IN THE COURT C F COMMON PLEAS

LORAIN CC UNTY, OHIO

JASMINE MERRIWEATHER, et al.,

Plaintiffs, Case No.

vs. 98 CV 120349

ELYRIA MEMORIAL HOSPITAL, et al.,

Defendants.

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Deposition of THOMAS TREVOR REILEY, M.D., called for examination under the statute, taken before me, Craig L. Knowles, CM, a Notary Public in and for the State of Colorado, by agreement of counsel, at 17229 Rimrock Drive, Golden, Colorado, on Wednesday, September 15, 1999, at 2:06 p.m.

APPEARANCES:

On behalf of the Plaintiffs:
Rubenstein, Novak, Einbund & Pavlik.
L.L.P.
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On behalf of the Defendant Elyria
Memorial Hospital:
Fallon Paisley & Howley L.L.P.
JOHN W. JEFFERS, ESQ.
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APPEARANCES, continued

On behalf of the Defendant Liengkong Siew:

Mazanee, Raskin & Ryder Co., L.P.A.
LYNNE K. SCHOENLING, ESQ.
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THOMAS TREVOR REILEY, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF THOMAS TREVOR REILEY, M.D.

BY MR. NOVAK:

Q. For the record, could we have your name, please?

A. Thomas Trevor Reiley.

Q. You are a physician, is that correct?

A. That's correct.

Q. Board certified in neurology?

A. Yes.

Q. Pediatric, as well as neurology?

A. Yes.

Q. And I am a little curious about the 1991 through '94 master's degree in health care systems. Can you tell me what prompted you to pursue that degree?

A. Yes. With the change in the health care environment, many physicians right now are getting training in health systems or M.B.A.s in the economics and sociology of medicine, and I am one of them.

Q. At the present time I understand you are the Assistant Clinical Professor, Division of Neurology, Department of Pediatrics at the University of Colorado Health Sciences Center, is that right?

A. That's correct.

Q. At the present time do you have any patients that you are actively treating in the hospital?

A. No.

Q. During the course of let's say any given month, on an average how many patients do you treat in the hospital?

A. None.

Q. Do you have an active clinical practice where you treat patients on a regular basis?

A. Yes.

Q. Where would that be at?

A. I have a clinic here in Golden. I also have clinics in Alamosa, Grand Junction, Greeley, Pagosa Springs, Durango and Cortez.

Q. When you say you have clinics there, what kinds of clinics are these?

A. These are state-sponsored clinics

through the Crippled Children's Program, which we call in Colorado the HCP program or Health Care Program for Children with Special Needs. And I see both indigent patients as well as private patients through those clinics.

Q. Now at these clinics that you have listed under neurology consultation, how often do you go to each of these clinics?

A. I am at the regional clinics for two or three days each quarter. Aside from Greeley, where I am at that clinic on a monthly or every-other-month basis for one day, I am also at the Regional Center for the Handicapped in Grand Junction one day per quarter and here in Colorado, or here on the east slope, the Wheat Ridge Regional Center. I am there for one day per month.

Q. How many days a year do you, on average if you can tell me, spend in a hospital setting?

A. In the hospital? I am there approximately one month a year.

Q. During that one month a year that you are in a hospital setting could you tell me what you do?

A. Yes. I oversee the clinical activities of the neurology residents at Children's Hospital.

Q. And when you say you oversee the clinical activity during that one month, then are you actively involved in the care and treatment of patients?

A. Yes.

Q. And during your care and treatment of patients, you obviously are familiar with standards of nursing care as they relate to those patients in the nursery, is that right?

A. At the Children's Hospital of Denver, yes.

Q. I assume at the Children's Hospital of Denver they have nursing care standards or guidelines for the nursery?

A. Yes.

Q. Would it be fair to state that as an assistant clinical professor at that facility it's well established, is it not, that when a nurse is given an order by a physician or this is a standing order, it's expected that the nurse is to comply with that order, is that right?

A. Not always.

Q. But if that nurse takes it upon herself to do something which might be injurious to the patient, that is really not good practice, is it?

A. As a generalization?

Q. Yes.

A. If any person does something injurious to a patient it is thought of as not a very good idea.

Q. Obviously you must write orders when you are there at the hospital?

A. Usually I oversee the residents' orders.

Q. When the residents write orders, obviously they would expect that the nurses comply and follow through with their orders, wouldn't they?

A. If the orders are appropriate for patient care, certainly.

Q. Have you ever been involved in situations where nurses have been peer reviewed for failing to comply with standing orders or hospital guidelines as respects the care of patients?

MR. JEFFERS: Objection. Go ahead.

10

MS. SCHOENLING: Objection.

A. Not personally at any of the hospitals I worked at. I have certainly had the opportunity of reviewing situations like that in law cases.

Q. Your web site has a Duke ending to it. Why is that?

A. It's actually a Denver University, DU.EDU.

Q. I thought it was Duke.

A. Yes. I am--

Q. Because you were a Duke graduate, I was wondering why.

A. I received my master's degree at the University of Denver. I am an ongoing graduate student there, and I also teach a few courses.

Q. All right. During the period of time that you spend one month out of a year with the residents in the pediatrics neurology setting, do you actively review CT scans and MRIs?

A. Yes.

Q. Obviously in the setting of training these physicians they become familiar with Balti's book on child neurology, do they not?

A. Yes.

Q. What about Menkes' books on pediatric neurology?

A. Yes.

Q. Those are pretty much staples in what I would call your industry, pediatric neurology, is that right?

A. They are two of the four or five that are viewed as being the best.

Q. Are you familiar with Vanrobes and Martins' book on neonatology?

A. No.

Q. Are you familiar with Av Fanaroff?

A. No.

Q. Are you familiar with Jeffrey Alschuler?

A. No.

Q. In 1987 and '88 you chaired a malpractice liability insurance task force at the Children's Hospital, Denver, Colorado. Could you tell me what that was about?

A. Yes. The hospital was paying huge premiums for its malpractice coverage of its doctors. The hospital paid the malpractice premiums for all of us who were employed there as contract docs, and we looked into whether or not

12

the per incident per year coverages were too costly or too wide-ranging and recommended a decrease in coverage for the docs to be more in tune with what our risks were.

Q. You also were a member of the Colorado Obstetrics and Gynecological Bar Association Consortium on Tort Reform. Could you tell me what that was about?

A. Yes. Prior to tort reform in Colorado the awards for bad baby cases was so high and malpractice rates were going up so much that we recommended that a fund be set up similar to Virginia, where children with disabilities could go to that fund and not have to go through tort.

As it turned out, though, tort reform took the form of a limitation of damages here in Colorado, which took the steam out of the engine towards that fund being established.

Q. What, to your understanding, is the cap on damages here?

MR. JEFFERS: Objection. Go ahead.

A. I believe that if a child dies as the result of malfeasance that the award is somewhere around $45,000. And that, the cap, I am not sure

of all the categories, but I know this is one cap at one million. But I am not, I don't know the details.

Q. Are you aware that n Ohio we do not have any caps?

MR. JEFFERS: Objection.

A. No, I didn't know that.

Q. Tort reform was struck down.

MR. JEFFERS: It hasn't gone to the United States Supreme Court yet.

MR. NOVAK: Pigs have wings.

Q. Would you tell me about your 1991-92 Chairman, Medical Errors Subcommittee QI Team, Children's Hospital.

A. In my master's degree training I learned about quality improvement and process analysis, and the first process that Children's Hospital attempted to change was the frequency of medication errors.

Q. Okay.

A. I chaired that group.

Q. How many times have you given testimony for any lawyers in the Cleveland, Ohio area?

A. I think this is the first time.

14

Q. Do you know how Mr. Jeffers got your name?

A. No.

Q. Did he ever communicate to you as to how he got your name?

A. I believe that he got my name through Robin Leach. Is that the name?

MR. JEFFERS: JoEllen Leach.

MR. NOVAK: Robin Leach was from Lifestyies of the Rich and Famous.

MR. JEFFERS: JoEllen Leach, which came from his articles.

Q. How many times have you reviewed cases involving brain damaged babies?

A. Over the course of my career, probably 50 times.

Q. And on those 50 occasions how many of those reviews were for the plaintiff, as opposed to the defendant?

A. Probably 50/50.

Q. And out of those 50/50, do you have a recollection as to how many you actually gave testimony on in court?

A. I have those records here for the last ten years, and it's 50-50, I believe.

will give you a copy of that if you like.

MR. JEFFERS: Do you have some additional ones?

THE WITNESS: I could print them off my computer.

MR. JEFFERS: Eventually.

THE WITNESS: Those cases that you see that went to deposition and trial are a mixture of cases. In this rendition there are only a few that were bad baby cases.

Q. Are you familiar with Steven Donn?

A. D-O-N-N?

Q. Yes.

A. Is he one of the persons who has offered an opinion in this case?

Q. Yes.

A. I have read his opinion.

Q. Dr. Michael Johnston, have you read his?

A. Yes.

Q. Have you read any articles that Dr. Johnston has written?

A. I have a very lengthy file that has some of his articles in it.

Q. When you say you have a lengthy file

16

that has some of his articles in it, what is the purpose of the lengthy file?

A. I have a file on, a neonatal file that is very broad. Some of his articles are in the broad file of neonatology. I also have a birth asphyxia file that is thick. Some of his articles are in that file.

Q. What is the purpose for having these files?

A. For teaching.

Q. Prior to today did you review any of Dr. Johnston's articles?

A. No.

Q. Prior to today could you tell us what literature you did review, other than the materials that you provided us with copies?

A. These are the only articles that I reviewed. I read sections of Volpe.

Q. Prior to today could you tell us what Mr. Jeffers provided you in the way of materials to review?

A. None.

MR. JEFFERS: Well, I mean, I sent depositions. Is that what you are asking?

MR. NOVAK: Right.

MR. JEFFERS: Not articles. He is asking about what I sent to you.

THE WITNESS: I am sorry. I reviewed a copy of the complaint, the Elyria Memorial Hospital labor and delivery records from November 11th, 1992; the records from the Rainbow Babies and Children's Hospital for the three admissions of Jasmine Merriweather, November 2nd through 23rd, 1992, January 4th through February 3rd, 1993 and August 2nd through 9th, 1993.

I was also sent the records from the Health Hill Hospital, February 3 through March 4, 1993, which included the discharge summary. The records of Dr. Max Wiznitzer, W-I-Z-N-I-T-Z-E-R, of the Cleveland Clinic. Office records of Dr. Abrigo, A-B-R-I-(3-0, which included other evaluations and therapy evaluations. The expert reports and depositions of Drs. Joel Engle and Howard Tucker, as well as Dr. Tucker's exam notes of Jasmine Merriweather. The depositions of Mr. and Mrs. Merriweather. The depositions of Dr. Siew, S-I-E-W, and nurses Lancer, Kapronica, K-A-P-R-0-N-I-C-A, Charles and Bartlebaugh. The transport and progress reports from University Hospitals dating from November 11th, 1992. The

MRI scan report of August 5th, 1993. A PT report of September 7, 1993. The discharge summary from the University Hospitals, 2-3-93. And the reports of Drs. O'Grady, Johnston, Donn and Todia, as well as the report of nurse Fink.

I also looked at lab reports from University's Rainbow Babies and Children's Hospital as previously mentioned November 2nd through November 23rd, 1992.

