State of Ohio,)
County of Cuyahoga.) SS:

IN THE COURT OF COMMON PLEAS

VERONICA FERRETTE, et al.,)
)
Plaintiffs,)
vs.) Case No. 370938
) William Coyne
FIREMAN'S FUND INSURANCE CO.,)
et al.,)
)
Defendants.)

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VOLUME II
THE DEPOSITION OF BARBARA E. SWARTZ, M.D.
MONDAY, MARCH 12, 2001

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The continued deposition of Barbara E. Swartz, M.D., called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Charles A. Cady, Registered Merit Reporter and Notary Public within and for the State of Ohio, taken at University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, Ohio, Ohio, commencing at 1:05 p.m., the day and date above set forth.

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BARBARA E. SWARTZ, M.D., CONTINUED DEPOSITION INDEX

BARBARA E. SWARTZ, M.D.

of lawful age, called for examination pursuant to the Ohio Rules of Civil Procedure, having been previously duly sworn, was examined and testified further as follows:

CONTINUED EXAMINATION OF BARBARA E. SWARTZ, M.D.

BY MR. LANSDOWNE:

Q Doctor, we're continuing your deposition. You're still under oath, and the previous admonition I had given you about answering out loud and so forth still pertain.

And again, I would remind you that at anytime you want to go back to a previous answer that you have given and amend it, clarify it, add to it, feel free to do so.

A Okay.

Q And that would include anything that was said last Friday as well.

A Understood.

Q I think that when we -- my notes, anyway, indicate that when we left last week, we were discussing your opinions with respect to perinatal issues in Veronica and what exactly you were going to say about that.

And am I correct that you are going to be

offering the opinion that perinatal issues with respect to Veronica contributed to cause her cognitive impairments today?

A Correct.

Q And the perinatal problems that we identified are the prematurity, birth weight, and icterus?

A Correct, I think we also mentioned the DES.

Q But I thought that we decided that DES in itself would not be causing cognitive difficulties.

A I said that I was unaware of that, that you would have to check with an obstetrician.

Q Okay. You're not going to be offering the opinion that --

A No.

Q Now, with respect to the prematurity -- oh, and by the way, for any of the perinatal issues that you're talking about, you're going off of records of a history given by the patient's, or Veronica's, mother? **Is** that what you're going from?

A From the medical records. Actually, **I** believe I had her birth records in here. Maybe we should check that.

Q You can check.

A They're also --

Q But if you do, it would be a big surprise to me.
A There was, yes, a visit by her mother to the pediatrician's when Veronica was quite small, so it may have come from the mother. But I actually thought it came from -- I might have the birth record from Babies and Rainbow Hospital.
Q Well, that would be really surprising, because she wasn't born at Babies and Rainbow.
A Okay. So you have some birth records that we haven't seen?
Q I'm just asking if you saw any birth records.
A Where was she born?
Q My understanding is she was not born there.
A I'll have to wade through this stuff now. Do you want me to look for it later?

MR. HENTEMANN: Do you have your report?

THE WITNESS: Well, it doesn't say in the report if it was from an actual birth record or from the mother. I remember reading the visits, that the mother brought her in at an early age for bloody stool, I believe it was. And she gave her own perinatal history of being on bed rest and being on DES.

Q The mother, you're talking about?

A Yes, the mother did.
Q Right.
A Then with regard to the birth weight, that was from someplace else, but --
MR. HENTEMANN: Are you functioning from page -- what page are you on?
Q I'm just going on page 2 of 8 of the second report, is when you talk about this. "In reviewing her chart, she was born prematurely," et cetera.
A Correct.
Q I just want --
A It was either from the mother's history or from a birth record. Maybe I can look tnrough these later. It might be in the old records over there.
Q It would be the records of University Hospital that the mother gave a -- it appeared, anyway, that the mother gave some kind of a history to the --
A That's probably where it came from, then. I can check later. That's what we usually do, ask the mother for that kind of information.
Q Sure, at that age.
But the point is, you really haven't looked

at the actual birth records, have you?

A I said I would have to look through the pile to check later, if you want me to.

Q Okay. Well, we might as well check now.

A All right.

Q We might as well get that through.

MR. ARGIE: Off the record.

(Discussion held off the record.)

THE WITNESS: Was it Cleveland Clinic?

BY MR. LANSDOWNE:

Q Your question was, was there a history given at the Cleveland Clinic?

