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IN THE COURT OF THE COMMON PLEAS
CUYAHOGA COUNTY, OHIO

GLORIA MASLANKA, Individually
and as Parent and Natural
Guardian of Shane Maslanka,

Plaintiff,

vs.

METROHEALTH MEDICAL CENTER,

Defendant.

No. CV-05-552424
JUDGE McDONNELL

CONTINUED DISCOVERY DEPOSITION of MICHAEL
PARKER SHERMAN, M.D., taken in the above-entitled
case before Tricia L. Gudgel, a Notary Public of
Menard County, acting within and for the County of
Sangamon, State of Illinois, at 10:00 o'clock A.M.,
on September 1, 2006, at 107 East Allen Street,
Springfield, Sangamon County, Illinois, pursuant to
notice.

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I N D E X

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E X H I B I T S

NUMBER	MARKED FOR IDENTIFICATION
(None.)	

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S T I P U L A T I O N

It is stipulated and agreed, by and between the parties hereto, through their attorneys, that the deposition of MICHAEL PARKER SHERMAN, M.D. may be taken for discovery purposes before Tricia L. Gudgel, a Notary Public and Certified Shorthand Reporter upon oral interrogatories, on the 1st of September A.D., 2006, at the instance of the Defendant at the hour of 10:00 o'clock A.M., 107 East Allen Street, Springfield, Sangamon County, Illinois;

That the oral interrogatories and the answers of the witness may be taken down in shorthand by the Reporter and afterwards transcribed;

That all requirements of the Civil Practice Act and the Rules of the Supreme Court as to dedimus, are expressly waived;

That any objections as to competency, materiality or relevancy are hereby reserved, but any objection as to the form of question is waived unless specifically noted;

That the deposition, or any parts thereof may be used for any purpose for which discovery depositions are competent, by any of the parties hereto, without foundation proof;

That any party hereto may be furnished copies of the deposition at his or her own expense.

1 (Whereupon the Deponent was
2 sworn by the Notary Public.)
3 M I C H A E L P A R K E R S H E R M A N, M. D.
4 having been first duly sworn by the Notary Public,
5 deposeth and saith as follows:

6 EXAMINATION

7 BY MS. REID:

8 Q Good morning, Dr. Sherman, how are you?

9 A Fine.

10 Q All right. We are here for your
11 continuation on the deposition on the Maslanka
12 case, and I'm hoping we will not take as long as we
13 did the initial time, all right?

14 A I doubt that will be the case.

15 Q Why is that?

16 A I think you're going to hear some
17 additional testimony today.

18 Q Okay. What makes you say that? Have you
19 reviewed additional information?

20 A No. I just don't think you ever gave me
21 the opportunity to go through the report by
22 Richard Martin and respond to it.

23 Q Oh, okay. All right.

24 Let me take this step-by-step. First of
25 all, you have not reviewed any additional materials

1 since we took your deposition on August 3?

2 A That is not correct.

3 Q That is not correct?

4 A That is not correct.

5 Q All right. What have you reviewed since
6 August 3?

7 A I reviewed -- I was sent the ultrasound
8 images. I think the complete set from the first
9 one to the last one.

10 Q These are the ultrasounds of the brain of
11 Shane Maslanka?

12 A And kidney ultrasounds.

13 Q Okay.

14 A And I was sent four volumes by
15 Mr. Kulwicki of hospital records. We had discussed
16 the nursing notes in my previous testimony, and
17 I've gone through those notes with particular
18 attention to nursing notes during the first days of
19 life and other vital sign records and entries
20 related to the infant's care.

21 Q Okay. Have you received any other
22 additional materials?

23 A I received my deposition.

24 Q Okay. Have you reviewed your deposition?

25 A I have.

1 Q All right. Let me just ask you a couple
2 questions about what you've received. The four
3 volumes of hospital records that you referenced,
4 are those subsequent records regarding
5 Shane Maslanka after his discharge from Metro?

6 A Let me go through them, please.

7 They're in four bound volumes. And the
8 first one has the nursing records, including flow
9 sheets. It starts on the 1st. And I'll see if I
10 can give you the final date, although it's
11 difficult to always identify the timing of the
12 records.

13 I'm towards the end of this and I'm
14 seeing a date of 10-9 towards the end of these
15 records, 10-9-01.

16 And then there's a small section called
17 graphic charts towards the back. So that was the
18 first volume, and the one that I spent the most
19 time reviewing, okay.

20 The second volume has the Cole Eye
21 Institute, it has EEG's and it has office notes
22 from the Cleveland Clinic Foundation. And that's
23 the bulk of those records, are from the Clinic --
24 Clinic -- Cleveland Clinic Foundation, okay.

25 Q Okay.

1 A The third volume is a smaller volume,
2 continuing care records. And this has the Metro
3 Health Center entries, and it has a small section,
4 Cleveland Clinic, okay. But for the most part,
5 this is Metro Health, okay.

6 Q What's the time frame of those -- the
7 Metro records in that volume?

8 A Well some of them are reproductions of
9 items that were in the original medical record,
10 like the eye examinations that were in the record.
11 And then there's -- I'm just quickly leafing
12 through it but there's 4-25, 2002, there is a
13 6-20, 2002, a 7-16, 2004, etc., okay.

14 Q Okay.

15 A And then the final volume, I think
16 they're a little bit out of order because I
17 reordered them for the depo according to
18 importance. This one -- the final volume is quite
19 extensive, and I'll go through the dates.

20 It has a surgery record for 1-23-02. It
21 has an ER record for 5-27-03. It has records from
22 6-6 to 6-7, 2002. It has records from 7-10 to
23 7-14, 2003. It has records from 7-10 to 8-2,
24 2003.

25 It has records from 9-17 to 9-21, 2003.

1 It has an ER record from 9-29, 2003. It has
2 records from 2-5 to 2-10, 2004. It has records
3 from 3-15-03 to 3-18-04. It has records from 5-5
4 to 5-11, 2004.

5 It has records from 8 -- I mean, excuse
6 me, 5-22 to 5-25, 2004. It has records from 6-28
7 to 7-14, 2004. And records from 11-23 to 11-30,
8 2004. And finally 2-15, 2005. Tonsil and adenoid
9 removal is the last one with anesthesia records,
10 clinical notes.

11 Q Am I correct, Dr. Sherman, that that last
12 volume you described are Cleveland Clinic records?

13 A Yes. Well at least some of the headings
14 on the entry say Clinic Cleveland Foundation (sic),
15 correct.

16 Q Okay.

17 A And it's labeled, the face page is
18 labeled Cleveland Clinic admissions because all of
19 them have face pages. The third volume that I
20 cited for you, which includes the cover letter from
21 August 8, okay, has medical records of
22 Shane Maslanka continuing care records.

23 And the second volume that I cited to
24 you, the heading on the face page is Clinic --
25 Cleveland Clinic outpatient records. And then the

1 very first volume is the Metro Medical Center
2 nursing records, which is from the original first
3 admission.

4 Q All right. Did you receive all those
5 records at one time?

6 A Yes, I did. They came in a large box.

7 Q On August 8?

8 A I believe that's correct.

9 Q And am I correct, and this is based on
10 what you just told me, that you focused primarily
11 on the Metro Health nursing notes?

12 A Well mainly on that part of the record,
13 that's correct.

14 Q All right. Now, Doctor, what I'd like to
15 do today, because my whole purpose today in
16 continuing this deposition, is to make sure I know
17 of and understand what your opinions are in this
18 case. So what I would like to do is kind of divide
19 them up.

20 One is talk about the opinions you've
21 come up with as it relates to your review of the
22 medical records in this case, and then separate
23 from that your opinions or thoughts about
24 Dr. Martin's report. Can we do that just for
25 simplification?

1 A That's correct.

2 Q All right. Now as it relates to your
3 opinions that you've come up with based on your
4 review of the record, are there any -- is there
5 anything additional you need to add to what you
6 told me at your prior deposition?

7 A Well I guess the only thing I would
8 emphasize is the preventive nature of the baby's
9 problems, based on knowledge of the ultrasound of
10 July 12, 2001. That's probably the most crucial.

11 As I indicated, that's a system failure
12 that they did not know the accurate assessment of
13 the gestational age, and therefore they took
14 actions that resulted in a preterm birth without
15 the benefit of betamethasone therapy.

16 And that that would have more likely than
17 not either prolonged the pregnancy and/or resulted
18 in substantial reduction in complications of
19 preterm birth.

20 Q You're not saying that the betamethasone
21 itself would have prolonged the pregnancy are you?

22 A No. But had there been at some point
23 after the appearance of the mother -- the
24 betamethasone, had there been at some time, and
25 this is hypothetical, to delivery within perhaps a

1 week of presentation, the betamethasone would have
2 reduced the complications of prematurity, or
3 extreme prematurity in this case.

4 Q I think you told me before that you can't
5 give me an opinion to a reasonable degree of
6 medical probability because it's outside your
7 specialty as to how long they may have been able to
8 extend Gloria Maslanka's pregnancy, correct?

9 A That would require the opinion of an
10 obstetrician or a perinatologist.

11 Q Fair enough.

12 Now aside from what you've just told me
13 about the system's failure, the rest of your
14 opinions, I assume based on your review of the
15 medical records, we covered during you're initial
16 deposition on August 3?

17 A I don't believe that is correct. We
18 didn't look specifically at laboratory values, such
19 as the hemograms in the first week of life, which
20 would have been a response to, you know,
21 conclusions drawn by Dr. Martin about the presence
22 of infection.

23 And we also didn't look at various
24 aspects of the record as it relates and is better
25 amplified in the nursing records on the first days

1 of life about laboratory values related to
2 metabolic acidosis.

