of your opinion about the effect of Acyclovir on this child?

A If I did it, yes.

Q I asked you if you would do it. You said you would try to do that. I said that would be an acceptable way of doing it. I just wanted to have that information before trial.

Did you, in fact, make any notation in that correction sheet of that information?

A I did not have an opportunity to read the chart at that time.

Q Well, Doctor, the deposition was taken when? The date is on the front page there.

MR. JACOBSON: Continuing objection to this line of questioning.

THE COURT: Thank you.

A July 31st.

Q And your signature page is dated when, Doctor?

A August 26th.

Q All right. And there's a letter to you right at the front of the deposition I gave you. That is what the court reporter used when she sent this to you to give you a chance to read it. What is the date of that letter?

A August 16th.

Q So you had what, approximately two weeks to review this transcript and make notations?

A I had nine days, yes.

Q In reading the deposition, you --

A No. Let me correct that. This was mailed on the 16th. So if I got it on the 17th or the 18th, and it was notarized on the 26th, you're looking at five or six days.

Q Well, you had five or six days to review the deposition, and indeed, you did make corrections?

A Yes.

Q And in making those corrections you had to read the entire deposition in its entirety to do that, right?

A Yes.

Q So you had to be reminded of what we had talked about on page 90 and 91 when you read it and corrected your deposition?

A Yes.

Q And, in fact, even if you go to the very end, in case you've forgotten what occurred on page 90 and 91, I again closed the deposition by asking you again, don't forget. Please give me this information about the Acyclovir, and you said that you would review the chart. Right?

A Correct.

Q Maybe you didn't have a chance to put it on that correction sheet, Doctor, but at any time since you read the deposition until you walked into court today have you ever provided that information in writing about your opinion about the effectiveness of Acyclovir?

A I have not.

Q Doctor, we talked for a moment this morning -- Mr. Jacobson asked you if there's anyway to really know with a great deal of certainty, perhaps even approaching hundred percent certainty, whether or not a patient has a herpes simplex encephalitis.

Remember that discussion this morning?

A Yes.

Q And you mentioned that there were three ways of really knowing for sure. One might be to do a brain biopsy, right?

A Correct.

Q One was not done and you're not advocating that one should have been done, correct?

A Correct.

Q Another way that one might know for sure is because of some tests. The technology that is available now we simply didn't have in 1989?

A Yes.

Q But so put that aside. The third thing you mentioned was antibody analysis, correct?

A Yes.

Q And in the CSF. We talked about this at your deposition. I was interested, too, in what you thought one might know for sure about diagnosing herpes.

And if you look at page 85 of the deposit we had some discussion about this.

A Yes.

Q Specifically page 85, your answer began at the bottom of 84 and carried over to the top.

A Yes.

Q Okay. Now, Doctor, at the time that you gave your deposition we talked about this subject, and you again mentioned brain biopsies is one option?

A Yes.

Q You said another way we could know for sure if you're able to isolate the virus in culture from the CSF?

A Yes.

Q Well, wasn't an effort made to isolate the virus in the culture from the CSF?

A Yes.

Q And wasn't that negative, Doctor?

A Yes.

Q Okay.

A As it is in 90 some odd percent of the cases.

Q But that is what you said at the deposition as being one of the two ways to really know. That would give you a specific diagnosis?

A That's correct.

Q Okay. Now, again at your deposition you didn't mention antibody analysis, did you, Doctor?

A No.

Q You spoke this morning a little bit about the subject, the fact that Lashawda had been ill the week prior and whether or not that might be a fact or another one of these clues you mentioned in trying to put this case together. Do you remember that?

A Yes.

Q You're now expression the view they she might have had some herpes on board in her body. The illness the week prior might have triggered some sort of systematic reaction and that might have been what prompted the condition, correct?

A Conceivable, yes.

Q But again, Doctor, we talked about at your deposition, and you did not know then the etiology of how she contracted herpes and you could not offer any theories on how she contracted it, isn't that true?

A You would have to refer me to a page.

Q Page 114, Doctor. We'll do it again.

Line 16 we were talking about herpes and how it behaves in the body. We talked about the central nervous system. I specifically asked you the question at line 16, page 114, "Do you hold any theories in this case as to what can explain how Lashawda contracted this --" referring to the herpes simplex encephalitis, "-- assuming that is what she had?" And at the time you said, "No."

A You're taking the entire thing out of context.

Q Doctor, we were talking about theories or how they might have contracted herpes simplex encephalitis in this case?

A You were referring to patho-physiological mechanisms. You didn't ask me specifically whether I felt that Lashawda's infection may have been predisposed to a previous illness.

Q Well, you don't even know that it was a viral illness the week before?

A Doesn't matter.

Q But that was not something that you brought up at the time of your deposition?

A I wasn't asked.

Q You were asked about theories of how she contracted the disease and your answer at that time was no?

A Again, out of context.

Q Doctor, regarding the giving this patient the administration of Acyclovir, you agree -- you would agree, Doctor, that if this patient had never had a herpes simplex encephalitis, the timing of when she was given Acyclovir would be irrelevant, correct?

A Yes.

Q Okay. And in your own experience with patients, and even in this case you concede or agree that giving Acyclovir, even if it is given within the time period that you think the standard of care requires, in your judgment, this patient may still

evidence some neurologic deficits?

A Yes.

Q Some irretrievable memory loss?

A Yes.

Q And some learning disabilities?

A Yes.

Q Now, Doctor, you offered an opinion here about Lashawda Wren's life expectancy. The fact is, you don't manager or care for patients, children or adults, who have neurologic impairments. That is not part of your practice?

A It's not part of my practice.

Q Okay. Doctor, you agree that you cannot assess this case prospectively, in other words, to make the diagnosis?

A That's correct.

Q You can only look at this case retrospectively?

A If you're looking for diagnostic parameters, yes.

Q You cannot prospectively make the diagnosis.

The only thing you can say at the time the caregivers were treating Lashawda, is whether or not a clinical illness is consistent with herpes?

A That's correct.

MRS. VANCE: Nothing further.