And then more recently I received and reviewed the prenatal records of Mrs. Merriweather from her obstetrician, Dr. Siew. The lab reports from Elyria Memorial Hospital from Jasmine's birth. And finally, photographs of Jasmine with her family taken prior to January 19th, 1999.

Q. Have you ever spoken to Dr. Siew or any of the nurses whose depositions were taken?

A. No.

Q. As part of your analysis do you feel that it was necessary or not necessary to speak to any of these individuals be it by phone or be it on an interview basis to determine whether or not these individuals could appropriately and adequately communicate orders, signs and symptoms.

between one another?

A. No.

Q. Based upon your review of the depositions, do you feel that these individuals could adequately communicate orders between each other, as well as changes in patients' conditions?

A. I have no opinion.

Q. Have you reviewed the Elyria Memorial Hospital Newborn Nursery Transitional Guidelines?

A. No.

Q. I am going to hand you a copy of these guidelines.

A. Thankyou.

Q. I would like you to take a quick look at those.

(Witness examines document.)

MR. NOVAK: While the doctor is looking at those, John, could I take a look at his notes?

MR. JEFFERS: Sure.

MR. NOVAK: Thanks, that will save some time.

THE WITNESS: I will be happy to give you copies of those, too, if you want them.

Q. I am looking at your notes here. It says Howard Tucker not a fellow member of the AAN. What is the AAN?

A. American Academy of Neurology.

Q. He is board certified. . You have a note: Therefore may not have his boards.

A. Right. That was a note to myself.

Q. He has been board certified. I think we all agree on that. Is there a reason why you have some question on this?

MS. SCHOENLING: Which board certification are you referring to, Bill?

MR. NOVAK: He is a board certified neurologist.

Q. I am going to ask, are there different certifications?

A. The fact his name was in last year's Child Neurology Society membership and was not in last year's American Academy of Neurology membership raised the possibility that he was not boarded, because the only requirement for being an AAN member is board certification. And that is not a requirement for the Child Neurology Society, you can be a pediatrician and be a member of the Child Neurology Society. So I

thought it was peculiar enough to at least raise the question.

Q. You have a note about Dr. Siew. It says: This memo demonstrates the doctor's poor grasp of the English language. Otherwise, no comment, no criticism. What does that mean?

A. I thought that his use of English in his depo was reflective of his nationality and was not as good as perhaps a native American.

Q. Does that create problems with respect to communications between nurses and a physician such as Dr. Siew, where he does not have the grasp of the language as you have described which would be like a native American?

MR. JEFFERS: Objection.

MS. SCHOENLING: Note my objection.

A. This is a potential for that whenever this is a person not using his or her native language.

Q. We will get back to these.

In looking at these Elyria Memorial Hospital Medical Center newborn nursery transitional phase notes, I want to ask you a few questions. It indicates that all infants are to be observed and cared for in the transitional

nursery phase for the first 24 hours or longer if deemed necessary.

Then it has a heading for vital signs, color, activity. Then it says: Respirations, 32 to 60, with no symptoms of distress, grunting, flaring or retracting. Then under 4 it says: Document. Report any variation from the above normals and report on nursery flow records.

You have had an opportunity, have you not, to read the Polly Kapronica's deposition?

A. Yes.

Q. By the way, I will also want to mention to you in line with what I just read, I am sure you are familiar with the nursing care plan that was in effect for baby girl Merriweather for November 11, 1992, is that correct?

A. No, I am not.

Q. But you indicated you reviewed the Elyria Memorial records?

A. Certainly did.

Q. Under number 2 it says potential for ineffective breathing pattern/cardiac output. Under C, nurse action intervention, it says

record and report significant findings, somewhat consistent with the transitional phase guidelines, is that right?

A. Yes.

Q. Then under number 4 it says potential for altered nutrition; nursing action intervention letter D says observe and report respiratory distress with feeding.

Is that pretty much standard in every hospital that you have worked in?

A. Certainly.

Q. Now you are aware, are you not, that at 1:30 a.m., Polly Kapronica was the only R.N. available to see Jasmine Merriweather as she was being fed by an L.P.N., and at the time that Jasmine had a spell of apnea, nurse Kapronica took it upon herself not to call any physician. Are you aware of that?

(The record was read as requested.)

MR. JEFFERS: I am not sure all your facts in your long statement are accurate, that is the only problem with it.

If your question is is he aware of what the record shows at that time, 1:30, that may be another question.

A. I think that it's possibly, if not probably true. And if it is true, it has no bearing on the case.

Q. Well, let me ask you this: Here was a question asked of her on page 16 of her deposition. The question was: At any time at 1:30 when this episode took place, is there any note in the chart that you reported this to any physician?

Answer. No, I didn't think it was necessary.

Wouldn't you agree with me that based upon the newborn nursery transitional guidelines, based upon the nursing care plan and the order in the nursing care plan, that nurse Kapronica when confronted with apnea and this episode that occurred at 1:30 was required pursuant to the guidelines and pursuant to the plan to report this?

MR. JEFFERS: Objection.

A. I don't know.

Q. Well --

A. It depends on how severe the episode was, how long-lasting it was, whether it was --

Q. We really don't know how long it was,

do we?

A. No.

Q. Because nurse Kapronica doesn't know how long it was, does she?

A. No.

Q. In fact, she didn't write down how long it was, did she?

A. Let me look at my notes.

Again, it makes absolutely no difference to the case. But I believe that the note that was written was that the infant was being fed by the L.P.N., became cyanotic in color, starting circumorally. Then the entire body became blue and the infant stopped breathing. Held the infant upside down and patted the back, and the infant began to cry and color became normal. Pulse ox was 98 percent before and after the episode.

MR. JEFFERS: I think it says 98, actually, in the record.

THE WITNESS: That is what I said, I believe. 98 percent before and after the episode. Went down to 84 percent during the cyanotic episode. Because the child recovered so rapidly, whether or not it was a nurse's

prerogative to either record it or to notify the doctor is subjective and again plays no role in this case.

Q. Well, you are assuming that the child recovered rapidly, aren't you?

A. Certainly.

Q. Because the fact of the matter is that Polly Kapronica has no recollection of the amount of time that this patient spent in this apneic state, isn't that correct?

A. I guess it would depend how soon after the event she was deposed as to how long it lasted.

Q. She doesn't record it, does she?

A. She recorded it in a nursing note.

Q. But she doesn't record the length of time that this episode lasted?

A. That's correct.

MR. JEFFERS: Other than by inference.

Q. It could have lasted a half an hour, couldn't it?

MR. JEFFERS: Objection. This is the could be, Chicken Little, sky will fall.

MR. NOVAK: You make the objections

only, otherwise you get a sock in your mouth today.

MR. JEFFERS: I am going to explain something to you. You have been a permanent open mouth, totally vocal individual on everything.

MS. SCHOENLING: Testifying individual. Come on, John.

MR. JEFFERS: Testifying. Forgot that. If I choose to make any comment, I am going to make it and you can say objection and then you can do whatever you want to do.

MR. NOVAK: I have only picked up on your verbosity and foul-mouthed garbage from the depositions I took of your nurses when you realized they were going into the tank.

MR. JEFFERS: Your self-serving comment is noted, as usual.

MS. SCHOENLING: You have got to give them credit, Doctor, they do it with civility.

THE WITNESS: Never happens in the doctor community.

Q. I guess my question is you made a comment, you said, well, there was a 98 percent pulse ox before the episode and a 98 percent after.

But the fact is that the 98 percent that is recorded after as recorded in the chart, the next one was at 4 o'clock, wasn't it?

A. I don't know. Again, assuming that that's the case, it makes no difference to this, to this case.

Q. So I guess my question is --

MR. JEFFERS: I am going to object, because I see what you are trying to do. But it says on that second one at 4 o'clock, pulse ox dropped again to 84, which is again an inference that it was back to 98 for the entire time between those two. So you are taking it out of context.

MR. NOVAK: John, are you telling me that the one under column 4 a.m. 98 percent is really a fudge because it was really 84 percent?

MR. JEFFERS: Say that again?

MR. NOVAK: Are you saying the nurse fudged in the column?

MR. JEFFERS: No, I am not saying --

MR. NOVAK: I heard that.

MS. SCHOENLING: I didn't hear that.

MR. JEFFERS: You hear things only Walt Disney writes about.

THE WITNESS: For the record the answer is that the note dated 1:30 a.m. which ends with nurse Kapronica's signature tells that the pulse ox returned to 98.

Then this is a nurse's note following her note that states that the pulse ox went down to 84 percent during the cyanotic episode. And then in a completely different entry at 4 o'clock in the morning this is an entry that the pulse ox again dropped to 84 percent and went to 98 percent.

Q. But once again, my question is this is no evidence in this case as to how long these episodes lasted, isn't that correct?

A. That is absolutely correct. And it's irrelevant to the case.

Q. Let me ask, if it's irrelevant -- let's assume hypothetically that up to 1:30 a.m. on the 12th, this child was perfectly normal and had an apneic spell which lasted an hour.

MR. JEFFERS: Are you saying perfectly normal in all respects, or in terms of --

MR. NOVAK: All respects between the time of delivery and time of the apneic spell.

MR. JEFFERS: Your experts have already testified that is not so.

MR. NOVAK: I am asking a question.

THE WITNESS: Let's let the apneic spells go for three hours. Let's say that that is what happened here.

Q. Did it cause cerebral palsy?

A. No.

Q. Brain damage?

A. No.

Q. So a child can have a spell of cyanosis, stop breathing for three hours, and you have no damage?

MR. JEFFERS: Objection.

A. A child would certainly expect to have cerebral palsy as a result of that. This child could not have had that happen to her.

Q. Now --

A. As we will see from the remainder of the testimony.

Q. We now have a 1:30 episode and a 4 o'clock episode. In your notes you wrote down: Not reported as a seizure.

A. Yes.

Q. Do you know if Polly Kapronica would

know the difference between a seizure or not a seizure?

MR. JEFFERS: Objection.

A. She is an R.N. in a neonatal unit. I am sure she is very capable.

Q. Do you know what experience she had?

A. No.

Q. When you use the words "very capable," aren't you maybe giving her a little more credit than she is due?

A. Well, we have done a study here in Colorado of school children and their ability to recognize seizures. And school children, with no medical training, are absolutely, one hundred percent accurate in recognizing a true seizure.

Q. Do you know what Polly Kapronica's educational background was before she saw this episode at 1:30 on November 11th, 1992?

A. Higher than grade school.

Q. Do you know what level of nursing she was in?

A. No.

Q. Would it make a difference to you to find out that she was in an orientation program

and this was kind of like her first round through the nursery?

A. No.

Q. It wouldn't make any difference to you?

A. Not at all, not in this case.

Q. So you are telling me then that a rookie nurse who didn't report a change in respiration pursuant to the guidelines, a rookie nurse who didn't report change in respiration pursuant to the nursing care plan that is a standing order in this chart, it wouldn't make any difference to you that she violated both of those orders and you honestly believe that this woman knew what a seizure was, is that right?

A. It makes, it makes absolutely no difference in this case whether her care of this infant was appropriate or not or whether she followed the rules or not, because no damage occurred to the baby because of whatever mistakes she may or may not have made.

Q. Doctor, that is not my question. My question for you is --

A. That will be the question for the jury.

Q. That is for Mr. Jeffers to ask, and you can go to down with him in front of the jury all you want.

My question for you is, when a nurse violates a guideline and a nurse violates a standing nursing care plan order, when a baby stops breathing, and doesn't report it to anybody until 8 o'clock in the morning and she has two episodes before that of apnea, isn't that a violation of good nursing practice?