3 And physical measurements of heart rate,
4 blood pressure, ventilator settings, blood gases.
5 We never covered in any detail those aspects in the
6 volumes -- the first volumes of records that I had
7 been sent or in the nursing records that I've been
8 subsequently sent.

9 Q Well then, let me put it to you this
10 way. The way I understand it is these subsequent
11 records, the nursing notes, provide further support
12 for the opinions that you've already given me; is
13 that fair?

14 A That's fair.

15 Q All right. But the opinions themselves,
16 and this is just what I want to be clear about; the
17 opinions themselves, you provided in a very lengthy
18 answer during the initial deposition we took on
19 August 3, right?

20 A There was a lengthy answer, however, if
21 you remember in the text of the deposition, I gave
22 you the opportunity to talk after I had been
23 talking for some considerable period of time. And
24 at that point, we had not gone into the exploration
25 of what aspects of the medical record drew me to --

1 either maternal or newborn, drew me to those
2 conclusions.

3 Q All right. I understand and we are
4 miscommunicating here. All I want to make sure
5 before I move on, and I'm going to ask you some
6 specific questions, is that based upon the answers
7 you gave in that initial deposition and then this
8 -- your further reference to the system failure
9 that you provided again today, that I know what
10 your opinions are?

11 A I think that you have an incomplete
12 assessment on my opinions but I think for the most
13 part, the major opinions were stated. I would not
14 say that all were stated.

15 Q Are there --

16 A Because as you remember, we closed the
17 deposition, you know, and that's why we're here
18 again.

19 Q All right. Well I mean, is there -- I
20 mean, as we sit here today, and I'm not talking
21 about further support for the opinions you gave me
22 back on August 3, but are there other opinions that
23 you want to list for me? Other deviations from the
24 standard of care that you saw or issues?

25 A Well, there has -- yeah. I think a major

1 one is this assumption that neutropenia was present
2 and therefore because there was neutropenia
3 present, there was in fact sepsis present. And I
4 do not believe that you heard my opinions to any
5 extent on that issue, or to any extent on the issue
6 of why I believe this baby was not infected at the
7 time of birth.

8 Q Well I'm just going to say that's per
9 your response to Dr. Martin's report.

10 A That's fine.

11 Q Okay. Adding that, and I will give you
12 an opportunity to educate me on your opinions about
13 that -- the infection issue, is there anything else
14 that we missed?

15 A Let me just try and go back in my mind
16 for one second, my reading of the deposition. Now
17 I think we covered the observation that now is
18 supported by the nursing notes that Dr. Kumar had
19 very little physical interaction with this infant
20 in the way of examinations.

21 I cited one place where they talk about
22 an assessment of this infant by a physician but I
23 never found a nursing entry that specifically said
24 Dr. Kumar examined or responded to the bedside to
25 assess the infant.

1 There appears that on the first day there
2 was some type of entry related to his knowledge of
3 a low blood pressure. But his name appears
4 sparsely throughout the nursing notes.

5 Q Okay. With that, you believe you've
6 covered everything?

7 A Yes. I believe -- I believe for the most
8 part we've covered everything.

9 Q All right. Fair enough. Let me pick up
10 about this, your opinions regarding Dr. Kumar's
11 involvement in this case. Is it your opinion based
12 upon your review of his notes and the nurses' notes
13 that Dr. Kumar did not ever perform a physical
14 examination or assessment of Shane Maslanka?

15 A I can't firmly document it. I don't find
16 any examination by him either in the medical
17 records or cited in the nursing records where he
18 examined the head, neck, listened to the lungs,
19 listen to the heart murmur, felt the pulses,
20 palpated the abdomen, did a neurologic
21 examination.

22 I just cannot find that among the
23 dictated notes that he provides, or an assessment
24 that would lead me to believe that there was a
25 thorough examination on a daily basis by Dr. Kumar,

1 as opposed to an examination by either a pediatric
2 resident or a fellowship staff. And the record
3 will speak for itself.

4 Q All right. Well is it fair to say that
5 you don't know what Dr. Kumar's routine is as it
6 relates to his assessment in examination of infants
7 in the NICU?

8 A I think that's a correct statement. I
9 don't know what his routine is.

10 Q And you don't know how the rounding
11 procedure with the residents and the fellows and
12 Dr. Kumar works; is that fair?

13 A That's fair to say.

14 Q All right. And you don't know because
15 you weren't there whether Dr. Kumar was present or
16 whether he was not when the residents or fellows
17 performed their assessment of Shane Maslanka in the
18 NICU, right?

19 A I think that's fair to say. But I've
20 already indicated to you that early in the course
21 of this infant, I believe there's one date in which
22 there's not an entry by Dr. Kumar.

23 Q All right. And have you --

24 A And we stated that in the prior
25 deposition testimony.

1 Q Right. Right. And you stand behind that
2 testimony as you sit here today?

3 A Unless you can produce the note.

4 Q Well I think -- it's not my obligation to
5 produce you the records. But based upon the
6 records you got from Plaintiff's counsel, you
7 believe there was no note by Dr. Kumar that date,
8 correct?

9 A That's the only assumption I can make.

10 Q All right. You made a mention that in
11 one of Dr. Kumar's initial note that he wrote Group
12 B status unknown, where in fact you believe that
13 the Group B status was known. Do you remember
14 that?

15 A Yes.

16 Q Is it your opinion that that notation by
17 Dr. Kumar was a deviation from the standard of
18 care?

19 A Yes, it is.

20 Q All right. Can we agree that PDA or
21 patent ductus arteriosus can be difficult to detect
22 in the initial days of life of a premature baby?

23 A No, we can't agree on that. I just have
24 a paper in press on that.

25 Q What's the name of that paper?

1 A It has to do with infared -- near-infared
2 spectroscopy for assistance in the diagnosis of a
3 PDA in infants. It would be an additional tool
4 that would be used based -- besides the clinical
5 examination.

6 The Gold Standard for diagnosis of PDA is
7 still the echocardiogram. It would be below the
8 standard of care in a 27-weeker where there's a
9 murmur on August 2, to not perform a echocardiogram
10 on that date. And as you know, none was performed
11 on that date.

12 Q The echocardiogram was performed the
13 following date, correct?

14 A In the afternoon, I believe at 4:30 on
15 the 3rd, that's correct.

16 Q You believe that that 24-hour delay in
17 the performance of an echocardiogram proximately
18 caused any injury to Shane Maslanka?

19 A I believe within a reasonable degree of
20 probability that it did.

21 Q How can you quantify that?

22 A Well, we've already -- in my previous
23 deposition testimony, the earlier you would treat a
24 ductus arteriosus to close it, the less likely
25 you're going to have pulmonary edema and pulmonary

1 injury that leads to bronchial pulmonary dysplasia.

2 And the less likely you are to have what
3 we call ductal steal, which blood goes back to the
4 lungs and not to the brain, creating an ischemic
5 state, which then can be associated with
6 intracranial hemorrhage.

7 Q Doctor, can we agree that a ductus
8 arteriosus can close spontaneously?

9 A We can agree on that. But that is far
10 less common at 27 weeks gestation than at near term
11 or term.

12 Q Well in your review of the records, did
13 you determine whether there was a point in time
14 when the physical examination of Shane Maslanka,
15 and this is prior to his surgery, indicated there
16 was no murmur present?

17 A Well there were times when there was no
18 murmur present but the time to address the patency
19 of the ductus is early in the hospital course. We
20 know that that's a serious complication. We know
21 that the baby had diastolic blood pressures in the
22 teens on the first and the second days of life.

23 And low diastolic pressures are commonly
24 associated with the presence of ductus arteriosus.
25 And that along with presence of a murmur appears to

1 have been ignored on both the 1st and the 2nd of
2 August.

3 Q Can you have a diagnosable ductus
4 arteriosus in the absence of a murmur?

5 A Yes, you can.

6 Q All right. So in your opinion,
7 physicians can and should diagnosis ductus
8 arteriosus even absent a heart murmur?

9 A They can diagnose it based on a number of
10 other criteria: There may be bounding pulses,
11 there may be a wide pulse pressure, there may be
12 low diastolic pressures, there may be a short
13 diastolic runoff time after the diachronic notch
14 and before the next up-stroke of the pressure wave
15 curve on an umbilical arterial catheter.

16 There can be an active precordium, there
17 can visible axillary pulses, all of which would be
18 indicative of ductus arteriosus in addition to
19 metabolic acidosis. And all of those are
20 indicators in the absence of a murmur.

21 There's a paper published which says that
22 in micro-premie, such as this child, or extreme
23 prematurity as is the case in this child, that
24 perhaps 50 percent of infants may not have an
25 audible murmur.

1 And when a murmur is present in a baby of
2 this size, it would be highly indicative of the
3 indication to do an echo, in addition to all the
4 other list of criteria that I've listed.

5 The shopping list that I personally and
6 other neonatologists go through in diagnosing a
7 patent ductus arteriosus in a baby of this immature
8 state on the first day, second day, third day,
9 fourth day, fifth day, sixth day, seventh day of
10 life.

11 Q Doctor, is there a range of diastolic
12 blood pressures which you believe is indicative of
13 a ductus arteriosus?

14 A Certainly diastolic blood pressures in
15 the teens would make one highly suspicious of a
16 patent ductus arteriosus. In a cranial ultrasound
17 study that I mentioned previously that I
18 participated in with Dr. Donald Shields at UCLA
19 Medical Center many years ago, we have found the
20 diastolic pressures below 22 were strongly
21 associated with intracranial hemorrhage.

22 And that -- and that addressing the
23 patent ductus arteriosus to prevent cerebral
24 ischemia due to diastolic hypertension was an
25 important factor in either preventing or

1 potentially minimizing intracranial hemorrhage in
2 these immature infants.