A Yes. She had some work done at the Cleveland Clinic.

Q There may be a history in there. But I'm pretty sure what you're referring to was University Hospital.

A The mother's history is at Babies and Rainbow.

Q I mean I don't know. I didn't do it. I'm just surmising from what I have reviewed, from the records that have been provided to me, and I have not been provided any birth records.

A And I also had the obstetrician's notes, but I don't see it.

Q Are the Rainbow records in this stack?

A They should be somewhere in there. That's what I'm looking for right now. I don't see it in this one.

Yeah, here in the intern's admission note, when she came in with bloody stools, it says, "Product of pregnancy in which mother spent most of the pregnancy in bed because of bleeding. The child was induced early. Weighed 4 pounds at birth.

"Patient spent first two weeks of life in incubator with jaundice. Mother described herself as a bleeder. Described treatment for delivery of both her children. Her child had vaginal bleeding for the first two months of life."

So that's where that came from.

Q And the record you were reading from was what, the University Hospitals?

A Yes.

Q Rainbow Babies and Children's record?

A Yes.

Q What was the date?

A 6-20-67.

Q 6-20-67?

A She was three years old.
Q Three years old?
A She came in for an admission.
Q So is that the only source of your knowledge about any of these perinatal issues?
A Yes. That's all I was given.
Q You don't know, for instance, what Veronica's Apgar scores are you, do you?
A No. That would be useful.
Q That would be important, wouldn't it?
A It would be a useful indicator, yes.
Q You don't know what her pH was at birth, if they even did a pH?
A We just -- yes, I don't. Obviously, we don't have those records.
Q Okay. But, again, those would be -- a pH level at birth would be useful information --
A It might be useful.
Q -- if you were trying to make a connection between cognitive problems and perinatal issues, correct?
A Well, it would be one additional fact. We already know, at least by the mother's description -- and that's generally the source of information we have on the patients --.is the

mother, that she had a couple of risk factors.

Q Right. But I mean if you're really trying to make a connection between perinatal complications and cognitive impairments, some of the things you'd want would be the Apgar scores, the pH at birth, whether there had been fetal distress, those kinds of things?

A It would be nice, but we almost never have that information. But in our presurgical evaluation in people with epilepsy, these are routine questions: "Were you too early? Were you too late? Did you have forceps? Did you have jaundice? Did you have to stay in the hospital longer than your mother?"

We also like to know what age they walked and talked at. I didn't find that in the records.

Q Did you find it said she met her milestones all on time?

A No, I didn't see that.

Q You didn't see that in the record.

Would that be significant?

A It would be useful.

Q And that's why you ask that question, --

A Sure.

Q -- if they met their'milestones, because if they don't meet their milestones, maybe that's an indicator of some problem?

A Sure. And school performance is another indicator.

Q School performance is another indicator.

Did you ask for the birth records?

A I asked for whatever records were available.

Q Okay. According to that information, anyway, Veronica was two weeks premature, correct?

A Correct.

Q Do you know roughly how many two-week premature babies are born at Rainbow Babies and Children's every year?

A No. You'd have to check their records.

Q Are all those babies who are born two weeks premature at risk for cognitive impairments?

A Are they all at risk? Yeah, I guess they're all at some risk, some increased risk over being a full term.

Q What percentage of babies born two weeks premature have cognitive impairments?

A I don't know. You could ask a perinatologist that.

Q Do you think it would be less than 1 percent?

A I wouldn't know that. I wouldn't want to speculate.
Q You have no idea?
A I would not want to speculate.
Q You have no idea between 1 percent and 100 percent?
A No.
Q And icterus, or jaundice, do you know how many babies have jaundice when they're born? What percentage?
A It's fairly common, but I don't know the exact percentage.
Q It's common.

Are all the babies who have jaundice at risk for -- actually, do you know of any literature that associates icterus and cognitive impairments?

A I can't quote you anything at the moment, no.
Q Well, is it possible that icterus is not associated with cognitive impairments at all?
A It's possible. But if somebody has to stay in the hospital two weeks for treatment, that's an unusually long period of time. Usually babies with icterus stay about a day.

And four pounds is pretty small for only

two months' prematurity. That's probably -- they usually don't let babies go home that are that small, so that's probably why she had to stay *so* long.

Q Do you mean two weeks premature?