MR. JEFFERS: Objection. You loaded the question in the beginning. It's an impossible question. You ought to read it back. It's really a lousy question.

MR. NOVAK: I will read it back for dense people like you.

MR. JEFFERS: I need a lot of help, Bill, because you are an intellect.

Q. Assume the following: That this is a nursing care plan in effect that requires the nurse to report findings or changes in breathing respirations.

I want you to assume that this is a newborn nursery transitional phase guideline for Elyria Memorial Hospital that requires reports of

any variations from normal in respirations.

I want you to assume that at 1:30 and at 4 o'clock nurse Kapronica took it upon herself not to call the physician because she didn't feel it was necessary.

I want you to assume that the first time she reported it to anybody was the nurse R.N. who came on at about 7 or 8 o'clock in the morning and that was the first time she did anything about those two spells.

Would it be fair to state, forget the causal issues, that when a nurse does what she did, in fact when a nurse doesn't do what she did, it's a violation of good nursing practices, isn't that right?

MR. JEFFERS: Objection.

Q. Forget the cause issue.

MR. JEFFERS: Objection.

A. Well, I don't know whether it would be or not in this circumstance.

Q. I mean, Doctor, I love you dearly, but you know and I know that if a nurse doesn't follow guidelines, if a nurse doesn't follow standing orders, that is bad nursing practice, isn't it?

MR. JEFFERS: That is a separate question, a hypothetical question unrelated to what she knew.

MR. NOVAK: I am asking you that now.

A. Generally speaking, most hospitals do the best work when people are following work orders that are well thought out and have been agreed upon by medical staff. And people who are not following work orders are not doing a good job,

On the other hand, if the work order itself is improperly written and if a nurse is using her own judgment as to what would be best for the patient, then standing orders can be abridged by professional persons including nurses if they feel in their professional judgment those standing orders are not in the best benefit of their patient.

Q. But professional judgment is based on education, training and knowledge, isn't that right?

A. That's correct.

Q. So assuming those factors to be in place, you have to assume Polly Kapronica knew

what she was looking at, is that right; had good training and understood what an apneic spell was, isn't that correct?

A. That is correct.

Q. You would not want nurses to violate standing orders and hospital guidelines of patients under your care, would you?

A. As a general sense, no.

Q. Now--

A. Certainly, no, if it made any difference in the patient's outcome, which of course it didn't in this case.

Q. I understand that is what you want to sell. But my question for you is, apart from the causation issue, the fact of the matter is that this nurse violated the guidelines and the standing orders, did she not?

MR. JEFFERS: Objection. You asked; he answered. Why should he bother answering again?

MR. NOVAK: Because he didn't answer the question I just asked.

The fact of the matter is she violated both the standing order and guidelines --

MR. JEFFERS: He just explained why it might not be.

MR. NOVAK: I am --

MR. JEFFERS: So it's tough.

MR. NOVAK: Are you telling me you are not going to let him answer the question? Do you want to fly back out here?

MR. JEFFERS: I am telling you you are getting ridiculous. This is repetitious.

Q. This is very simple. We will move on.

The fact of the matter is she violated the guidelines and she violated the standarding orders, didn't she?

MR. JEFFERS: Objection. Asked and responded.

Q. Whether you believe it had anything to do with the cause.

MR. JEFFERS: Objection.

A. If the child's episode was momentary, with a very brief fall of the pulse ox 0 2 from 98 to 84 to 98, she may have met the intent of the guideline and standards by recording it in her nursing note and not notifying anyone.

If it was a more prolonged episode

she certainly would have abridged both the guideline and the nursing orders by not having notified anyone or recorded it as such.

Q. But the problem is in this case we really don't know how long it is. So maybe you think it's a violation then, and maybe you don't, right?

MR. JEFFERS: Objection.

A. That's correct.

MR. NOVAK: At least I got that out of him, John.

MR. JEFFERS: Give yourself a gold star.

MR. NOVAK: I am going to put it right on your forehead.

MR. JEFFERS: You can't miss. But you are much younger, and you will be there soon.

Q. Let me ask you this: Regarding this communication issue --

MR. JEFFERS: Objection. This is no communication issue. Go ahead.

MS. SCHOENLING: I will join in the objection.

Q. Regarding the language issue --

MR. JEFFERS: Objection.

Q. -- you have reviewed the chart of Jasmine Merriweather's mother, did you not?
A. Yes.
Q. Prior to the delivery did you see any progress notes written by Dr. Siew?
A. I'd have to look back at the notes. But let me look at what notes I took of those records.
What I wrote from my review of Dr. Siew's notes was good monthly follow-ups throughout the pregnancy.
Q. But was that a progress note?
MS. SCHOENLING: I think he said those were his notes.
MR. NOVAK: I know.
Q. I am asking, in the chart is there any progress note of Dr. Siew evaluating the care and treatment of this patient once she commenced labor up to the time of delivery?
MS. SCHOENLING: I am sorry. You are not talking prenatally, you are talking when she went into labor?
MR. NOVAK: Right. Once she went into labor, up until the time of delivery.
A. I see a series of notes that are

very, very difficult for me to read, with the date of November 11th.

MR. JEFFERS: It says delivery note.

THE WITNESS: November 12th and November 13th.

Q. I want you to assume the first note you are looking at is a note post delivery, and there was no note between the time of the onset of labor and the delivery?

MS. SCHOENLING: Objection.

Q. Does that surprise you?

MS. SCHOENLING: Objection.

MR. JEFFERS: Objection. By the way, it should be noted for the record that Dr. Reiiey is not here and has not been asked to make judgments relative to Dr. Siew.

MR. NOVAK: I understand.

MR. JEFFERS: Just so you know.

MR. NOVAK: I understand.

MR. JEFFERS: So I object.

A. I have no opinion.

Q. So you have no opinion about this physician's failure to put down any progress notes of the, from the period of time, the onset of labor up to the time of delivery, is that

right?

MS. SCHOENLING: Objection.

A. I don't know what the requirements were for physician entries at this hospital for admitting obstetricians, nor do I think I want to know.

Q. You read the report of Dr. John Patrick O'Grady, is that right?

A. Yes.

Q. Have you had a chance to look at his book entitled Operative Obstetrics?

A. No.

Q. Mr. Jeffers has filed a pleading with the court indicating that he also intends to use Dr. O'Grady as one of his experts. I just wanted to ask you a question as a general principle --

MR. JEFFERS: What year is that book?

MR. NOVAK: I don't know.

MR. JEFFERS: Tell me.

MR. NOVAK: I don't know. I don't know.

MR. JEFFERS: That apparently must have been after 1992.

MR. NOVAK: Yes, it is. It is.

MR. JEFFERS: It is after 1992?
MS. SCHOENLING: 1995.
MR. NOVAK: Whatever.
MS. SCHOENLING: John.
MR. JEFFERS: It's 1995?
MS. SCHOENLING: Yes.
MR. JEFFERS: I object.
MR. NOVAK: You can object because it has to do with Dr. O'Grady's book.
Q. Anyway, the question I have for you is the following:
MR. JEFFERS: Are you going to preface your reading?
Q. I want you to tell me if you agree or disagree with the general proposition in the preface that Dr. O'Grady writes', let me read this to you: In the preparation *of* this text our purpose is to promote thoughtful, compassionate and technically and ethically competent clinical practice with close attention to patient communication and meticulous record-keeping.
MS. SCHOENLING: Object.
Q. Would you agree as a general statement?
MS. SCHOENLING: Note my objection

based on the reference to the publication and any other reference to this publication.

MR. JEFFERS: Object.

MR. NOVAK: I am going to blow these pages up for the trial.

MS. SCHOENLING: We were hoping you would.

Q. As a general principle in a teaching hospital that you are in would you agree with that --

MR. JEFFERS: In his teaching hospital?

A. The answer is certainly.

Q. All right. Do you feel an OB/GYN who doesn't write a progress note from the onset of labor to the time of delivery is comporting with the notion of meticulous record-keeping?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

MR. JEFFERS: Already asked and answered.

MS. S~HOENLING:He's already told you he doesn't have any opinions on that.

MR. NOVAK: That is not what he said.

MS. SCHOENLING: Yes, it is what he

said.

MR. NOVAK: Well, I am changing it a little bit now, this is a different question.

MR. JEFFERS: The subtleties are too much. Go ahead and answer if you can.

A. I don't remember the question.

(The record was read by the reporter.)

A. The answer is that there are circumstances in certain deliveries where the only time to write the note is at the time of delivery.

Q. Now, I would also ask you a question from Dr. O'Grady's book, page 333. And I would ask you if you agree with this statement in general: It is imperative to an effective defense that the medical records adequately reflect the physician's ongoing thought process in providing obstetric care. Do you agree with that?

MR. JEFFERS: Objection.

(Discussion off the record.)

Q. It is imperative to an effective defense that the medical records adequately reflect the physician's ongoing thought process

in providing obstetric care.

MS. SCHOENLING: Note my objection.

Q. As a general statement do you agree with that?

MR. JEFFERS: Objection.

MS. SCHOENLING: Note my objection.

MR. JEFFERS: Page 333?

MS. SCHOENLING: Yes, 333.

MR. NOVAK: Yes.

A. As a general statement I think that is true for any, any physician.

Q. When you looked at this chart, during the period of time of her labor are you able to glean anything from that chart of Dr. Siew's thought process?

A. I wasn't asked to do that and I didn't attempt to do that.

Q. I understand that. But you did review the chart, didn't you?

A. I did.

Q. I guess is there anything, progress notes, handwritten notes of Dr. Siew, anything in the way of records that would document --

MR. JEFFERS: Orders, for example, things of that nature, anything?

Q. Document his thought process as to how he was to approach this patient from the time she was admitted to the time she delivered?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

A. I have no recollection.

Q. You indicated earlier -- by the way, there were some questions in Dr. Tucker's deposition about cerebral edema. Would you agree that this is no mention of cerebral edema either at Elyria Memorial Hospital or at the first admission at University Hospital?

A. That's correct.

Q. Now would you also agree that you don't have to have cerebral edema in every instance of hypoxic ischemic encephalopathy?

A. I think that that is false.

Q. Now are you familiar with Chapter 7 of Dr. Volpe's book, the chapter dealing with hypoxic ischemic encephalopathy, 1987 edition, page 182, where he indicates the following after he goes on to discuss the experiments with the animals and he says the following: Our own experience and that of others leads to the conclusion that brain swelling per se is not a

prominent feature of hypoxic ischemic encephalopathy in the human newborn.

A. In the selective neuronal necrosis and in the pontocerebellar tract necrosis, the edema may be very subtle. But whenever this is destruction of or damage to brain cells there are site toxic edema either within the cell or surrounding the cell that may or may not be prominent to testing.

Q. That could be why the CT scan didn't show anything in the first admission, isn't that right?

A. If we are assuming that this child's injury occurred because of hypoxic ischemic encephalopathy that occurred intrapartum, then there had to have been some evidence of either injury or edema on one of the early films.

Q. But you don't have to have that happen all the time?

A. You have to have it happen all the time. It may not be edema, but it will be evidence of some softening, some change in brain structure.

Q. Doctor, I have handled a number of these cases and I have to tell you, my personal

experience is that I have not seen edema on all of the CT scans. So I guess my question for you is --

Let me finish, John.