3 Q Do you consider Shane Maslanka to have
4 been a micro-premie?

5 A Well, not technically he wasn't a
6 micro-premie because he wasn't below a thousand
7 grams but he was a baby that would have extreme
8 prematurity because he was between 23 and 27 weeks
9 of gestation.

10 But that's not the issue here. The issue
11 is, is he probably wouldn't have been 27 weeks
12 gestation, born at that age, had it not been for
13 the actions taken by the obstetrical staff in the
14 absence of their knowledge of the 7-12-01
15 ultrasound.

16 Q Well in fairness, I mean, I don't want to
17 go back to this again. You can't give an opinion
18 as to how long they could have maintained this
19 pregnancy, correct?

20 A I cannot give an opinion to that but I
21 can give an opinion regarding causation of injuries
22 to an infant that is inappropriately born at 27
23 weeks gestation.

24 Q Fair enough. Are there -- let me step
25 back.

1 What are the potential treatments in your
2 opinion for a ductus arteriosus in an infant born
3 with extreme prematurity?

4 A Well, there's both preventive therapy and
5 there's an intent-to-treat therapy. The preventive
6 therapy would be pharmacologic with indomethacin.
7 That has been published by Ron Clyman and others as
8 I cited previously but my wife worked with Ron
9 Clyman and Ron Clyman is a personal friend.

10 In addition to that, there is the use of
11 indomethacin as a prophylactic agent to prevent
12 intracranial hemorrhage. And it is generally
13 believed that one reason why indomethacin may
14 prevent intracranial hemorrhage when used in that
15 manner, is because it closes the ductus and
16 prevents the diastolic hypertension and ischemia to
17 the brain, which then leads to the bleeding.

18 After you look at either preventative or
19 intent-to-treat indomethacin therapy,
20 intent-to-treat indomethacin therapy is applied
21 when you have evidence of a hemodynamically
22 significant ductus as you had here. That was based
23 on the fact that the ultrasound showed left side
24 volume overload when it was performed.

25 It's my more likely than not opinion that

1 Dr. Kumar misinterpreted the clinical presentation
2 on the day of life. He thought there was Grade 4
3 RDS. Dr. Martin states in his letter that this was
4 mild RDS. But in fact, significant left to right
5 flow through a ductus can give a picture of more
6 severe --

7 Q I don't --

8 A Wait a minute. Let me finish, please,
9 okay. I've been patient with your questions, and
10 you will get to the answer here that you so
11 desire.

12 So, you know, left to right shunting on
13 the 1st and the 2nd would present as more pulmonary
14 disease, even though it is heart failure.

15 Now after you -- so there was a definite
16 evidence for intent-to-treat as well on day one and
17 two of life, and to do diagnostic studies to look
18 for a patent ductus arteriosus, the Gold Standard
19 being echocardiography. And assisted by the
20 physical examination and clinical record.

21 After that therapy, either if it fails or
22 a person believes indomethacin pharmacologic
23 therapy cannot be applied, then surgical ligation,
24 which was ultimately performed but the wait in this
25 case it occurred. And that would be a therapy

1 which would be a hundred percent effective in
2 closing the ductus where indomethacin at 27 weeks
3 gestation may not be entirely effective.

4 There are other things that we do to try
5 and close the ductus and that is minimizing fluid
6 administration in the first days of life, provided
7 that you don't have hypernatremia. If the course
8 is complicated by hypernatremia, you may have to
9 give more fluid therapy than you would want to.

10 And then that aggregates the potential
11 for having a patent ductus arteriosus. And in fact
12 in this case, a hypernatremia was present. And in
13 my opinion is more likely than not due to the
14 amnioinfusion therapy that was provided during the
15 intrapartum period.

16 Q Okay. Is it your opinion in this case
17 that the standard of care required the
18 administration of indomethacin to treat the ductus
19 arteriosus?

20 A Yes. It is more likely than not in my
21 opinion that had the study been performed on the
22 1st or the 2nd, that indomethacin could have been
23 safely given to this infant.

24 Q Can you say to a reasonable degree of
25 probability whether or not the indomethacin would

1 have caused the ductus arteriosus to close?

2 A There probably would have been a greater
3 than 50 percent chance of closure at 27 weeks. And
4 that's based on data that we generated at UC Davis
5 Medical Center in studying the ductus arteriosus,
6 and is a reason why we performed the study that's
7 in press.

8 Q Potentially though, the indomethacin --
9 strike that, let me phrase it another way.

10 There are also studies that indicate that
11 indomethacin has some -- may not be effective in
12 the closure of ductus arteriosus in the premature
13 infants, correct?

14 A That's a broad statement and presented as
15 a broad statement that would be true but the --

16 Q Well, I mean it as a general statement.
17 I know that you can qualify it but I just meant it
18 so the record -- clear, as a broad, general
19 statement.

20 A Well, as a broad, general statement it's
21 true but I think presenting that to a jury would be
22 subterfuge with regards to the truth, okay, of what
23 indomethacin does to close --

24 Q Dr. Sherman, I just --

25 A Look it, look it --

1 Q (Continuing)--get through this
2 deposition. And I'm not committing any subterfuge
3 as we sit here today.

4 A Okay. But you are very, very aware that
5 the effectiveness of indomethacin at 23 or 24 weeks
6 gestation is not as effective as it would be at 27
7 weeks of gestation or even closer to 28 weeks of
8 gestation.

9 So it is -- it is -- you can't -- in
10 medicine, we do not select the facts that we want
11 to present. We present a full knowledge of what
12 the literature says.

13 Q Fair enough.

14 Doctor, if the appropriate intervention
15 had been -- had taken place as you see in this
16 case, on what date do you believe the ductus
17 arteriosus would have closed?

18 A Usually the course would take three
19 doses, and usually within 24 to 48 hours the ductus
20 may be effectively closed.

21 Q So by the 4th?

22 A By -- well, it depends on whether you
23 applied the therapy on the 1st or the 2nd but
24 certainly by the 3rd or the 4th the ductus
25 arteriosus may have been closed, thereby avoiding

1 central nervous system and pulmonary morbidity.

2 Q All right. And that's my next question.
3 Let's assume that the ductus arteriosus was closed
4 by the 4th.

5 A Yes.

6 Q Can you state to a reasonable degree of
7 probability whether or not Shane Maslanka would
8 have still suffered from intraventricular
9 hemorrhage?

10 A I would say more likely than not he would
11 not have suffered intraventricular hemorrhage and
12 he would not have had the subsequent complications
13 that are stated in the nurse's notes. They clarify
14 in the nurses' notes that the baby was put back on
15 the ventilator on the 12th because of CHF or
16 congestive heart failure.

17 And so undoubtedly, there had been
18 increased left to right flow creating a problem
19 from the early tendance of this baby's birth. And
20 therefore taking the ductus out of the picture,
21 which is more likely than not to have occurred
22 within indomethacin therapy, would have either
23 prevented or minimized subsequent complications
24 related to diastolic hypertension.

25 Things such as the pulmonary bleed may

1 not have occurred. Pulmonary bleeds are associated
2 with coagulopathies. Coagulopathies are associated
3 with an increased risk of intracranial hemorrhage.

4 Q But just so I'm clear, your opinion to
5 the jury will be, had the PDA been treated
6 appropriately --

7 A Right.

8 Q (Continuing)--to a reasonable probability
9 --

10 A Right.

11 Q (Continuing)--Shane Maslanka would not
12 have suffered an intraventricular hemorrhage?

13 A That's correct. On the 1st or the 2nd,
14 and I think there's -- it's up to debate about --
15 especially having reviewed the ultrasounds, it's up
16 to debate about the presence of intraventricular
17 hemorrhage on when the first ultrasound was
18 performed.

19 Q All right. We'll get to that in a
20 minute.

21 Had the PDA been treated appropriately as
22 you have set forth, do you have an opinion to a
23 reasonable degree of probability as to whether
24 Shane Maslanka would have suffered from PVL?

25 A Could you restate that question, please.

1 Q Of course. Let's assume that the
2 physicians had treated the PDA appropriately and
3 the ductus arteriosus closed by August 4 as we
4 discussed before.

5 A Right.

6 Q If that is the case, can you state to a
7 reasonable degree of probability whether or not
8 Shane Maslanka would have suffered from PVL?

9 A Well first of all, I assume by PVL you're
10 talking about periventricular leukomalacia,
11 manifest after the month of August by cystic
12 periventricular lesions that were present on
13 ultrasound?

14 Q That's exactly what I'm talking about.

15 A Okay.

16 So the timing of periventricular
17 leukomalacia, as we know those cystic structures in
18 the periventricular tissue occur -- occur, as
19 thought, two to three, maybe four weeks but an
20 average of maybe three weeks after an event where
21 there was periventricular ischemia.

22 If we go back to when those appeared, it
23 would put the timing perhaps during the intrapartum
24 period and might be associated with the fetal heart
25 rate decelerations that were seen in this baby. I

1 can't make a conclusion on that because I don't
2 have a conclusion on the severity of those heart
3 rate decelerations.

4 With the occurrence of the hypertension
5 post birth related to the ductus arteriosus, that
6 will be a cause of periventricular leukomalacia.
7 And more importantly, when a bleed like a --
8 particularly a Grade 3 intraventricular hemorrhage
9 occurs, then there may be pressure in the ventricle
10 that leads to ischemia of the tissues right below
11 the wall of the ventricle and therefore -- and
12 therefore PVL would show up at some time later.

13 And if you calculate that, if you look at
14 the Grade 3 hemorrhage identified on the 15th and
15 then you look at the PVL identified in September,
16 you will have timing.