A No. I mean her weight, four pounds.

Q I know. But you said two weeks premature.

A Oh, I'm sorry. Yes.

Q Do you know how many four-pound babies are born every year at Rainbow Babies and Childrens?

A No, I don't. You can check the records.

Q Are all those babies at risk for cognitive impairment?

A I would think they are.

Q Do you know what percentage of four-pound babies --

A No.

Q -- develop cognitive impairment? It could be less than 1 percent?

A I wouldn't know. I wouldn't want to speculate.

Q No idea between 1 percent and 100 percent?

A No. I would not want to speculate.

Q Okay. Given your lack of knowledge about the percentages of these types of problems actually causing cognitive impairments, what is it that

makes you able to say that in Veronica's case, these things more probably than not contributed to cause her cognitive impairment?

A Because in my work with people with epilepsy, these are very important risk factors both for cognitive deficits and for subsequent seizures. That's why they're included in our routine history and physicals. They're part of epilepsy databases, part of the recognized risk factors.

Q But what is it that makes it specific to Veronica that *you* can say that more probably than not in her particular case they contributed?

A Because of my experience with these types of problems, these type of risk factors.

Q But isn't it the case that much more frequently these so-called risk factors do not lead to cognitive impairments?

A I wouldn't want to speculate on that. I think it's probably the case that most people that undergo those risk factors are never tested adequately or never tested thoroughly as somebody coming to medical attention is tested.

Q And so there's --

A so I don't know that you can even get the data on that.

Q Well, that again leads me back to my question, then.

If you don't know what the percentage of people who have these risk factors end up having, actually having cognitive impairments, it could be 1 percent, 2 percent, 3 percent --

A I know in the population that I deal with, it's a fairly high percent.

Q What percent?

A Oh, 25 to 30.

Q 25 to 30 in diagnosed epilepsy patients?

A Yes.

Q Which is a particular high-risk group in and of itself, isn't it, diagnosed epilepsy patients?

A High risk for what?

Q For cognitive impairments.

A Well, there are two distinct problems. People with epilepsy are frequently normal, but the problems often do run hand in hand. They're not the same pathophysiology, but they may both come from the same initial insult.

Q Okay.

A And very frequent seizures themselves can contribute to poor cognitive functioning.

Q I see. Well, even if it's 25 to 30 percent in

epilepsy patients -- and you're saying 25 to 30 percent of your epilepsy patients who have these risk factors that we're talking about also have cognitive impairments. Is that what you're saying?

A I would say that perinatal risk factors in general and, yes, they would have coincident cognitive impairments.

Q Well, that's certainly less than half, right?

A 30 percent is a large percentage in medical terminology.

Q Right.

A It's less than half.

Q Okay. Well, then, isn't it more problem if you just -- based upon your experience, 70 percent don't have these coincident impairments.

Isn't it more probable that these risk factors did not affect Veronica Ferrette?

A No, I would not say that. In my population, that 70 percent is made up of other risk factors, not normal individuals.

Q I don't understand what you mean by that.

A Well, you're assuming the other 70 percent therefore have no risk factors, and that's not what I said. The other 70 percent of my practice

have other risk factdrs, just not the same ones.

Q But I'm talking about, the people who were born two weeks premature have some jaundice, a somewhat low birth weight.

What percentage of those people develop cognitive impairments?

A You asked me that before, and I said 1 would not want to speculate on that.

Q Okay. You wouldn't want to speculate on it in general, but in Veronica's case you are going to testify that more likely than not these are the effects, right?

A Correct, because I'm not speculating on a percentage of a whole group.

Q Okay.

A I'm applying my experience to the case at hand.

Q You have reviewed many medical records of Veronica Ferrette.

When is the first time that anybody diagnosed any cognitive impairments?

A Well, certainly as early as 1993.

Q And what would that be?

A Dr. McPherson's report.

Q You take that to diagnose cognitive impairments?

A I believe it did.

Q Can you identify where you get that information?
A Sure. I can find it if I take a minute.
I'm sorry. It was mainly a psychosocial inventory.
Q So Dr. McPherson didn't diagnose any cognitive impairments, correct?
A No. She only diagnosed emotional and psychological problems.
Q Right. Okay. Let me ask the question again, then.
When is the first time that anybody diagnosed any cognitive problems?
A Well, nobody had tested her before the incident, so most neuropsychologists would look back at her school performance to try to get some premorbid history.
Q So we're clear here, nobody diagnosed any cognitive problems for Veronica Ferrette prior to her poisoning by carbon monoxide, correct?
A Correct, because nobody tested her.
Q Okay. Did you look at her school records?
A I saw the report of her GPA by several other people, in the records, several other neuropsychologists.
Q Did you look at her high school performance?