MR. JEFFERS: I know. I am just, I find your statement amazing.

MR. NOVAK: Let me finish.

Q. Are you telling me, then, that every time this is a hypoxic ischemic insult during the labor and delivery process, perinatal, that you will always see edema on a CT scan taken within 24 hours?

MS. SCHOENLING: Objection.

A. No.

Q. You won't?

A. No.

MS. SCHOENLING: You mischaracterized his testimony.

THE WITNESS: No, you won't see it within 24 hours.

MR. NOVAK: I think I did.

MS. SCHOENLING: You think you did mischaracterize his testimony?

MR. NOVAK: Yes.

MS. SCHOENLING: I do, too.

Q. Let's talk a little bit about the timing of the episodes. The delivery occurred I believe at 1:10 p.m. on the Ilth, is that right?

A. 1:10 on November 11th.

Q. The first episode occurred at 1:30 a.m. on the 12th, the next episode occurred at 4 a.m., and I believe the next episode occurred at 8:00 a.m.

MS. SCHOENLING: Will you tell me the page in Volpe referenced in the set of questions?

MR. NOVAK: 182.

Q. Would you agree with this general statement, that generally one sees seizure activity within a period of 12 to 24 hours following what I will call an HIE insult?

A. Yes.

Q. Would you agree with me that the timing of the seizure activity in this newborn does fall within the parameters of that 12 to 24 hours?

A. Yes.

Q. In fact, Dr. Johnston has written the HIE, you will see the neurologic manifestation within a 12- to 24-hour period, is that right?

A. Yes.
Q. Dr. Volpe has written about that, hasn't he?
A. He has written about seizures as being one of the signs of HIE in the first 24 hours.
Q. Dr. Menkes has done the same, isn't that is right?
A. Yes, one of the signs.
Q. So in terms of the seizure activity this patient does fit the picture, is that right?
A. Just -- yes.
Q. If we are talking about this 12- to 24-hour period, when we are able to then relate, assuming that this is a hypoxic ischemic insult that occurred during labor and delivery, we are able to relate that back to the labor and delivery time, aren't we?
MR. JEFFERS: Objection.
MS. SCHOENLING: Objection.
Q. Assuming that is the case.
MS. SCHOENLING: Note my objection.
Q. Based upon this clinical manifestation.
A. I can't make that assumption,

therefore it's ridiculous to answer your question.

Q. My question is this: From a timing standpoint you have indicated that you agree with Johnston, Volpe and Menkes that you generally see seizure activity within 12 to 24 hours after an insult, is that right?

A. An HI insult, yes.

Q. Seizure activity which this child had followed from a period 12 to 24 hours, isn't that right?

A. Yes.

Q. You would agree with me that the episode at 8:00 a.m. was a seizure activity, was it not?

A. No.

Q. The reason is?

A. The child was described as having circumoral cyanosis with intercostal retractions. There was no description of a seizure.

Q. Would you agree with me apnea is a manifestation of a seizure?

A. It can be manifestation of a seizure. It can also be a manifestation of many

other types of alterations in neonate's physiology.

Q. We know the patient had apnea at 1:30 a.m., 4 a.m. and 8:00 a.m., isn't that correct?

A. I am not aware there was apnea at 4 a.m.

Q. But we do know there was apnea at 1:30?

A. Yes, sir.

Q. And apnea at 8:00 a.m.?

A. Yes.

Q. And we agree with the notion that apnea is a clinical manifestation of seizure activity. The question then becomes whether or not the observer understands whether or not the apnea they are seeing is related to the seizure activity, is that right?

MR. JEFFERS: Objection.

MS. SCHOENLING: Join in the objection.

A. That is true. However, I am going to have an apneic episode right now, and I'd like to have you tell me whether it's a seizure.

Q. I am not a nurse. Okay. But you are not --

MR. JEFFERS: But you graduated from high school.

Q. You are not sticking your tongue out, are you? And you haven't arched your back. And I don't think you are having a seizure.

A. But I did have an apneic episode for 20 seconds.

Q. At 4 a.m. when the infant's back became stiff. You would agree with me, would you not, that that can be a clinical manifestation of seizure activity?

A. Yes, I would call that a possible seizure.

Q. Would you agree that poor suck is a manifestation of seizure activity?

A. No.

Q. How about gagging?

A. Possibly.

Q. How about a patient who is fussy?

MR. JEFFERS: Fussy?

MR. NOVAK: Fussy.

A. No.

Q. I guess the bottom line, Doctor, is what it all boils down to is whether or not what is described here is an accurate portrayal of

what was going on between the period of 1:30 a.m. and 8 o'clock, isn't that right?

A. What it all boils down to is whether or not the questioning that I have been getting from you for the last hour and 20 minutes has any relevancy to the case. That is what it boils down to.

Q. But, see, what you think is relevant to the case is his defense. What I think is relevant may be totally different. Could we agree?

A. I work enough for plaintiffs to know what is relevant and this is irrelevant.

Q. How much are you being paid by Mr. Jeffers?

A. $550 an hour.

Q. How much has he paid you to date?

A. I don't know. Probably $5,000.

Q. Then he will pay you for preparation time before trial, right?

A. Yes. Probably similar to the amounts that you are spending on your own experts.

Q. Okay. Now you think this is irrelevant. Let me ask you this: I want you to assume that this patient had an insult prior to

the 1:30 episode of apnea. I want you to assume that. I want you to assume that the episode at 1:30 was seizure activity. Can you do that for me, just assume those facts?

A. I will make a hypothetical leap with you.

MS. SCHOENLING: Note my objection.

Q. Would you agree with me that assuming an insult occurred during labor and delivery, which is going to be the testimony of our experts, and assuming that there was seizure activity that occurred at 1:30, that early recognition of seizure activity and prompt treatment at 1:30 was mandatory on the part of that nurse?

MR. JEFFERS: Objection.

A. Absolutely not.

MS. SCHOENLING: Objection to the question.

Q. Are you familiar with Dr. Johnston's article written also by Dr. Donn on birth asphyxia issues in neurologic management, did you ever see that one?

A. Not that article, but I am familiar with his opinions.

Q. Would you agree with this general statement?

MR. JEFFERS: Can I have the year and date on that?

MR. NOVAK: 1989.

MR. JEFFERS: I should say the article.

MR. NOVAK: I gave you the article.

MS. SCHOENLING: What is the title?

MR. NOVAK: The article is called Birth Asphyxia Issues in Neurologic Management.

MS. SCHOENLING: Thank you.

MR. JEFFERS: And the publication?

MR. NOVAK: Blackwell Scientific Publications, and it's on page 106.

Q. This is what the comment is. It says: Aside from maintenance of adequate cerebral profusion, prevention of convulsions or their rapid control when they occur has the strongest rationale of any intervention in the asphyxiated infant. As outlined above seizures are likely to add a major insult to the preexisting injury, and vigorous but safe anti-convulsive therapy is strongly indicated. Attention needs to be given to the identification

of infants who should be placed on prophylactic anticonvulsants after asphyxia since the seizures are difficult to stop once they begin.

Do you agree with that statement?

A. Absolutely not.

Q. So you don't agree with Mr. Jeffers' two experts that he is going to use, Dr. Donn and Dr. Johnston, right?

MS. SCHOENLING: Actually, they are my experts.

MR. NOVAK: They are his experts, too.

A. I believe that comment in that article is dated by it being 1989. And subsequent writings by virtually all experts on seizures in HIE would dispute that 1989 interview.

Q. But at the time this patient was at Elyria Memorial Hospital in '92, this would have been the standard, wouldn't it?

MS. SCHOENLING: Objection.

A. No, I don't believe so.

Q. Well, let me ask you this.

A. I know what I have just said is controversial, but that is just not modern

thinking about the danger of seizures in the asphyxiated newborn.

Q. Dr. Donn, in an article called Asphyxia Neonatorum --

A. Date?

Q. 1986, Journal of Family Practice, page 545, said: Early identification -- I am sorry. Anticipation of the sequelae of asphyxia neonatorum and aggressive treatment of problems as they first arise will be the key to reducing the high morbidity associated with this unfortunate event.

A. That is absolutely false.

Q. So the two statements the two experts that have been retained by Dr. Siew and Mr. Jeffers has incorporated into his own case, you believe these two statements are false?

MR. JEFFERS: 1989 and 1986.

A. Let me clarify what I said. They are referring to seizures which were due to hypoxic ischemic encephalopathy based on the science of 1986 and 1989. We now know that thinking was false. It is irrelevant to this case because this particular child, now getting back from the leap of -- into fantasy that we had a few minutes

ago, this child did not have seizures that were related to intrapartum asphyxia. So regardless of whether or not their writings were true or false, it made absolutely no difference in this case.

Q. Assuming that this newborn did have a hypoxic ischemic event, would you agree with the general statements that I read to you from those two articles?

A. No.

Q. As the standard existed in 1992?

A. No.

Q. And you feel those statements are false, is that right?

A. That's correct.

MR. JEFFERS: You will be able to get to ask both of them their opinions on that.

MR. NOVAK: Sure. They will probably say, gee, I think I am going to change my mind now.

MS. SCHOENLING: I doubt that is what they are going to say.

MR. JEFFERS: We have not progressed in medicine, you have to understand.

MR. NOVAK: I know. You haven't

60

progressed) either.

MR. JEFFERS: Of course not, I am a regressive person, all Marines are.

Q. Let's talk a little bit about multi-organ failure, multi-organ injury. Do you feel it has to occur in every case?

A. No.

Q. Then you would agree with me that, are you familiar with Perlman's studies that indicated that out of all of the instances of perinatal asphyxia that he studied, only about 67 percent had multi-organ failure and out of that, 70 percent, it was really into one organ, that being the kidney?

A. That's correct, the kidney with or without involvement of the lung.

Q. Are you aware that Dr. Johnston has also written in instances of hypoxic ischemia encephalopathy if you see multi-organ injury it's generally the kidney and it exhibits a rise in the serum creatinine, is that right?

A. I am not aware of that article.

Q. But would you agree that if you have some injury to the kidney you will see a rise in the serum creatinine?

A. No. I can't agree with that.
Q. Would you tell me what a rise in the serum creatinine is indicative of?
A. It can either mean a laboratory error or it can mean a renal dysfunction.
Q. Can you have a rise in the serum creatinine in the face of an hypoxic ischemic event that occurred 24 hours earlier?
MR. JEFFERS: Objection.
A. Youcan.
Q. Youcan?
A. Youcan.
Q. Are you aware that this newborn had a serum creatinine at University Hospitals, .9, as recorded on the 12th?
A. Yes.
Q. And a .9 recording in a newborn a little over 24 hours of age is not a normal recording, is it?
A. That's correct.
Q. Are you also aware when we are talking about multi-organ injury that this infant had grossly bloody stools at University Hospitals?
A. No.

Q. And that this patient also had some anemia, you are aware of that, aren't you?

A. Yes.

Q. Grossly bloody stools can lead to blood lab results that demonstrate anemia, isn't that correct?

A. Yes.

Q. And grossly bloody stools can be a manifestation of an underlying enteritis, isn't that correct?

A. Yes.

Q. This patient had an increase in the serum creatinine, this patient had grossly bloody stools and, by the way, this patient also had bouts of tachycardia at University Hospitals, isn't that correct?

A. Yes. This is all true.

MR. JEFFERS: Two questions. Okay. All right. You just asked him two questions. I don't know whether you were just responding to the latter half.