17 So therefore prevention of the Grade 3
18 hemorrhage by treatment of the ductus arteriosus
19 and prevention of that bleed or prevention of the
20 bleed by the administration of betamethasone, and
21 enably, either one of those could have had more
22 likely than not a preventive affect on the PVL.

23 Q All right. So if I'm hearing you
24 correctly, which I may not be, it's your opinion
25 that multiple factors, including the treatment or

1 the mismanagement of the PDA, the failure to use
2 betamethasone and perhaps the sustained bradycardia
3 during labor were all proximate causes of the PVL;
4 is that correct?

5 A Well, the major one would have been delay
6 in preterm birth, okay. By properly knowing the
7 gestational age of the infant based on the 7-12-01
8 ultrasound, so prevention of premature birth is
9 strongly correlated with prevention of
10 intraventricular hemorrhage.

11 Administration of betamethasone is
12 strongly associated with the prevention of
13 intraventricular hemorrhage. Prevention of fetal
14 distress is certainly associated with prevention of
15 intracranial hemorrhage.

16 And we know that there was some type of
17 intrapartum distress because the baby had a mild
18 elevation of enucleated red blood cells on the
19 hemograms on the days after birth, then
20 disappeared.

21 And then of course, you know, the
22 ultimate prevention is antenatal not postnatal.
23 But certainly taking the patent ductus arteriosus
24 out of the equation, especially when it's causing
25 diastolic pressures in the teens is very, very

1 important in preventing cerebral ischemia and
2 subsequent brain injury.

3 Q All right. I'm assuming, and you correct
4 me if I'm wrong, that you can't attach a percentage
5 to each of those factors as to, you know, the lack
6 of betamethasone was a 25 percent factor in the
7 development of the PVL, the PDA was X percentage?
8 Can you do that?

9 A I cannot and it would be very interesting
10 to see if you have experts that certainly can.

11 Q No. I don't think I will but you never
12 know what you might say, so I just wanted to make
13 sure.

14 A That's kind of a cryptic slam, wasn't it.

15 Q All right. Let's -- I want to talk to
16 you about a couple of other opinions you had when
17 we initially took your deposition, just to make
18 sure I'm clear.

19 You talked about the child's respiratory
20 status and that the -- and the partial pressures of
21 oxygen. Do you recall that?

22 A The partial pressure of oxygen in the
23 arterial blood?

24 Q Right.

25 A Yes, correct.

1 Q That it was in the 55 to 80 is normal, I
2 think you told me?

3 A There's different textbooks but 50 to 70,
4 55 to 80 appears in different commonly used
5 educational handbooks that are used by pediatric
6 house staff.

7 Q Is it your opinion based upon that
8 discussion we had about the partial pressure of
9 oxygen that the ventilator management for
10 Shane Maslanka deviated from the standard of care?

11 A Well, you know, we're -- you -- really,
12 that's not an appropriate question. The
13 appropriate question is the management of the
14 delivery of oxygen. Ventilator management is one
15 aspect of lung care but control of the inspired
16 oxygen concentration is another aspect of care.

17 And you're asking me a question that
18 could be more simply answered that you could bring
19 the PAO2 into the normal range and not result in
20 hyperoxic eye or other injuries by appropriately
21 managing the inspired oxygen concentration.

22 We talked about the very first elevation,
23 which I believe was perhaps 261 and then it got
24 better, and then the next episode of hyperoxia was
25 156. Again, this speaks to the fact that one, you

1 have good intraarterial oxygenation.

2 You can draw your own conclusions or the
3 jury will regarding whether this baby was hyperoxic
4 on too many occasions. But you can also draw your
5 conclusions of whether that supports this severe
6 pulmonary disease.

7 One of causes of having high PAO2's is
8 the fact that the ductus arteriosus delivers more
9 oxygenated blood to the lungs through the left or
10 right flow, and therefore that's further support of
11 a significant ductus early in the course of this
12 infant.

13 Q Let me ask you using your term, because I
14 apologize if I didn't use the correct term of art,
15 but it is your opinion that the oxygen management
16 for Shane Maslanka was below the acceptable
17 standards of care?

18 A Generally speaking, repeated elevations
19 in PAO2 of that nature are generally considered if
20 they are repeated -- on a repeated basis, are
21 considered deviations in the standard of care by
22 many, many neonatologists; not only experts in
23 litigation testimony.

24 And therefore we've even covered that
25 this last week and put in a new protocol for

1 maintenance of oxygen saturations in our own
2 Level 3 NICU. We did the same thing at UC Davis.
3 And so I think that all -- this baby was born in a
4 time frame when everybody was paying attention to
5 PAO2's and saturations.

6 I saw saturations in the nursing records
7 like 98 percent, which would be well out of range.
8 And you can judge the occurrence of the saturations
9 and/or the PAO2's and judge -- your own experts can
10 come to a conclusion of whether this fell outside
11 the standard of care but...

12 Q It's your opinion it did?

13 A I think the most -- most of the majority
14 of most neonatologists, not experts, would agree
15 that it did.

16 Q All right. You brought up initially, and
17 I think it was mentioned again here this morning,
18 the issue of hypernatremia?

19 A Yes.

20 Q And in your opinion it was due to
21 amnioinfusion, correct?

22 A Well the baby didn't have any other
23 external source of sodium after birth, and sodium
24 was quite high early on. That can be due to
25 transepithelial water loss but to be occurring of

1 that nature without providing free water.

2 And it's somewhat unusual to have so high
3 sodiums like that in a 27-weeker as opposed to a
4 23- or 24-weeker. And so the sodium loading from
5 the amnioinfusion was a likely culprit, more likely
6 than not culprit in the high sodium.

7 Q You can't say one way or the other
8 because you're not an obstetrician as to whether or
9 not the performance of an amnioinfusion itself was
10 below the standard of care; is that correct?

11 A That's correct.

12 Q Fine. Are there other potential causes
13 for hypernatremia in a premature baby, other than
14 amnioinfusion and transepithelial water loss that
15 you're aware of?

16 A Well certainly if a baby is hypotensive
17 and you have to administer saline to treat
18 hypotension on a repeated basis, or if you give
19 blood which has a lot of sodium to treat
20 hypotension on the same basis, these small immature
21 infants will be sodium loaded, and the sodium will
22 in fact rise.

23 And in fact this baby did receive sodium
24 for hypotension, the hypotension undoubtedly was
25 related to the patent ductus arteriosus. And so

1 that will be part of the paradigm.

2 And then of course the babies will lose
3 free water from the skin. Less so in a 27-weeker
4 than in a 23- or 24-week gestation infant but that
5 still can be a source of the sodium rising in an
6 immature infant.

7 But again we must, must point out that
8 this baby need not be born immaturely had the
9 proper gestational age been known, based on the
10 ultrasound that was done two weeks or more before
11 birth.

12 Q But, and I just want to be fair here, I
13 mean, you can't tell me whether the child would
14 have been born then at 28 weeks, 29 weeks, 30
15 weeks, you can't state that, correct?

16 A I can't state that.

17 Q Right.

18 A But any delay in birth improves
19 mortality. In other words, you have a lower death
20 rate and you have fewer complications. And you
21 have fewer complications when you delay delivery
22 and provide betamethasone.

23 Q But we can agree that there's still
24 morbidities associated with the delivery of
25 premature infants even if the perfect care is

1 provided, correct?

2 A There is but this was a needless delivery
3 at 27 weeks. This -- remember this baby was
4 actually induced to be delivered, okay. And it's
5 even stated in Dr. Martin's letter and I quote: It
6 was not apparently recognized by the obstetric team
7 managing this patient that this was a 27-week
8 gestation infant, and neither antibiotics nor
9 antenatal steroids were administered.

10 I take that -- my interpretation of that
11 sentence is, is that there was a failure of
12 standard in care in those three interventions,
13 okay, admitted by your own neonatal expert.

14 Q That's your interpretation of his
15 report?

16 A That's my interpretation of his report.
17 Why did he put it in there?

18 Q I think Dr. Martin will explain that to
19 us.

20 A Okay.

21 Q Let's talk about the ultrasound for a
22 minute.

23 A Yes.

24 Q You have now taken a look at the
25 ultrasound films themselves; is that correct?

1 A That's correct.

2 Q I take it from your testimony that you
3 disagree with some of the interpretations of the
4 ultrasound?

5 A That's correct. Actually they're
6 overstating the ultrasound report of the first
7 ultrasound. There's no clear indication of that
8 report. And we've covered this before but I can
9 read the -- I can read the report again.

10 Q Well you don't have to read -- you're
11 talking about the 8-3-01 report?

12 A 8-3-01 report.

13 Q Right. And you believe it's overstated
14 that this was a Grade 2 intraventricular bleed?

15 A It doesn't state that it was a Grade 2
16 bleed.

17 Q It says Grade 1 to Grade 2 bleeds
18 bilaterally, correct?

19 A Well, you know, you either have Grade 1
20 or you have a Grade 2, you don't have a Grade 1 to
21 2, okay. You may have a Grade 1 hemorrhage, which
22 is a subependymal hemorrhage; and you may have a
23 Grade 2 hemorrhage, which is an intraventricular
24 hemorrhage.

25 And the description of both hemorrhages

1 should be separately described on the report. But
2 the report only describes a Grade 1 subependymal
3 hemorrhage.

4 Q All right. So you believe that the
5 appropriate interpretation of the 8-3-01 head
6 ultrasound would have been a Grade 1 hemorrhage?

7 A A bilateral Grade 1 hemorrhage, and I
8 have further comments on that. I don't believe
9 one, there was not ventricular dilatation. The
10 ventricles are of normal size.

11 There's no -- you can look at the
12 subependymal hemorrhages, which I'm doing right
13 now, and you can see their hyperechoic, they have
14 -- they're very, very bright, okay, indicative of
15 blood.

16 And similar clotted blood within the
17 ventricular system should have a similar
18 hyperechoic appearance. And you can look at the
19 ventricles and you cannot identify a hyperechoic
20 appearance that is the same as the subependymal
21 hemorrhages on the images.

22 And you can compare that -- that
23 hyperechoic appearance in the subependymal
24 hemorrhages to the choroid plexus, okay, which is
25 less ectogenic.

1 Now, you also have additional testimony
2 by your expert, a Marilyn Segal, and I believe that
3 her interpretation of the subependymal hemorrhages
4 is also -- is not correct, and I can explain why;
5 if not now, at trial.

6 Q All right. So you disagree with both the
7 report from the Metro Health Medical Center
8 radiologist and with Dr. Segal?

9 A That's correct. And I virtually looked,
10 either independently myself or with pediatric
11 radiologists, virtually thousands of cranial
12 ultrasounds probably at this gestational age and
13 younger gestational ages, older gestational ages.
14 I have enormous experience in this area.

15 Q Did you review these ultrasounds with a
16 pediatric radiologist?

17 A No, I did not. But I can tell you right
18 now -- actually, we don't have a pediatric
19 radiologist here. The films are read by a general
20 radiologist and oftentimes the general radiologist
21 defers to my opinions about ultrasound findings.

22 Q Who is that general radiologist at your
23 facility?

24 A Dr. Scott Long.

25 Q Do you have disagreements with the

1 interpretations of any of the other head
2 ultrasounds?

3 A No. I do agree there was a Grade 2 on
4 the 7th, and a Grade 3 on the 15th.

5 Q All right.

6 A I do believe that there was subsequent
7 finding consistent with periventricular
8 leukomalacia.

9 Q Ultrasounds?

10 A That's correct.

11 Q All right. So the only interpretation
12 that you dispute then is the one of August 3 of
13 2001?

14 A That's correct.

15 Q All right. Doctor, have you submitted a
16 bill to Mr. Becker or Mr. Kulwicki for your review
17 of this case to date?

18 A I believe there was an earlier bill but
19 there hasn't been any recent bills.

20 Q Do you have any idea of what the time
21 frame of your initial bill was?

22 A No, I don't. I think it probably would
23 have been earlier this year but I can't tell you
24 the time frame.

25 MS. REID: Mike, will you provide me a copy of

1 Dr. Sherman's bill to date.

2 MR. BECKER: I don't have a problem with
3 providing you with bills that we have from
4 Dr. Sherman until today's deposition. I think
5 that's a fair request.

6 MS. REID: All right. Thank you.

7 Q Dr. Sherman, can we agree that patients
8 have a responsibility to provide an accurate
9 history to their physicians?

10 A As they may understand it, patients may
11 be ill informed by the physicians caring for them
12 regarding, you know, their medical history.

13 Q All right. But, I mean, it's fair --

14 A I assume you're -- this is a hypothetical
15 question you're asking.

16 Q I'll qualify it, it is a general,
17 hypothetical question.

18 A Right. And I don't believe you have any
19 knowledge of what or how it was explained to the
20 mother, you know, prior to her appearance in the
21 intrapartum period.

22 Q I think I do have some knowledge about
23 that. But be that as it may, my question is in
24 general, hypothetically: Can we agree that
25 patients have a responsibility, to the best of

1 their knowledge and understanding, to provide an
2 accurate medical history to their physician?

3 A I would agree with that, and also it's
4 the responsibility of the physicians to act on the
5 basis of all available medical information on the
6 patients that they're treating, which was clearly a
7 deviation of the standard of care in this case.

8 Q Fair enough.

9 A Fair enough. You said it.

10 Q Dr. Sherman, if -- I want you to assume
11 that -- well, I'm trying to think of the best way
12 to ask this question.

13 Is it your opinion that had appropriate
14 care been provided, and I'm taking specifically the
15 administration of betamethasone and the management
16 of the PDA. Had that occurred in this case, would
17 Shane Maslanka have avoided all the deficits he
18 currently suffers from?

19 A That's a very compound question that I'm
20 surprised Mr. Becker didn't object to, and
21 therefore I ask that you restate it and maybe break
22 it down.

23 Q All right. Do you want me to break it
24 down by deficit?

25 A You know, I mean, it was a very, very

1 difficult question to understand.

2 MR. BECKER: Doctor, why don't we have the
3 court reporter read the question back.

4 MS. REID: Were you sleeping Mike? Your
5 witness wants you to wake up.

6 MR. BECKER: No, I'm with you.

7 MS. REID: All right.

8 MR. BECKER: Read the question. Ms. Court
9 Reporter, if you'd read the question back. And,
10 Doctor, if you don't understand the question --

11 THE DEPONENT: Just tell her.

12 MS. REID: You can tell me, that's fine. I'll
13 just rephrase it, I can accept the fact that you --

14 THE DEPONENT: I couldn't really -- I mean it
15 was a very compound or complex question with many
16 variables in it.

17 MS. REID: All right. Well here, I mean --

18 THE DEPONENT: Well, perhaps the court
19 reporter would like to read back -- what Mr. Becker
20 asked for.

21 MS. REID: That's fine.

22 (Whereupon the requested
23 portion of the record was read
24 back by the Reporter.)

25 THE DEPONENT: Do you have any comments,

1 Mr. Becker?

2 MR. BECKER: No. I follow the question,
3 Doctor, but maybe --

4 THE DEPONENT: Well, I can't answer the
5 question and the reason why is the question is
6 incomplete. It doesn't address the issue of
7 avoiding preterm birth. And we're only dealing
8 with two of many issues there, and therefore I
9 cannot answer that question.

10 MS. REID: All right.

11 Q In order to answer that question, you
12 would need me to factor in the timing of the
13 delivery as well as all of the other medical issues
14 you pointed out to me through the course?

15 A That's correct. And you already told me
16 that you can't -- that you can't tell me when the
17 baby would be born. The baby might have been born
18 at 35 weeks.

19 You know, since I can't really state when
20 the baby was born, it really is a hypothetical
21 question as to what exactly would have been the
22 outcome of the infant.

23 Obviously it would have been better but
24 you want an answer that all deficits would
25 disappear. We don't know -- since we don't know

1 the delay in the duration of time from presentation
2 to birth, you know, it's not a question that's
3 answerable.

4 Q All right. And that's based on the
5 premise that you don't have an opinion as to
6 whether this baby would have been born at
7 27-and-a-half weeks or 35 weeks, correct?

8 A That's correct.

9 Q All right. I'm saving Dr. Martin's
10 report because it's my understanding that you have
11 some comments you would like to make about that; is
12 that fair?

13 A Dr. Martin's report and your radiology
14 expert's report.

15 Q Any preference of order we take these in?

16 A No.

17 Q All right. Well why don't we -- well
18 let's address Dr. Segal's report because it's --
19 tell me what your --

20 A It's shorter.

21 Q You already told me that you disagree
22 with her interpretation of the 8-3 ultrasound,
23 correct?

24 A That's correct.

25 Q Is there anything in addition to that,

1 that you disagree with?

2 A No.

3 Q Okay. So is there anything else we need
4 to cover in Dr. Segal's report?

5 A I believe that -- I think we should cover
6 her interpretation of the timing of the bleed based
7 on the 8-3-06 ultrasound.

8 Q All right. Well I think, and correct me
9 and I'm just trying to tie things up if I can. I
10 thought you told me in your initial deposition that
11 you disagreed with that because it didn't match the
12 clinical presentation that you saw in your review
13 of the records?

14 A That's correct. And also now I've had an
15 opportunity to actually look at the images and I
16 believe based on extensive experience of reviewing
17 ultrasounds, either myself and/or with pediatric
18 radiologists, that my opinion of what she is
19 concluding is incorrect.

20 Q Tell me specifically what you're
21 referring to?

22 A Okay. With regards to the subependymal
23 hemorrhages, you will see lucencies within the
24 subependymal echogenic areas. And it's her
25 conclusion that that results in a cystic

1 subependymal hemorrhage that would be -- and she
2 says there are slightly cystic suggestions that are
3 a few days old, okay.

4 When you go from a hemorrhage to a cyst,
5 a cyst by definition is a thick-walled structure,
6 okay, with a uniform thick wall. These lucensies
7 within the subependymal hematomas are not -- are
8 not cystic in nature.

9 They're lucensies but they don't have a
10 well developed, well formed wall such as the
11 formation of a total clot, fall by the lysis of the
12 clot and a well-formed wall lateral to the cystic
13 structure.

14 What these actually represent are
15 hematomas that are recess in origin. I can't tell
16 you whether they might be intrapartum or on the 1st
17 or 2nd but they -- chances are they're more likely
18 on the 1st and 2nd based on what I'm just going to
19 say.

20 The fact that there are lucensies there
21 is that the blood has not completely clotted within
22 the hematomas. And therefore it shows up as a
23 lucency within the hematomas and it doesn't have a
24 nice uniform cystic appearance.

25 And therefore it's not really appropriate

1 to call it a cyst, the proper designation is
2 there's lucencies within the subependymal
3 hematoma. And among the potential explanations for
4 that, the most likely one in my opinion, is it
5 represents unclotted blood within the hematoma that
6 it will subsequently clot, and then the hematoma
7 will resolve.

8 And in fact -- and in fact if you go to
9 the ultrasound on the 7th of August, okay, and you
10 look there, you'll see that a similar lucency
11 appears on some of the images and that -- but they
12 now are more uniform in nature, suggesting that the
13 baby is in fact forming a resolution of the
14 subependymal hematoma.