THE WITNESS: I think all those were true.

Q. Now to have multi-organ injury doesn't mean permanent injury to each of the

organs necessarily, but it can mean some compromise to those organs, isn't that right?

A. Yes.

Q. Would you agree with me that grossly bloody stools is indicative of some compromise in the GI?

A. No.

Q. Are you telling me that grossly bloody stools in an infant that is 48 hours old is a normal finding?

A. No. But you didn't qualify that. A child who swallowed a lot of maternal blood and has rapid transit can have grossly bloody stools from the mother's blood.

Q. A child who has had a hypoxic ischemic event can have enteritis manifested by grossly bloody stools, isn't that correct?

A. That's correct.

Q. A child who has a hypoxic ischemic event can have a compromise of kidney function which can lead to elevated serum creatinine, isn't that correct?

A. That's correct.

Q. We know this patient had both grossly bloody stools and an elevated serum creatinine,

is that correct?

A. I am not aware of the grossly bloody stools.

Q. I am going to show you a chart from University Hospitals' record that is a physical assessment chart and -- under gastrointestinal, and it's dated 11-14. Take a look at that.

(Witness examines document.)

A. This is a, there are two entries in the chart on this page.

Q. Yes.

A. Dated November 14th. Stool sent for SSYC in roto virus, positive grossly bloody stools. Then the next note at 2200, continues to have grossly bloody stools.

And then the next entry at 0400, 11-15-92, no stools so far.

Q. No stools?

A, No stools. Yes.

Q. Okay. Are you aware this newborn also had positive guaiac at University Hospitals?

A. I wasn't aware of that, but it wouldn't surprise me if the stools were bloody.

Q. Did Mr. Jeffers tell you anything about what happened to the cord blood in this

case?

A. I believe it was sent to the laboratory to be held in a cooler for three days.

Q. How did you find that out?

A. He told me.

Q. When you say to be held in a cooler for three days -- when did he tell you that, today?

A. Yesterday, perhaps.

Q. Did he tell you that I might be asking you about the fact it was refrigerated?

A. Yes.

Q. Given the fact that this patient was transferred to University Hospitals as a high risk patient, wouldn't it have been appropriate to analyze that cord blood?

A. I believe that the purpose for holding cord blood, at least at Children's Hospital, if we are sent it from the outlying hospital, you have to remember that no babies are born at Children's, they are always sent in from the outside birth, so the cord blood is held elsewhere. The reason for holding that blood is usually for Rh typing, programs for culture. And I see no reason why this child's blood should

have been saved or analyzed at birth.

Q. Well, everything I read in terms of metabolic acidosis, and sometimes I don't read things too accurately because I try to put my own spin on them, but everything I read tells me what you really want to do is have the cord blood pH'd because that is the most accurate assessment of metabolic acidosis of the newborn, isn't that correct?

A. It's correct that is the most adequate assessment. But it's not correct every child should have an ABG on cord blood.

Q. Right. But this child at 1:10 p.m. was assessed as a newborn who had fetal distress, are you aware of that?

A. Yes, I am.

Q. So wouldn't it be nice for the doctors who you say were struggling with what the cause was of this seizure activity, wouldn't it be nice for them to know whether or not the cord blood was in fact below 7.0?

MR. JEFFERS: Object.

A. It theoretically would have been wonderful for this lawsuit. But given the fact the child had Apgars of 6 at 1 minute and 8 at 5

minutes is absolutely no reason for cord blood to have been analyzed.

Q. You and I know Apgar scores are entirely subjective, aren't they?

A. Yes.

Q. So the only scientific demonstration of metabolic acidosis would have been the cord blood?

A. That's correct. But it's simply not a standard of care for cord blood to have studies done when the Apgars are 6 and 8.

Q. Right, I understand that. Except that is assuming that the person who records the Apgars is recording them accurately, is that correct?

A. That's correct.

Q. We also know that the more accurate assessment of Apgar scores in determining whether or not this is any neurologic issue would be the ten-minute and 20-minute Apgar score, isn't that right?

A. That is not true.

Q. You are familiar with ten- and 20-minute recordings, aren't you?

A. Absolutely. When the five-minute

Apgar score is low you are obliged to do ten. If the ten is low you are obliged to do 15, and if the 15-minute is low you are obliged to do a 20. When the five-minute Apgar score is normal as it was in this case you're under no obligation to continue performing Apgar scores.

Q. That is assuming that in the face of the bruises on this child's face, in the face of the notation of fetal distress, in the face of the meconium, that Dr. Siew or staff at Elyria Memorial Hospital did not engage in a self-serving rendition of the Apgar scores, isn't that right?

MS. SCHOENLING: Objection.

MR. JEFFERS: Objection.

A. I have no opinion on that. That never occurred to me.

Q. It never occurred to you that a physician or a nurse could create an Apgar score?

MR. JEFFERS: Objection. This is so far out, you know, this is bad of you.

MR. NOVAK: Bad of me?

MR. JEFFERS: It really is.

MR. NOVAK: Do you want to take me

out back and spank me or something?

THE WITNESS: We have a spanking room downstairs, actually.

MS. S~HOENLING:I was hearing conversation by Bill yesterday about morality. He was preaching to me.

MR. NOVAK: I obviously was not preaching to the choir, was I?

MS. SCHOENLING: I am not sure what the obviousness of this is.

Q. I guess what is concerning to me, Doctor, is that there are reports from Drs. Johnston and Donn and yourself and Dr. O'Grady and Dr. Todia and they talk about metabolic acidosis. But the fact of the matter is that the only true indicator as to whether you have it or not would have been the cord blood which the hospital did not analyze, is that right?

A. The hospital did not analyze this, nor were they obliged to.

Q. I understand. But that was the true indicator of metabolic acidosis, wasn't it?

A. That is true. Had it been measured we would not be sitting here.

Q. And this hospital somehow disposed of

70

it, didn't they?

A. No, they kept it for three days.

Q. And then disposed of it?

A. That was the, apparently as it is in most hospitals, the policy.

Q. You say in your report the doctors at University Hospitals were struggling with whether or not this was from an infection, whether or not this was from beta antagonists, whether or not it was from hypoxic ischemic encephalopathy, is that right?

A. They never assumed it was from hypoxic ischemic encephalopathy.

Q. They never assumed that this newborn's neurologic manifestations at University Hospitals were secondary to hypoxic ischemic encephalopathy, is that what you are telling me?

A. What I am telling you is that the people asked to come in and give opinions about what the cause were, child neurologists, have never been of that opinion.

Q. By the way, you're familiar with the cord blood reporting are you not that was taken at Elyria Memorial Hospital, not cord blood, but blood gas at 1359 hours?

A. Yes.
Q. It was 7.21, was it not?
A. 7.21 on 11-11-92.
Q. And 7.21 is acidotic, is it not?
A. Yes.
Q. By the time that recording was done this patient was receiving 02, isn't that correct?
A. That's correct.
Q. 02 is given to reverse acidosis, isn't it?
A. It was being given to reduce respiratory acidosis.
Q. Right. But if you have metabolic acidosis it would help reverse it, wouldn't it?
A. Yes, to a certain extent.
Q. I have a couple questions to ask you about your report.
A. Certainly.
Q. Did you get a letter from Mr. Jeffers outlining this case?
A. I received a cover letter with the material sent to me.
Q. Could I see it?
MR. NOVAK: May I, John?

MR. JEFFERS: Sure.

MR. NOVAK: I was just curious if there were interesting spins.

MR. JEFFERS: No, I didn't even write it.

Q. You know what, I am going to take a look at your whole file before we are done.

A. Sure.

MR. JEFFERS: What is the date on that?

THE WITNESS: That is not the first one. The first one was in January. Here it is.

Q. This is a note in here that says there seemed to be some questionable genetic factors related to this child. It's signed by JoEllen Leach. Did she tell you what she felt were the questionable genetic factors?

A. Yes, the extra digit.

Q. Are you aware today that there was no extra digit?

A. Yes.

Q. Kind of a red herring.

A. Yes? Like others.

THE WITNESS: There were several red herrings. That was a pink herring.

Q. By the way, you did see the photographs of the child, as well?
A. Yes.
Q. You would agree with me that the picture as presented by this child today is a pretty catastrophic one?
A. Yes.
Q. Thankyou.
A. You are welcome.
Q. Let's look at your report. You say here that this report reviews the facts of this case and my opinion on probable cause, is that right?
A. Yes.
Q. Okay. Now at the time that you wrote this report, did you have available to you the three articles which you gave us today on intrapartum asphyxia and cerebral palsy?
A. Yes.
Q. And the Perlman article and the other Karin Nelson article?
A. Yes.
Can I take a break?
MR. NOVAK: Sure.
(Recess.)

Q. What is Synapse Consultation, P.C.?
A. That is the name for what I am. I do my neurology through it. I bill whatever medicolegal I do through Synapse using my federal ID number and in any consultation work I do on community health or ISO 9000 or utilization management, I bill all through Synapse.
Q. This is all through your home address?
A. Uh-huh.
Q. You don't have an office per se?
A. I have clinical offices --
Q. At each of those clinics?
A. Yes. Then I have my business office here at home.
Q. But in terms of having an office where you actually pay rent for an office space, you don't have that?
A. I do down here in Golden at the Health First office, I pay rent for that practice site.
Q. Okay.
A. But the reason for using this as my business site is that I actually do all the prework on all my patient care here preparing the

charts. There is just no reason for the correspondence to go to that office.

Q. During the course of let's say the last year, 1998, what percentage of income did you derive from medical/legal versus your other work?

A. 30 percent medical/legal, 70 percent everything else.

Q. I want to get back to the initial newborn profile at Elyria Memorial Hospital.

A. Okay.

Q. You are aware of the note of fetal distress number [redacted] and meconium fluid number 2, is that right?

A. Yes.

Q. Is there a reason why you didn't put the fetal distress or mention it in paragraph 2 of your report, although you did mention the meconium stain.

A. No.

Q. Obviously someone at Elyria Memorial felt that the fetal distress was significant enough to write it down. Is there a reason, then, why you didn't pick that up and put that in there?

A. If the Apgar scores were abnormal I would have included it.

Q. Okay. I will get to the next paragraph. We have already agreed that Apgar scores are subjective, is that right?

A. Yes.

Q. And so were you stating improvement in Apgar scores from 1 to 5 minutes is not suggestive of intrapartum hypoxic ischemic injury, that is based on the assumption that the Apgar scores that are recorded for this infant at about 1:10 p.m. to 1:30 p.m. are in fact accurate, isn't that right?

A. No, that is not true. That is just one of the reasons that I feel that this was not HIE.

Q. I understand. But this one reason is based on the assumption that the Apgar scores that were recorded were in fact accurate?

A. That's correct.

Q. Okay.

MR. JEFFERS: Now we have said that I think 13 times.

MR. NOVAK: I think 15 times.

THE WITNESS: No, I think it was only

ten, actually.

MR. NOVAK: I saw the Big Labosky 45 times; I am going to watch it another time.

MR. JEFFERS: You will probably miss your plane.

MR. NOVAK: Because I am the dude.

MR. JEFFERS: I don't care.

MR. NOVAK: The dudarino.

MS. SCHOENLING: That is really what this is all about.

Q. Then we go to the next paragraph where you talk about the arterial blood gasses being never in the range associated with hypoxic ischemic injury, but the fact of the matter is that the literature in general talks about metabolic acidosis as being related to cord blood, isn't that right?

A. That's correct.

Q. Although arterial blood gasses are helpful, it's kind of nice to have the cord blood recording as well, isn't it?

MS. SCHOENLING: Objection.

MR. JEFFERS: Object. Object to the commentary. Is that a question?

MR. NOVAK: It's kind of nice.

78

MR. JEFFERS: You already asked it.
MR. NOVAK: I did, and I think he agrees. Okay.
THE WITNESS: Previously answered, not necessarily the way you thought I did.
Q. You said this is no evidence of multi-organ hypoxic ischemic injury, same paragraph?
MS. SCHOENLING: Fourth paragraph.
Q. But we went through this patient's chart and we did see bloody stools, did we not?
A. Yes.
Q. And we did see an elevated serum creatinine, did we not?
A. Yes.
Q. We also saw neurologic manifestations, did we not?
A. We saw a seizure.
Q. Well, there was also seizure activity at University Hospitals, wasn't there?
A. That's correct.
Q. It was recorded on EEGs, was it not?
A. That's correct.
Q. The next paragraph says --
A. However, we did not, we did not see

evidence of multi-organ hypoxic ischemic injury. That statement is still true.

Q. Whatever. The next paragraph is Jasmine's initial child neurologic exam performed 11-12-92 revealed head circumference of 32 centimeters.

I am going to show you a recording on 11-12-92, and it's different than --

A. 33.5.

Q. Yes.

A. Yes.

Q. You are also aware that the Elyria Memorial Hospital chart has a recording on this child as being appropriate for gestational age at 32.5, aren't you; you are aware of that?

A. I did not have that sheet in my file. I would love to see it.

Q. Did Mr. Jeffers kind of like pull that sheet out before he sent it to you, is that what he did?

MR. JEFFERS: You know what, Bill, your suggestions are really bad again. That is all I am going to say. You don't care what the hell you are saying.

Q. I guess my question, let me ask it,

80

Doctor. Did Mr. Jeffers send you this sheet?

MS. SCHOENLING: Can I see that when you are done?

A. Yes. Yes, he did. I don't know where it is in my file. I have seen this before.

Q. And it does indicate that that newborn is appropriate for gestational age, isn't that correct?

A. In the 25th percentile, yes.

Q. In fact, appropriate for gestational age is anywhere between, what, the 10th and 90th percentile?

A. That's correct.

Q. That is the Lubchenko chart which a lot of hospitals use?

A. Yes.

Q. Also, at 4:15 there was an additional exam at University Hospitals which you don't mention in your report which was an SAR admit note?

A. That's correct.

Q. Did you see in that admit note where there was lethargy and hypotonia?

A. Yes.

Q. Would you agree with me lethargy and hypotonia are neurologic manifestations of hypoxic ischemic encephalopathy?

A. They can be.

Q. But you did not mention those in your report, did you?

MS. SCHOENLING: Objection to the question.

Q. Now --

A. Just a moment, I haven't answered the question. The transport note indicated the child was moving all extremities with good suck, positive Moro without focal deficits.

The SAR note noted symmetrical posture, lethargy, hypotonia, equal movements of all extremities, cranial nerves grossly intact.

Q. My question simply was lethargy and hypotonia can be clinical manifestations of hypoxic ischemic encephalopathy, isn't that correct?

A. They can be, yes.

Q. You go on to say Jasmine was born significantly anemic, but her anemia, we know --

MR. JEFFERS: What we are referring to is the head size graph. It's right here, in

the materials.

MR. NOVAK: Mr. Jeffers, I would never accuse you of skulduggery.

MR. JEFFERS: I would hope not.

MR. NOVAK: Because you are a gentleman and a scholar.

MR. JEFFERS: You know what? Finally you spoke the truth. Except maybe not so scholarly.

Q. In the first full paragraph you write that Jasmine was born significantly anemic, a finding not suggestive of acute hypoxia or ischemia.

You would agree with me, however, the anemia could be related to the bloody stool she was having?

A. The anemia was present prior to the diagnosis of bloody stools by two days.

Q. Right. One day. Twodays?

A. Twodays.

Q. But there was a positive guaiac on the 12th?

A. I don't know that.

Q. It says Jasmine's treating physicians had great difficulty treating seizures, you go on

to talk about that.

Then you say seizures due to peripartum asphyxia most commonly begin during the first 72 hours of life.

Seizures did begin during the first 72 hours of life, did they not?

MR. JEFFERS: This is a comma after that.

MR. NOVAK: I will finish.

A. Yes.

Q. But metabolic infection, we don't have that here, do we?

MR. JEFFERS: It's metabolic, comma, infection --

Q. Is there supposed to be another word following metabolic?

A. No.

Q. Is there any infection in this case?

A. Not proven.

Q. Was there any trauma?

A. Not --

Q. Was there any proven remote hypoxic ischemic injury?

A. No.

Q. Were there any cerebral

malformations?

A. No, not diagnosed.

Q. Were there any placental issues?

A. Not diagnosed.

Q. The reason there weren't any, because for some reason Dr. Siew and the hospital decided not to do an analysis of the placenta, is that right?

MR. JEFFERS: Objection. You know damn well the hospital doesn't --

MR. NOVAK: John, don't cuss during the deposition, please.

MR. JEFFERS: Well, you do.

MR. NOVAK: No, I don't.

MR. JEFFERS: in past depositions.

MR. NOVAK: I have used "hogwash" and "horse apples", but never "damn."

MR. JEFFERS: Whatever. I am sorry I offended your sensitivities, whatever that might mean.

A. I believe the placenta was not examined in this case.

Q. If this is an instance of fetal distress, let me ask you from the standpoint of a physician who works in a teaching hospital who

sees on occasion patients who arrive in a nursery as a result of fetal distress. Do you know how it comes about that the placenta is sent to pathology, who makes the decision?

MR. JEFFERS: Objection.

A. I don't know that. However, I know that it -- when I am reviewing a clinical case and trying to figure out what happened to the child, if the child had evidence of peripartum asphyxia as evidenced by low Apgar, persistent low Apgar scores, evidence of HIE on the clinical exam, it is always useful to look retrospectively at the placenta. There not being any of those signs in this child, it was probably not thought of as being appropriate to save the placenta.

Q. Are you familiar with a corporation called Placental Evaluations, Inc.?

A. No.

Q. Are you familiar with any corporations on the West Coast or in the central region of the country where you are located where hospitals will, when they think there may be a risk problem, send the placentas out to a private corporation to be analyzed for risk analysis and then have the placental analysis sent back to the

risk manager of the hospital? Are you familiar with that at all?

MR. JEFFERS: Objection. That depends on who is ordering it to be done.

A. We have a placental registry here in Colorado.

Q. Did Mr. Jeffers at any time tell you that this placenta was sent to Placental Evaluations, Inc., by Eiyria Memorial Hospital, given that this corporation is located in Toledo in close proximity to Elyria?

A. No.

Q. You say that Jasmine's treating physicians did not assume that her intractable seizures were due to hypoxic ischemic injury. I guess my question, I want to kind of look at a couple of these here.

In the first neurologic exam didn't the physician say the infant may have suffered from asphyxia although Apgar scores were fairly good, this is the most likely cause?

MR. JEFFERS: We are reading from which one now, University --

MR. NOVAK: , First neurologic exam.

A. That exam was --

MR. JEFFERS: That was on the 12th, wasn't it?

MR. NOVAK: On the 12th.

A. Not a neurologic exam, that was the NICU exam. Written by Troy Dominguez.

Q. So when you refer to a neurologic exam on 11-12-92 on page 1, your description as a neurologic exam is incorrect, isn't it?

A. The neurologic exam on 11-12 that I am referring to is the exam by the child neurologist.

Q. Yes, but the neurologic exam that has the 32 centimeter measurement is the one done by Troy Dominguez?

A. No, the one done by the child neurologist.

Q. I am looking at --

A. Next page. Next page.

Q. Hold on. Here it is. HC 32, Troy Dominguez' exam.

A. Right. But this is also a child neurology exam several pages back.

Q. Here is a neurology exam. And this one, that is the --

MR. JEFFERS: Why don't you give --

Q. Can you find where it was?
A. It says child neurology.
Q. Neuroconsult?
A. That's it.
Q. Would you agree with me that a true knot in the cord can cause cord compression and can lead to perinatal asphyxia?
A. Yes.
Q. We do know that this infant had a cord that had a knot?
A. Yes.
Q. At various stages it was recorded as having a true knot?
A. Yes.
Q. Would you also agree with me that cord compression can produce elevated fetal heart recordings?
A. Yes.
Q. I want to get to this thing about the head circumference and your opinion that you say that at birth it was at or below the third percentile indicating congenital microcephaly, do you see that there?
A. Yes.
Q. That ultimately becomes your final

conclusion in the case, doesn't it?
A. It's one of the pillars of my opinion.
Q. Right.
Q. With respect to one of those pillars you took the 32 centimeter recording even though at the same time there was a recording done of 33.2, is that right?
A. That's correct.
Q. And another of 32.5, right?
A. Correct.
Q. Now the 32.5 was at Elyria Memorial. You have already testified that this recording was appropriate for gestational age, was it not?
A. That's correct.
Q. That would not be indicative, would it, of congenital microcephaly?
A. Only as a relative term.
Q. And then, by the way, are you aware this child had two nucleated red blood cells as recorded at University Hospitals?
A. In what specimen? I mean two nucleated red blood cells --
Q. An erythrocyte profile was done on 11-12 and 11-13. Were you aware of that?

90

A. No.
Q. That there were two nucleated red blood cells?
A. No.
Q. Are you familiar with the studies done on the number of nucleated red blood cells and the number as being related to when an asphyxia event takes place?
A. I am very much of aware of that research. I am also aware that the researcher who reported that has now been discredited and is no longer being asked to do that sort of work.
Q. Do you know who that researcher is?
A. Naeye.
Q. N-A-E-Y-E?
A. Yes.
Q. The head circumference charts at University Hospitals, you have seen those, I am sure. This is one --
A. Yes.
Q. Okay. The one at birth on the chart that I am looking at now is within normal limits, is it not?
A. Yes.
Q. Okay.

A. With the plot of the head being at --
Q. 33 -- that is the weight.
MR. JEFFERS: Do you want --
THE WITNESS: Right. This one is plotted at 33.3, rather than at the 32, which two of the examiners measured it at.
Q. Okay. And then this is --
A. Which by the way is, in retrospect makes absolutely no difference, as we will see. We can plot them anywhere you want.
Q. Then this is a head circumference at three months that is recorded on the chart.
A. That is actually a length and weight there. There you go.
Q. Of 40.
A. Yes.
Q. That is above the 50 percentile, isn't it?
A. That is the point.
Q. Wait a minute now.
A. That is the point.
Q. Then--
MR. JEFFERS: What month was that?
THE WITNESS: Actually, I have them all plotted out for the first many months.

Q. I know you do, I saw them. I did my own plot. It's a little different than yours. Then this is one reported at nine months that is just a hair below the 50th percentile, is it not?

A. That's correct.

Q. Now would it be fair to state that each one of those in and of themselves do not indicate congenital microcephaly?

A. The grouping of head circumference that were noted during the first day or two of birth of 32.5, 33.2, 32 and 32 are almost, well are either at or just above the third percentile for the patient's age.

Q. What about the Lubchenko chart at Elyria Memorial Hospital, are you telling me they didn't know what they were measuring there?