15 And the subependymal hematomas are in
16 fact somewhat less prominent on the 7th. You still
17 see a lucency within the hematoma on the coronal
18 views, and one of those coronal views shows a very
19 nice thickened wall around the -- where there's a
20 much greater lucency, it's not a gray scale like on
21 the initial images.

22 Again, indicating resolution of a
23 hematoma that probably occurred -- probably more
24 likely than not on the first or second day after
25 birth.

1 Q Does that cover your opinions about that
2 film?

3 A I think that people can look at the
4 images and they can see a clear difference between
5 the 15th and the 3rd with regards to wall formation
6 within the subependymal hematoma.

7 Q Dr. Sherman, prior to you moving your
8 practice to southern Illinois, when you worked at
9 UC Davis and other institutions, there were
10 pediatric radiologists that you worked with, I
11 assume?

12 A Yes, there were two.

13 Q There were two, okay.

14 A In fact, I published articles with one of
15 them.

16 Q Who was that?

17 A That was -- we published an article in
18 Active Pediatric in 2003, Dr. Wooten: W-O-O-T-E-N.

19 Q Well during that time frame when you were
20 working or had the availability of a pediatric
21 radiologist, how many times or what percentage of
22 the times would you interpret a head ultrasound of
23 a newborn without using the expertise or discussing
24 the ultrasound with that pediatric radiologist?

25 A Well pediatric radiologists unfortunately

1 don't spend time in-house on nights and weekends
2 like neonatologists. So when we had to have
3 decision making about a serious intracranial
4 hemorrhage in a very immature infant in the middle
5 of the night or on a weekend, particularly after
6 hours on a weekend because they were there from
7 9:00 to 12:00 on Saturday mornings.

8 But on those weekends, we had to rely on
9 our own interpretations of the ultrasounds. And in
10 fact, neonatologists are tested on their board
11 examinations on their competency to read cranial
12 ultrasounds.

13 Q I'm assuming, and again correct me if I'm
14 wrong, that if you had the opportunity to avail
15 yourself of the expertise of a pediatric
16 radiologist that's something you certainly would
17 do?

18 A That's something I would do, yes.

19 Q Okay.

20 A I wouldn't say that all neonatologists
21 all the time will have agreement, okay, with the
22 pediatric radiologist on --

23 Q That wasn't my question --

24 A I realize that.

25 Q Have we covered your comments about

1 Dr. Segal's report then?

2 A Yes.

3 Q All right. Should we move on to
4 Dr. Martin's report?

5 A Yes, please.

6 Q All right. You had covered some opinions
7 about Dr. Martin's report in your initial
8 deposition. Do you recall that?

9 A Right.

10 Q Was there comments you wanted to make in
11 addition to what you already explained to me back
12 on August 3?

13 A There are additional comments. I wanted
14 to go through his letter to Mr. Malone on a line by
15 line basis. Okay?

16 Q Okay.

17 A First of all there's a statement there:
18 Was some tobacco exposure, okay. Now this was a
19 1100 gram baby born at 27 weeks gestation. That
20 would place the baby at a reasonably high birth
21 weight percentile wise.

22 The one complication, or couple
23 complications associated with tobacco exposure
24 would be a restriction in birth weight, which was
25 obviously not present here.

1 The only other complication, which my
2 wife and I have published on, are changes in heart
3 rate related to tobacco exposure that may have some
4 meaning with regards to the increased risk of SIDS
5 in woman who use tobacco.

6 As we know, then, the tobacco exposure
7 here neither produced a lowering of birth weight,
8 and certainly we know the patient did not die of
9 sudden infant death syndrome.

10 The next sentence I would like to cover:
11 In late June she had a positive urine culture for a
12 Group B strep. That was negative in mid July,
13 approximately two weeks prior to delivery.

14 Dr. Martin very well knows that carriage
15 can come and go with Group B strep. And whether a
16 mother is positive one time or negative another
17 time is still below the standard of care to not
18 provide some type of penicillin, chemoprophylaxis,
19 in a preterm delivery when Group B strep has been
20 identified during pregnancy. So that's, in my
21 opinion, a self-serving statement on his part.

22 And then we have the fact that
23 spontaneous rupture of membranes occurred
24 approximately 12 hours prior to vaginal vertex
25 delivery. We've already covered the fact that

1 rupture of membranes can still result in many weeks
2 delay before delivery of an infant.

3 And then there's a statement: It was not
4 apparently recognized by the obstetrical team
5 managing this patient that this was a 27-week
6 gestation. And neither antibiotics nor antenatal
7 steroids were administered.

8 Q And we've covered your opinions or
9 thoughts about that statement, right?

10 A That's correct. But it doesn't hurt to
11 restate it about 50 times. Because really,
12 clearly, that the issues in this case are really
13 obstetrical as it results to the major
14 complications this baby suffered because they're
15 more likely than not preventable.

16 The X-ray was consistent with mild
17 respiratory distress syndrome. I presume that
18 having made that statement, Dr. Martin had access
19 and looked at the X-rays. And it's my
20 interpretation that in this particular infant, the
21 left right flow through the ductus was significant.

22 It was based on hard forensic evidence of
23 low diastolic pressures on blood pressure
24 measurements from umbilical lines. And it's also
25 manifest, as I said, by the potential for having

1 elevated PAO2's in the arterial blood as a
2 consequence of right to left shunting.

3 Now, we're going to fall into a later
4 part, so I'll cover it here. Babies who are septic
5 at birth, typically have low APGAR scores because
6 they are depressed from infection. And this is
7 well stated in a number of sources.

8 And this baby's APGAR scores were 7 at
9 one minute and 8 at five minutes, which would be
10 considered reasonably normal APGAR scores in a baby
11 of 27 weeks gestation.

12 Q We discussed this. Not to interrupt you
13 but I am interrupting you. But we discussed this
14 initially, in your initial deposition. That you
15 don't think the APGAR scores are clinically
16 correlated with a baby with infection?

17 A That's correct.

18 Q All right.

19 A Okay. And then he talks about the baby
20 -- we talked about the administration of
21 dexamethasone and how dexamethasone can lead to the
22 occurrence of cerebral palsy, okay.

23 And that there were grave concerns even
24 in 2001 about administering dexamethasone to
25 achieve extubation, even because of the potential

1 risks to the baby from the effects of dexamethasone
2 potentially and brain development.

3 As we've also talked about, dexamethasone
4 can suppress the immune system, particularly the
5 TH1 helper cells lymphocytes, and that can of
6 course be associated with infection.

7 And in fact the baby -- he doesn't talk
8 about this but he talks about there was successful
9 intubation or extubation after the dexamethasone.
10 This is in the next sentence: Apart from a brief
11 reintubation for apnea around August 31, 2001.

12 Well he doesn't candidly state that the
13 reason for reintubation around August 31, 2001 was
14 due to coagulate negative staphylococcal bacteremia
15 and the apnea was caused by it, and could be linked
16 to the dexamethasone therapy.

17 Q The administration of dexamethasone at or
18 around the time of extubation was below the
19 standard of care?

20 A No. They provided a course of
21 dexamethasone. It wasn't just to prevent laryngeal
22 edema around the time of extubation was actually to
23 -- it was actually applied to reduce lung
24 inflammation, to facilitate extubation from the
25 ventilator and to a nasal canula.

1 Q Well was that, the administration of that
2 dexamethasone course inappropriate?

3 A Well, I mean that's -- I don't think that
4 -- that's a controversial point that has not yet
5 been litigated, or I'm not aware of it, related to
6 the administration of dexamethasone and the
7 subsequent occurrence of cerebral palsy.

8 Q Well my question is and I --

9 A You're question is, is whether that was
10 appropriate.

11 Q Well was it --

12 A It's problematic but there will be some
13 testimony by some experts that it still may have
14 been within the standard of care.

15 Q What's your opinion?

16 A Well, I try -- well I'll give you the
17 exact opinion that we use in speaking with
18 parents.

19 If a baby is going to die because of the
20 ventilator and oxygen therapy at three weeks of
21 age, then we would apply dexamethasone therapy.
22 And we would have the parents be fully informed
23 that there was risks of cerebral palsy. And that's
24 what we did at UC Davis Medical Center in year
25 2001.

1 That having been said, this baby did not
2 appear to be dying as a result of oxygen and
3 ventilator therapy.

4 Q Do you believe, Dr. Sherman, that the
5 administration of dexamethasone in this case was a
6 proximate cause or factor in the development of
7 Shane Maslanka's CP?

8 A I think that the far overwhelming reason
9 for cervical palsy in this case was the failure to
10 undertake proper obstetrical care. And there was
11 some contribution of failure to properly manage the
12 patent ductus arteriosus. But the major concern I
13 have as a neonatologist is the obstetrical care in
14 this case.

15 Q Are we done then with the first page of
16 the report?

17 A Yes. We are going to go to page two
18 now.

19 Q Okay.

20 A And he talks about the 3rd and the 4th
21 that there was, and I'll quote: A patent ductus
22 arteriosus was diagnosed at this time. And this
23 was likely reason for blood-sustained intratracheal
24 secretions.

25 It's well known that a PDA can lead to

1 pulmonary hemorrhage. As you know from the medical
2 record, obviously Dr. Kumar was not of that
3 opinion. He wanted to get an ENT consult to
4 determine the cause of the bloody secretions.

5 And I believe almost any fellow that I've
6 taught has been taught -- or any resident that I've
7 taught for that matter, that patent ductus
8 arteriosus and congestive heart failure is a sign
9 of blood in the intratracheal tube.

10 You've heard of bloody pulmonary
11 secretions in adults who have congestive heart
12 failure, bloody pulmonary secretions occur in
13 infants who have heart failure from patent ductus
14 arteriosus.