A. The only thing that can be said about the Lubchenko charting at Elyria was the head circumference was on a lower percentile than either weight or length. And because the head size was measured at a lower level the next day, that may or may not have been an accurate head circumference.

Q. Except that the growth record at University Hospitals as recorded for birth has

the head circumference, the length and weight virtually in the same percentile grouping, don't they?

A. But they had the head circumference plotted at 33.2 centimeters rather than 32. If they had plotted it at 32 it would have been on the third percentile.

Q. So what you want to do to make your theory work is to discard the 33.2 and 32.5, is that right?

A. No, not at all true. I will allow you any of those measurements. The child had a low-normal or absolutely no head circumference at birth. It makes absolutely no difference whether it was low-normal or low.

The point of how we interpret the head size at birth relates only to what then happened after birth.

Q. But we all know that as this child progressed, the brain gets necrosis and it shrinks, doesn't it?

A. The brain gets necrosis and doesn't grow.

Q. It doesn't grow in proportion *to* the rest of the body?

A. No, it doesn't.
Q. That is why your plotting is recorded the way it is?
A. That's correct.
Q. And you can have lack of brain growth from hypoxic ischemic encephalopathy, can't you?
A. Absolutely. And there was no absence of growth in this child's brain. This child's brain continued to grow at or above the percentiles that were present at birth, whereas in virtually every child with significant hypoxic ischemic injury at birth the head stops growing for a period of time and then grows at a lower percentile than it was at the time of birth, every single time.
Q. But that is what your chart indicates, doesn't it?
A. Absolutely not.
Q. If I were to draw dots on your chart, that is what would occur, wouldn't it?
A. No. Not at all. The child's head grew normally to, at an advanced rate for the first five months.
Q. Then what happened?
A. Then the, then for as yet unexplained

reasons the head stopped growing at about seven or eight months for about four months as if an injury occurred at six or seven months.

Q. You know, Doctor, I reported at about 25 months a 47-centimeter circumference and then I reported at 30 months a 46-centimeter circumference. And I guess the bottom line is doesn't it all depend who is doing the measurement? I mean, you and I could go in and try a pair of pants on, and depending where the guy puts the tape measure on us is going to depend on how we get our suit fit.

A. All I can say is, if that is what you are assuming, then we are going to have a very interesting time in court with the jury.

Q. Well, I guess when I blow these charts up and make them ten-by-ten they are going to be really interesting, because the fact of the matter is that the three graphic charts in University Hospitals all have the head circumference within normal limits, don't they?

A. Yes. When we show the other measurements and show the plot over time you are going to wish you stopped.

Q. Oh, God, Doctor, I am shaking in my

boots, believe me. But let me ask you this question. Let me ask you this: Are you telling me that the 33.2 was an inaccurate measurement?

A. It may have been.

Q. Are you telling me the 32.5 at Elyria Memorial was an inaccurate measurement?

A. May have been. Doesn't make any difference. The child's head circumference continued to grow above the rate it grew in utero after birth for nine months.

Q. Your statement says the head circumference at birth was at or below the third percentile indicating congenital microcephaly.

My question for you is, we have two measurements at birth which have this child appropriate for gestational age, don't we?

MS. SCHOENLING: Objection.

A. Yes. I will yield that this may have been a typo, because clearly the head circumference was at or slightly above the third percentile, indicating relative congenital microcephaly.

Q. Would you agree with me the word "typo" means a misspelling? This is an

inaccurate statement, isn't it?

A. Yes, it is.

Q. Let's go down to the next paragraph.

A. Let's stay with the paragraph that we were just talking about first.

Q. I am kind of asking the questions.

MR. JEFFERS: But he hasn't finished his answer.

MR. NOVAK: What was the question? I asked him if it was an inaccurate statement. He said yes, it was.

MR. JEFFERS: He continued on to describe it. He is going to finish his sentence.

Q. Goahead.

A. The child's head circumference subsequently grew at or above the third percentile for at least the next four months. Had any kind of brain damage occurred at the time of birth, head growth would have plateaued, followed by growth on lower percentiles. This did not happen in this child. Had it occurred I wouldn't be sitting on this side of the table.

Q. But that is based on the recordings

you did on the measurements of the head circumference, right?

A. It's based on a plotting of all of the various recordings of head circumference from the chart.

Q. You didn't miss any, did you? You plotted every one out?

A. I hope I did.

Q. I want to know under oath today did you plot every head circumference noted in every document Mr. Jeffers sent you so when we blow that thing up for the jury that is going to be one hundred percent accurate, is that what you did?

A. I am going to take a moment to be sure that that is what I did.

(Pause.)

THE WITNESS: I did not plot the October 15th, 1993 head circumference of 34 centimeters.

Q. Okay.

A. Because I believe it was miswritten. It should have been written 44 centimeters. This is no way it could have been 34 centimeters at ten months.

Q. You know --
A. But I will certainly plot it now.
Q. That takes your chart a little out of whack, doesn't it?
A. Certainly does.
Q. Let me ask you, Doctor, you said --
A. I believe that I have plotted every head circumference that is available on the chart except for the October 15, 1993 head circumference of 34 centimeters which is impossible.
Q. Did you plot the 33.2 that was recorded?
A. Yes.
Q. Did you plot the 32.5?
A. Yes.
Q. Did you plot the 46 at 30 months?
A. I don't have that one.
Q. Did you plot the --
A. Wait a minute. Let me do it now. 46 at 30 months?
Q. Yes.
MR. JEFFERS: Where do you have that, Bill, do you have it right in front of you?
MR. NOVAK: I did this on my own

extrapolations.

THE WITNESS: Okay.

Q. Did you plot at 25 months the 47?

A. No.

Q. So --

A. But I have now.

MR. JEFFERS: What is that last one?

MR. NOVAK: 47 at 24 months. 25 months.

Q. So today you have made it as complete as we think it can be, right?

A. I think so.

Q. Now you say that the cause of her brain condition has never been determined.

A. That's correct.

Q. I am going to ask you how do you reconcile that statement with the analysis we have already been through? You would agree we don't know if it was placental, right?

A. That's correct.

Q. We don't know if it was maternal, right? Is there anything maternal that could have caused this?

A. We don't know.

Q. Diabetes?

A. There were no high risk --
Q. Maternal indicators?
A. Maternal indicators that would indicate this was a high risk pregnancy or high risk labor.
Q. How do you reconcile that statement --
MS. SCHOENLING: Which statement?
Q. That it's never been determined, with the records of the Cleveland Clinic where they say etiology perinatal asphyxia?
A. That I believe is an EEG report.
Q. Would you agree it says etiology, perinatal asphyxia?
A. That is a clerical entry based on whoever phoned in the report.
MR. JEFFERS: What date was that?
MR. NOVAK: March 31st, 1994.
Q. Doctor, you would agree with me you don't know if it was a clerical entry?
A. I have done and performed and read so many EEGs to know exactly how that is recorded and it's done by the phone, as for the existing complaint, as since it was the mother that set up that appointment she probably was asked what the

indication was.

Q. Do you think that this mother knows what the word "etiology" is? Do you know that?

A. I am sure that she knows what the word "reason" means.

Q. Or cause, right?

A. Or cause.

Q. It says perinatal complications. You would agree with me the words "hypoxia" and "asphyxia" and "hypoxemia" all have different meanings, don't they?

A. Yes.

Q. The word "asphyxia" has a specific meaning, doesn't it?

A. Yes, it does.

Q. Now on page 5 of that very same report of the clinic it says perinatal complications asphyxia. Now your statement that the cause has never been determined is not consistent with that statement, is it?

A. Well, again, it's a clerical entry. It has nothing to do with a physician's impression.

Q. As far as you know?

A. As far as I know.

Q. It says --
A. There had been no child neurologist that ever stated this was perinatal asphyxia or hypoxic ischemic encephalopathy. As a matter of fact, every child neurologist that has reviewed the case has said the opposite or not made an opinion.
Q. Who were those?
MS. SCHOENLING: Except for Howard Tucker, of course.
Q. Who were those?
A. David Rothner did not offer an opinion as to cause.
Q. Did not offer?
A. Was not asked. The two child neurologists who saw the child during the hospitalization in November of 1992 and in January 1993 both stated in their reports that it could not be hypoxic ischemic encephalopathy or asphyxia.
Q. Do you know anything about Dr. Hotwitz?
A. I don't know who Dr. Hotwitz is.
Q. He is the pediatric neurologist you are talking about who was Dr. Wiznitzer's

superior at the time those records would have been documented in 1992, do you know that?

A. I don't know anything about that.

Q. He has since retired from the University Hospitals. But do you know what his leanings have been historically regarding issues of birth related brain damage?

A. No.

Q. Now you say a rare cause of neonatal encephalopathy is likely to have caused the disability. We already indicated that we can't document a placental cause, we don't have any maternal causes. What is this rare cause?

A. Well, every year at the Child Neurology Society meetings a new cause for neonatal encephalopathy is commented upon. I can't remember a year when we haven't had that.

For example, five years ago Darrell DeVivo reported on a disorder that did not allow glucose to be metabolized normally in the brain, whereas it did allow for glucose to be metabolized everywhere else. That had never been reported before.

There are metabolic disturbances that are only now being elucidated that someday we

will have answers for all neonatal disasters.

Q. When you say it's a rare cause, as you sit here today you don't know or have a cause, do you?

A. No. And as has been pointed out by virtually every authority on neonatal neurology, only 20 percent of children with cerebral palsy today can have that cause be blamed on perinatal factors. And of the causes of birth asphyxia, 20 to 30 percent are completely unknown.

Q. Dr. Johnston has on occasion testified for the defense in cases providing testimony very similar to what you said regarding the statistics on cerebral palsy. In those cases juries have come back with verdicts in excess of $2 million. Does that surprise you?

MR. JEFFERS: Objection.

MS. SCHOENLING: Objection.

MR. JEFFERS: 'That again is inappropriate questioning. I don't know why you keep this stuff up.

Go ahead. It doesn't matter whether it surprises you or not, it's a totally irrelevant question, an improper question. In fact, an idiotic question.

MS. SCHOENLING: Note my joining in Mr. Jeffers' objection.

MR. NOVAK: I never make personal attacks on you.

MR. JEFFERS: Oh, today I heard three or four of them. Pretty cruel.

A. I was not aware of that situation.

Q. Let me ask you, in looking at Dr. Todia's report who is going to be deposed on Friday.

A. Yes.

Q. You said the following?

MR. JEFFERS: Let him get the report. Do you have it?

A. I have got his report opinion notes, I have got it.

Q. He says: It should be noted in making a diagnosis of intrapartum asphyxia causes a neonatal neurologic deficit requires all the following:

1. Profound umbilical acidosis.

Well, we couldn't have profound umbilical acidosis in this case because the cord blood was gone, is that right?

A. That's correct. We couldn't have it

either because the Apgars were 6 and 8.

Q. I will get to that.

2. Persistance of an Apgar score of 0 to 3 for longer than five minutes, except we don't have any scores recorded longer than five minutes, do we?

A. Right. Because we had an attainment of 8 at five minutes so there would be no way to have a 0 to 3 beyond that.

Q. You and I at least both agreed on one thing today, that is that Apgar scores are subjective?

A. Just as this deposition is.

Q. Now he also says: 3. Neonatal neurologic sequelae. We have already gone through this, and we have indicated, have we not, that this infant did have at University Hospitals hypotonia, isn't that correct?

A. He had one notation of hypotonia on one time.

Q. He had a notation of lethargy, is that right?

A. On one occasion.

Q. Had issues relating to his gaze, sight?

A. On one occasion.
Q. And seizure activity throughout?
A. That's correct.
Q. You would agree with me that those are neurologic sequelae?
A. There are neurologic sequelae of many different types of neurologic embarrassment. One rarer cause in this case would be proposed HIE.
Q. Then he says multi-organ symptom dysfunction. We had tachycardia as recorded in cardiovascular studies at University Hospitals, didn't we?
A. In an anemic child.
Q. You could also have tachycardia in a child who has had a hypoxic ischemic event, isn't that correct?
A. Possibly.
Q. Gastrointestinally he says, we know we had bloody stools, is that right?
A. On two occasions.
Q. Pulmonary, the child did have mild respiratory distress on its transfer to UH, didn't it?
A. That's correct.
Q. Then renal, we had an elevated serum

creatinine, did we not?
A. On one occasion.
Q. 'Then Dr. Donn, he doesn't say anything about congenital microcephaly in his report. You have observed that, didn't you?
A. Yes.
Q. So did that trouble you, that Mr. Jeffers is using Dr. Johnston and Dr. Donn as experts who may not necessarily agree that this child had congenital microcephaly?
A. I am not sure that they plotted the head circumferences and, therefore, may not be aware of the fact that this child's head circumferences were low at birth and became improved after birth.
Q. Except there was no indication in Dr. Donn's report of congenital microcephaly, was there?
A. That's correct.
Q. Then he lists on page 2 some numbers. He says that there is no evidence of any significant fetal distress leading to neonatal depression, except we saw the neonatal transfer form which listed one fetal distress and two meconium stains, didn't we?

A. I believe Dr. Donn was also privy to the neonatal heart rate monitoring strips and the nurses' notes from this patient and, therefore, formed his own opinion as to whether there was fetal distress.

Q. He says there should have been profound metabolic acidosis. Once again, we have the problem where we don't have this cord blood, right?

A. Right.

Q. Okay.

A. He also said normal Apgars.

Q. But --

A. No multi-organ involvement, no HIE.

Q. Right.

A. In addition he also said no neuroimaging evidence of edema or damage.

Q. You know, I guess I am having a little trouble. First off you are not a neuroradiologist, right?

A. Correct.

Q. That is a real highly technical specialty which requires a lot of training, doesn't it?

A. That's correct. But I think, didn't

you ask me earlier whether or not when I was training the residents whether or not I reviewed films with them? And I said I did.

Q. Right. But in terms of reviewing films as a neuroradiologist can, they are on a different level, aren't they?

A. Yes.

Q. That is what they get trained for?

A. That is true.

Q. The thing that I am having trouble with is, if there was some injury or insult that antedated labor and delivery, then why is it that we have a normal CT scan and normal MRI that is recorded in January of '93?

A. Right.

Q. Why is that?

A. Well, could it be that this child had a difference in brain development rather than an injury, and perhaps the problem in this baby lies at the microcellular level that would never show up on a CT or MRI scan until years and years and years of intractable seizures.

Q. Except it didn't take years and years, it took eight months, didn't it, for an MRI to come back demonstrating an abnormal MRI in

August of '93?

MR. JEFFERS: Can you just give him the date?

MR. NOVAK: I believe it is '93. It indicates myelination of the white matter. Here it is, August 9th, '93.

Q. I am sorry. Demonstrates diffuse atrophy. Do you see it there, delayed myelination?

A. Yes.

Q. Okay.

A. After nine months of continuous seizures.

Q. Nine months. I guess the thing that troubles me is, can't you have an MRI like this as being related to hypoxic ischemic encephalopathy?

A. Certainly, if earlier scans prior to nine months of nearly continuous seizing had also demonstrated earlier evidence of injury and if the head size had slowed its growth because of this purported serious injury, which did not happen in this case.

Q. We do know there was something going on with this infant during labor and delivery

because the fetal heart rate was elevated, wasn't it?

A. I don't recall.

Q. The fetal heart rate was elevated. I think we all agree on that.

MR. JEFFERS: You can say it. I am not agreeing.

Q. There was a true knot in the cord, wasn't there?

A. There was a knot in the cord, apparently loose at the time of birth but may have been tighter at other times.

Q. What happens with a true knot is, at various stages during labor the knot can get tight and loosen up and tight and loosen up based on the contractions, right?

A. Yes.

Q. Last two questions I am going to ask you; I will get out of your hair.

A. Okay.

Q. The basis of your opinion. These articles, right?

A. Yes.

Q. Your training. And what else?

A. That is it.

Q. So if I study these articles and based on what you have told me so far today, I should have a grasp as to why you are going to testify the way you are that there was some rare cause that precipitated this, right?

MR. JEFFERS: Not necessarily will you be able to mentally come to that conclusion.

MR. NOVAK: I may not, because I am rather dense.

A. That will be the source of my opinion.

Q. Also, your plotting on the chart of the head circumference sizes?

A. Yes.

Q. Is there anything else that you haven't told me that you would like to tell me before we quit?

MR. JEFFERS: Objection. You have to put a specific question.

THE WITNESS: I like that question.

MS. SCHOENLING: Objection.

Q. The reason I ask that question is because in case I miss something in your opinion that you haven't told us somewhere along the line I should know.

MR. JEFFERS: I guess that is your problem for not asking the right question.

But go ahead, if you want to answer that one.

Q. Mr. Jeffers is going to ask you the following question.

MR. JEFFERS: Okay. He will answer your question.

Q. This is the Rule 26 (b)(4)(b) question that would normally be asked: Do you have an opinion as to what the cause was of her disability?

MR. JEFFERS: I thought we discussed that ad nauseam.

A. Like the very thoughtful doctors at the University Hospitals during Jasmine's first year of life, I have no knowledge of what caused her problem.

But what you didn't ask me, which is what I would like to answer, is why you might have asked did the doctors at the University Hospitals take so much time and trouble to be working this child up for rare causes of seizures.

Q. I know the answer to that.

116

A. Yes, I think I do, too.
Q. Okay.
A. And that is that there was no history suggestive of definitive hypoxic ischemic encephalopathy, there was no evidence of injur on the early neuroimaging films and, therefore, the child had a relatively high probability of having an inborn error of metabolism or even a degenerative disease. And a series of metabolic tests were performed. When those tests came back negative, a metabolism consult was then called in.

In addition, the child was given a trial of Pyridoxine. At our hospital if a child has a history of perinatal asphyxia, none of those tests are ever done. They are only done when the cause is unknown.

And so we would have to say that I am no more wise than the good doctors at the University Hospitals. The cause of this child's encephalopathy, which somehow allowed for her head to grow normally for four to nine months, has yet to be elucidated.

MR. JEFFERS: You say you knew the cause, Bill.

MR. NOVAK: I think I do, but I am not going to tell him. I will save that one for trial.

MR. JEFFERS: We would like to know.

MS. SCHOENLING: That is the first time Dr. Novak has been speechless.

MR. NOVAK: I have got to hold something back.

MR. JEFFERS: This is repetition.

Q. One thing that bothers me. In the charts that you got was an infant hearing assessment reporting form. Those forms go to the Ohio Department of Health for purposes of qualifying this child for some state support. And presumably, you don't want to put fraudulent statements on those reports which go to state agencies.

This is a statement that says seizure disorder secondary to birth asphyxia, dated January 13th, 1993.

MR. JEFFERS: Who is it signed by?

Q. Wait. It's signed by Gale Murray, Ph.D., at University Hospitals. It says the above information was obtained from, there is a box crossed off that says medical records.

Now we don't like people to send fraudulent reports to state agencies, do we?

A. No. In fact, it's probably against the law.

Q. Yes.

A. I remember a movie starring Jimmy Stewart, where they were trying to prove the existence of Santa Claus. And they got a number of people to write letters to the U.S. Post Office attesting to the existence of Santa Claus. And when the government then unloaded all those reports or letters to Santa Claus in front of the judge, the judge was forced to admit that there was Santa Claus. That reminds me somehow of this case.

Q. I hate to tell you, you are wrong again. It wasn't Jimmy Stewart, it was William Payne and Maureen O'Hara and Miracle on 34th Street?

A. No, it wasn't.

MR. JEFFERS: It was.

THE WITNESS: You are right. Miracle on 34th Street.

MR. JEFFERS: The principle still applies.

THE WITNESS: If you can prove to a jury that was HIE it will be like a miracle on 34th Street.

Q. I have done it many times.

A. I know you have.

BY MS. SCHOENLING:

Q. Doctor, I represent Dr. Siew, and I just have a very quick set of questions for you.

You have reviewed Dr. Donn's report, yes?

A. Yes.

Q. Dr. O'Grady's report?

A. Yes.

Q. And Dr. Johnston's report, is that correct?

A. Yes.

Q. My question to you is, after reviewing their reports, do you have any fundamental disagreements with anything contained within any of those three reports?

A. No.

Q. As I have listened to your testimony and I have read your report and I have tried to comprehend the opinions that you have offered here today, I want to make sure that my

understanding is correct. And that is, it is my understanding that you have no criticisms of the care and treatment that was rendered by Dr. Siew, that is the obstetrician in this case, is that correct?

A. Let me say that I was not asked to review his care. Whether his care was good, bad or indifferent, it had absolutely no impact on this child's Apgar. Therefore, the question is irrelevant to me.

Q. In follow-up to that then, we are talking about not only his care and treatment during labor and delivery, but I assume you're also talking about his care and treatment during the prenatal care?

A. I would answer the same way.

MS. SCHOENLING: That is all I have. Thank you.

MR. NOVAK: Doctor will send you the bill and you will give me the bill so I can give him a check, right?

MR. JEFFERS: Whatever you like.

MR. NOVAK: I prefer you send it to him. I feel awkward when I get it direct.

MR. JEFFERS: Sure.

THE WITNESS: Wouldn't want that.
THE REPORTER: Read and sign?
(Discussion off the record.)
MR. NOVAK: I would like the reporter to mark the notes Exhibit 1.
MR. JEFFERS: Yes.
MR. NOVAK: He can give the original back to him.
The graph is Exhibit 2. And the photographs, 3.
(Thereupon, Plaintiffs' Deposition Exhibits 1, 2, 3, 4 and 5 were marked for purposes of identification.)
(Recessed at 4:34 p.m.)

SIGNATURE OF WITNESS

The deposition of THOMAS TREVOR REILEY, M.D., taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

It was agreed by and between counsel and the parties that the Deponent will read and sign the transcript of said deposition.

DEPOSITION ERRATA SHEET

RE: MERRIWEATHER -v- ELYRIA MEMORIAL HOSPITAL, et al.

Deponent: THOMAS TREVOR REILEY, M.D.

Deposition Date: September 15, 1999

To the Reporter:

I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.

CERTIFICATE

The State of Colorado,)
SS:
County of Teller.)

I, CRAIG L. KNOWLES, a Notary Public within and for the State of Colorado, duly commissioned and qualified, do hereby certify that the within named witness, THOMAS TREVOR REILEY, M.D., was by me duly sworn to testify to the truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced Witness was by me reduced to stenotype in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that I am not a relative, counsel or attorney for any of the parties or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Teller County, Colorado, this 16th day of September, 1999.

Craig L. Knowles /RRS

Craig L. Knowles, CM
Notary Public within and for
the State of Colorado

My commission expires June 25, 2002