15 And this is a cause that could have been
16 avoided by early treatment of the PDA on day one or
17 two because of the symptoms that were manifest;
18 including the presence of diastolic hypertension,
19 the presence of a murmur and other factors that I
20 mentioned in past testimony.

21 Q You don't agree with the general
22 statement that PDA can cause pulmonary hemorrhage?

23 A Pardon me?

24 Q Can PDA cause a pulmonary hemorrhage?

25 A Yes, it can.

1 Q Okay. Go ahead.

2 A And also indomethacin can prevent that
3 from occurring.

4 Indomethacin therapy was withheld because
5 of intraventricular hemorrhage, I think you have my
6 testimony on that point now, as to the August 3
7 ultrasound.

8 But in fact, earlier examination of the
9 ductus on the day of birth or the second day of
10 life is on August 2, well could have resulted in,
11 you know, avoidance of the things that we've
12 already discussed.

13 Now in the very end of that paragraph it
14 says: Ligation of the PDA was performed on August
15 19, 2001. Well the baby was put back on the
16 ventilator and according to the nurses' notes, this
17 was because of congestive heart failure.

18 That was on the 12th and there's yet
19 again a week delay before a PDA surgery is
20 performed. And I guess I would question more
21 likely than not why earlier intervention for
22 ligation of the PDA, given the reasonably good
23 clinical status of the baby, did not occur.

24 Q Does the surgeon's opinion as to the
25 infant's clinical status factor into the timing of

1 surgical intervention?

2 A Yes, it does. But I don't see anything
3 in the medical record that states that the surgeon
4 wanted the surgery delayed. They consulted them on
5 the 16th, they did it on the 19th, you still have
6 from the 12th to the 16th that's unexplained why
7 they didn't consult pediatric surgery.

8 Q Next paragraph.

9 A I'm sure you did want to move on.

10 Q I'm just trying to get through, Doctor,
11 that's all.

12 A Okay.

13 Initial blood culture from August 1, 2001
14 was negative. In the absence of intrapartum
15 antibiotics in a septic infant, you would expect
16 the blood culture to be positive, okay.

17 And if you really thought the baby had
18 infection, okay, then you would have considered
19 doing a lumbar puncture. But even in the presence
20 of ventriculitis, which Dr. Martin assumes could be
21 infectious on the 8-7 ultrasound, no lumbar
22 puncture was performed, no antibiotics were given
23 at high doses to treat meningitis.

24 And in fact the ventriculitis that
25 appears on the 8-7, 2001 ultrasound represents

1 ventriculitis that is due to blood irritation.

2 It's a common occurrence that once there is
3 intraventricular blood, that there will be
4 irritation of the ventricle.

5 As you can note on the ultrasound that
6 was done on the 3rd, there's no mention of
7 ventriculitis due to intraventricular hemorrhage.
8 So the explanation that there was a ventriculitis
9 caused by early onset neonatal sepsis is simply not
10 true.

11 The ventriculitis was caused by the
12 hemorrhage, it's a common occurrence. I've seen it
13 in virtually hundreds, if not thousands, of cases
14 of intraventricular hemorrhage in neonates.

15 Now let's go to something that I really
16 think was self-serving, and also factually
17 inaccurate in his letter. And I will provide the
18 actual numbers to Mr. Becker and Mr. Kulwicki so
19 they can use them at the time of trial in
20 questioning Dr. Martin.

21 And that is the following statement:
22 However there was a persistent neutropenia from
23 August 1 to August 6, 2001 with neutrophil counts
24 of 1,000 to 1,400 per cubic milliliter, falling to
25 less than 1,000 on August 6, 2001.

1 Well if a baby is septic and you -- and
2 they would have neutropenia and the lowest counts
3 would be right after birth and then they would
4 rise, okay.

5 But let's really review the record --

6 Q Doctor --

7 A Now wait, you're going to listen to this
8 because this is very, very accurate and it's
9 forensic evidence, okay.

10 Q I can listen to what I want listen to,
11 Dr. Sherman, number one; number two, I don't want
12 to go through every lab result in ---

13 A No. We are going to go through these lab
14 results or you're not going to have full discovery
15 and Mr. --

16 Q Are you lawyer, Dr. Sherman?

17 A No. I'm not a lawyer but I can tell you
18 that the neutrophil count on the 1st was 1649, the
19 neutrophil count on the 3rd was -- there were two
20 counts, one was 3,002, one was --

21 Q Contrary to your belief, I mean, I have
22 the labs in front of me. I'm familiar with what
23 they are, that's why I don't think it's necessary
24 to repeat them.

25 A No, no, no. You don't want to hear this

1 testimony. I will tell you this is a hematology
2 report, it's a thing in the Metro Health system
3 record --

4 Q I'm aware of it, Dr. Sherman that's what
5 I'm -- you don't need to --

6 A You're trying to get this testimony to
7 not go into the record. You look at how you
8 calculate whether there's a neutropenia or not, is
9 based on the total number of neutrophils in the
10 manual differential count times the white blood
11 cell count, okay.

12 That was not done by Dr. Martin and I
13 have the numbers right in front of me because I've
14 calculated them, okay.

15 Q Here's what we're going to do because I
16 --

17 A And there's also not in evidence what
18 neutropenia definition is, which in the June 2006
19 Journal of Perinatology we published that article
20 on neutropenia; the definition was less than a
21 thousand white neutrophils per cubic millimeter,
22 okay.

23 And I can find no count, okay, between
24 the 1st and the 6th where you do the proper
25 calculation of neutrophils per cubic millimeter

1 that is less than a thousand.

2 And in fact -- and as a matter of fact
3 only two of them, one on the 5th and one on the 6th
4 are below 1500. And in fact one on the 8th, two
5 days after the one on the 6th, has an absolute
6 neutrophil count of 2878.

7 So, you know, the letter, Dr. Martin will
8 have to stand by, okay.

9 Q We will, Dr. Sherman. You believe that
10 Dr. Martin's calculations are wrong, correct?

11 A That's correct.

12 Q And you don't believe that Shane Maslanka
13 had any evidence of persistent neutropenia,
14 correct?

15 A That's correct.

16 Q You're going to pull the lab values that
17 you have in front you and I have in front of me to
18 show that at the time of the trial, correct?

19 A That's correct.

20 Q All right. Let's move on then.

21 A Okay. I will provide the actual numbers
22 on chart. Now there's more --

23 Q You put a list together already?

24 A I've already put together a list.

25 Q Do you have that with you today?

1 A The list today, no. I put it in the
2 record. I have written the actual numbers in two
3 copies of hematology profiles.

4 Q Okay. And you're going to provide that
5 to Dr. Becker?

6 A That's correct.

7 Q All right --

8 A Along with other things because probably
9 more importantly than the absolute neutrophil count
10 is something called the immature total neutrophil
11 ratio. Where you create a ratio of the number of
12 immature neutrophils to the total neutrophils, and
13 values that are associated with sepsis are usually
14 above a value of .2 to .3.

15 And in fact, if you do calculations on
16 the number of bands or other immature neutrophils
17 to the total number of polys, you'll find out that
18 all of the values in the first six to eight days of
19 life fall below .3.

20 And in fact, in the first -- on 8-1 and
21 8-3 those values, except for one where they have an
22 elevated value that then goes down, the value on
23 the first day is .09. The value on the third, one
24 value says that it's .27. A value done on the same
25 day, later in that day, again says it's .09 for the

1 ratio of immature neutrophils to mature
2 neutrophils.

3 That's one of the common tests that we
4 run to determine bacterial infection, along with a
5 C-reactive protein, which no C-reactive proteins to
6 my knowledge were performed on this infant.

7 So in addition to that, the -- except for
8 a platelet count of 147 on the 4th, there were
9 platelet counts from the 1st of 266; 200,000 on the
10 3rd, another one 184; one on the 4th, 198; one on
11 the 5th, 173. If you have serious bacterial
12 sepsis, you will have low neutrophil counts often
13 in association with neutropenia.

14 Q Have you made notations about the
15 neutrophil counts as well?

16 A Pardon me?

17 Q Have you made notations about the
18 neutrophil counts as well?

19 A About the -- I'm not quit understanding
20 your question.

21 Q You described that there were some
22 notations you had made for Mr. Becker about the --
23 whether there was evidence of persistent
24 neutropenia?

25 A Right. I wrote down the A and C values,

1 okay.

2 Q All right.

3 A You know, above the white blood cell
4 counts on these two pages that cover -- that will
5 cover the 1st through the 8th, okay.

6 Q Okay. And that's what you're going to
7 provide to Mr. Becker?

8 A That's correct.

9 Q All right.

10 A But these values that are said to be a
11 thousand to 1400 per cubic millimeter are in fact
12 not correct. And in fact -- in fact, of the values
13 up to the 8th; one, two, three, four, five of those
14 values are above 1500 as far as the absolute
15 neutrophil count is concerned.

16 This baby did not have an infectious
17 neutropenia. I happened to take the opportunity to
18 look up whether Richard Martin is an expert in
19 neonatal leucocyte biology.

20 Q Where did you look that up?

21 A I looked it up in Pub Med. If you look
22 at my vitae, which you have, you will find out that
23 since 19 -- for 30 years, I have been a basic
24 scientist and a clinician studying leucocyte--
25 neonatal leucocyte biology, okay. It's my area of

1 expertise.

2 Q And it's not Richard Martin's?

3 A It is not Richard Martin's.

4 Q You believe you're a better expert on
5 this issue than Richard Martin?

6 A I would believe so. If it came to airway
7 obstruction or apnea or things of that nature, he
8 would be the expert but he is not an expert in
9 neonatal leucocyte biology.

10 Q You don't take -- you don't believe his
11 opinions has any credence in this case, do you,
12 Doctor?

13 A Well that's a self-serving statement. I
14 won't answer it.

15 Q Why do you believe things are
16 self-serving so much, Doctor?

17 A Because Richard Martin knows that there
18 is an expert testimony standard put forth by the
19 AAP, okay. And he knows that members, fellows of
20 the American Academy of Pediatrics are to provide
21 honest scientific testimony in deposition or at
22 trial, okay.

23 And to provide less than that, you know,
24 not candid testimony, one's interpretation. Or to
25 serve as an expert for a health system that is also

1 aligned with Case Western Reserve University School
2 of Medicine, is something that I personally,
3 ethically, have not seen in any of the testimony
4 I've given at deposition or trial in many, many,
5 many years. In fact, I've never seen it before.

6 So there are -- I have deep concerns --
7 deep, deep concerns about the fact that this person
8 is an advocate, okay.

9 Q But do you believe -- and I want to leave
10 this point because I really would like to get
11 through with this deposition.

12 Do believe that Dr. Martin providing
13 testimony in this case, or the opinions he is
14 authored in his report violate an ethical duty?

15 A In my opinion, if I was involved with a
16 sister institution that was also under the umbrella
17 of the medical school that I taught at, I would not
18 be allowed to provide testimony for that sister
19 institution. So yes, I do believe that he's
20 violated an ethical standard.

21 Q You believe he's violated the standard
22 set forth by the American Academy of Pediatrics
23 regarding expert testimony?

24 A I'm very concerned about it, yes.

25 Q Any other comments you have about

1 Dr. Martin's opinions regarding infection? Without
2 going through all the lab results, please.

3 A Okay. One of the things that he talks
4 about here is the jaundice but he doesn't talk
5 about the significant scalp bruising that this baby
6 had that would have been related to a preterm
7 delivery, that was not based on proper knowledge of
8 the gestational age.

9 And the bruising itself could have
10 consumed coagulation factors that may be important
11 in preventing intraventricular hemorrhage down the
12 line.

13 There are a certain group of
14 obstetricians that believe that a baby at this
15 gestational age might be better delivered and
16 delivered atraumatically, or with less trauma, by
17 cesarian section. But that's not an opinion that I
18 can give.

19 The next paragraph has a statement where
20 he reveals the bilateral Grade 1 to 2.

21 Q Well let me just -- we have talked
22 extensively about your disagreement about -- or
23 what your opinions are or your interpretation of
24 the ultrasounds.

25 A Right.

1 Q I mean, I would prefer not to repeat that
2 now because I think we've covered that at length.

3 A Yeah. I think -- I think the next
4 paragraph that deals with the -- and includes the
5 ventriculitis and involves ventricular dilatation,
6 I think we have in fact covered that and we need
7 not cover it.

8 Q All right.

9 A The very next paragraph talks about
10 evidence of retinopathy of prematurity but
11 Dr. Martin does not speak to the issue of
12 hyperoxemia or high O2 saturations, and it's role
13 in the pathogenesis of retinopathy of prematurity.
14 And we've covered that I believe as well.

15 Q Okay.

16 A And then the last paragraph it says: In
17 my opinion Shane suffers from severe morbidity
18 associated with preterm birth and it's
19 complications. But again I will state that this is
20 a major obstetrical issue because to blame preterm
21 birth adds to a reduction of mortality and a
22 significant reduction of morbidity, particularly
23 when betamethasone is administered.

24 And he said: He experienced mild RDS and
25 progressed to be BBD but he doesn't address the

1 issue that BBD is a complication of an untreated
2 patent ductus arteriosus as described by Bank Lori
3 (phonetic) and others repeatedly in the literature.

4 And that is the most likely explanation
5 for the pulmonary morbidity that this baby suffered
6 because I agree with Dr. Martin, the baby's RDS was
7 mild in nature.

8 Q I'm going assume, Dr. Sherman, that you
9 disagree with everything Dr. Martin says in his
10 final report because those are his ultimate
11 opinions; is that fair?

12 A I think that that is an overstatement of
13 my testimony. And I certainly will agree with him
14 that about many of the factual things in this case
15 including the --

16 Q No, no. I --

17 A (Continuing)--including the PO2 of 260,
18 okay.

19 Q No, no, no. You're not listening to me.
20 We are at the final paragraph, where
21 Dr. Martin -- the final paragraph of Dr. Martin's
22 report.

23 A Yes.

24 Q Where he sets forth his ultimate
25 opinion. I understand there's going factual things

1 you're going to agree about.

2 A Right.

3 Q But I'm going to assume for the purposes
4 of brevity here --

5 A Right.

6 Q (Continuing)--that you disagree with
7 Dr. Martin's ultimate opinions in this case?

8 A Yeah. This baby was -- did not have
9 early onset neonatal infection. I just provided a
10 lecture on August 16 to the family practice
11 residents on early onset neonatal infection. You
12 can look at my vitae, you will see that I've
13 lectured on this very topic in recent years.

14 The -- it -- his opinion that this is
15 supported by metabolic acidosis cannot be supported
16 in the fact that the metabolic acidosis would be
17 caused by patent ductus arteriosus. And that the
18 low diastolic pressures will lead to tissue
19 ischemia and a metabolic acidosis.

20 And that very commonly a significant
21 patent ductus arteriosus is treated with pressor
22 support during the neonatal period. And that there
23 is really far more likely explanations, more likely
24 than not explanations in this particular infant for
25 metabolic acidosis and pressor support. I stated

1 those previously.

2 And the timing of the PVL on the
3 ultrasound would not suggest, as I've stated and
4 you can look up the timing on PVL after an ischemic
5 insult, could not be associated with intrauterine
6 infection.

7 This baby was not infected in utero. But
8 I do agree with him that the administration of
9 betamethasone would have reduced the likelihood of
10 the occurrence of intraventricular hemorrhage or
11 the severity of intraventricular hemorrhage.

12 So on that very point, I end the
13 discussion of his report. And see we are in
14 agreement.

15 Q Right. On that one point.

16 A On many points. I certainly agree with
17 him about the fact that the APGAR scores were 7 and
18 8, and that's inconsistent with neonatal sepsis.

19 I certainly do agree that a PAO2 of 261
20 actually occurred and that can be associated with
21 morbidity, such as retinopathy of prematurity.

22 Q Dr. Sherman, do you feel satisfied we've
23 covered your opinions in this case?

24 A Well we really haven't covered all of my
25 opinions because there may be some new discussion

1 that needs to occur. I only have Dr. Martin's
2 report, I don't think we have his deposition
3 testimony yet.

4 There will probably be other defense'
5 experts and other plaintiff's experts in this
6 case. And after I've had an opportunity to review
7 their deposition testimony, there may be other
8 unusual statements made that have to be addressed
9 with regards to my opinions.

10 Q Well I mean, I take that as that doesn't
11 necessarily change your opinions, it might just be
12 something you want to comment on as this case
13 progresses?

14 A That's correct.

15 Q All right. But as far as with the
16 materials you have in front of you today and you
17 had in front of you in the beginning of August,
18 you've been able to express the opinions,
19 understanding that at times I told you not to get
20 into the factual basis for all of your opinions?

21 A Understanding that, that's correct.

22 Q All right. Have you requested any
23 further information from either Mr. Kulwicki or
24 Mr. Becker at this point?

25 A No, I haven't. But they know that I will

1 want to see deposition testimony as it occurs and
2 is relevant to my testimony.

3 Q Have you prepared any other notes or --
4 that you are -- other than what you have described
5 that you're intending to provide Mr. Becker or
6 Mr. Kulwicki?

7 A I only plan to provide with them because
8 I think it's clearly an error based on their
9 forensic laboratory information why, you know, the
10 neutrophil counts and other parts of the hemogram
11 in this case are inconsistent with neonatal
12 infection.

13 And I probably will provide them but they
14 have already heard my discussion of point-by-point
15 why intrauterine infection and evidence of
16 intrauterine infection, both on an intrapartum
17 basis and on a postnatal basis did not exist.

18 MS. REID: All right. With that, Dr. Sherman,
19 I don't have anymore questions for you today.

20 THE DEPONENT: Okay.

21 MS. REID: Appreciate your time.

22 THE DEPONENT: Thank you.

23 FURTHER DEPONENT SAITH NOT.

24

25

1 I, MICHAEL PARKER SHERMAN, M.D., having read
2 the above and foregoing, find the same to be true
3 and correct with the following additions and/or
4 corrections, if any:

5 Page _____ Line _____ Change:

6 Page _____ Line _____ Change:

7 Page _____ Line _____ Change:

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23 Michael Parker Sherman, M.D. (9-1-6) DATE

24

25

1 STATE OF ILLINOIS)
2) SS
3 COUNTY OF MENARD)

4 C E R T I F I C A T E

5 I, Tricia L. Gudgel, a Notary Public and
6 Certified Shorthand Reporter in and for said County
7 and State do hereby certify that the Deponent
8 herein, MICHAEL PARKER SHERMAN, M.D., prior to the
9 taking of the foregoing deposition, and on the 1st
10 of September A.D., 2006, was by me duly sworn to
11 testify to the truth, the whole truth and nothing
12 but the truth in the cause aforesaid; that the said
13 deposition was on that date taken down in shorthand
14 by me and afterwards transcribed, and that the
15 attached transcript contains a true and accurate
16 translation of my shorthand notes referred to.

17 Given under my hand and seal this 5th day
18 of September A.D., 2006.

19 *Tricia Gudgel*

20 Notary Public and

21 Certified Shorthand Reporter

22 License No. 084-004053



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