A No. That wasn't provided to me.
a Did you ask for it?
A I asked for whatever records were available, as I said.
Q Okay. Would you want to see her high school records, then?
A Well, college and high school would be fine.
Q Okay. Do you have any indication that her high school or college records show cognitive impairment?
A Well, she did not perform very well in college.
Q Are you saying that her performance in college indicated a cognitive impairment?
A Yes. I mean if you're not performing up to average, you have some mild cognitive impairment or you have some emotional problem or you're just not responsible and you're not studying, not doing the work. It's hard to say which one.

But when neuropsychologists evaluate a person with whom -- who has had no previous testing, that's the kind of information they have to go by, what their premorbid functioning was.

Q Well, that's fine for the neuropsychologist, but we're here asking you as the neurologist.

Are you able to say one way or the other

whether her school records indicate a cognitive impairment?

A No, you can't say that a hundred percent.

Q And when you say she was doing poorly in college, what are you referring to?

A I think her GPA was below a C for the first couple years, and then she herself acknowledged with one of her neuropsychologists that she had worked hard to bring it up to above a C.

Q And did she?

A She worked to bring it to, like, a C from a D average, was my understanding.

Q A C average; above a C average.

She graduated from college?

A I'm not sure she graduated. I only saw reference to three years of records. She said she graduated, but I didn't see that specifically. She may have.

Q If she graduated from college, wouldn't that be significant to you?

A It depends on the college.

Q Okay.

A You know, I'm not the one saying she has major cognitive deficits. I don't believe she has major cognitive deficits, so we're talking about

minor cognitive deficits at this point. And certainly you can get through high school and college with that.

Q Okay. Are you aware of any research regarding delayed symptoms from carbon monoxide poisoning?

A I've seen some reference to it.

Q What have you seen?

A That you can have some delayed symptoms, anywhere from two to 40 days, after the insult, and that these also show a good prognosis for recovery.

Q What articles specifically have you looked at?

A I don't remember the author's name.

Q When did you look at it?

A In January, as I said before.

Q Is that the article that's still in your folder?

A No. That's just a general review of toxins.

Q So your opinion, then, is that Veronica had mild cognitive problems, but was able to get through high school and college with her mild cognitive problems?

A Correct.

Q And it just went undiagnosed for 34 years; is that right?

A I would agree to that.

Q Okay. Have you seen any --

A Let me just say, I would agree that's possible. I think we don't really have any testing on her beforehand, but I certainly agree that's possible.

Q Well, she's undiagnosed, right? Whether it's because she didn't do testing or whatever, she's just not diagnosed, right? She went through her whole life --

A That's what I just said.

Q All right. I thought you were adding something to that, qualifying that in some way.

A Well, I'm saying that **I** think that's possible. I'm not saying that I know it for certain, since she wasn't tested.

Q Well, you know she wasn't diagnosed. That's the point, isn't it?

A No. I think that's saying something different. When you say, you know, that she has deficits that weren't diagnosed versus she may have had deficits but wasn't tested, those are two completely different statements.

Q Well, what are you saying?

A The latter.

Q That she may have had deficits?

A I believe she may have had preexisting deficits

that simply were not'brought into a testing arena.

Q Okay. And she may not have had deficits?

A She may not have.

Q You can't say one way or the other?

A I think --

MR. HENTEMANN: Are we talking prior?

A We're kind of -- you know, do you want to give me the test? Which test? I mean what deficit? It's too broad a term.

Q Well, you're the one who identified in your report --

A I identified risk factors for subsequent cognitive deficits and seizures. That's what I identified. And when we looked at her from all of her risk factors, I thought those were significant.

Q Well, what you said is, "She may have some minor neurocognitive problems"?

A I'm still saying the same thing.

Q Okay. All I'm trying to find out is, did she have the minor neurocognitive problems before she was exposed to carbon monoxide?

A Well, I'm sure we'd all like to know that. My

opinion is that she probably did.

Q And they were undiagnosed until after the carbon monoxide poisoning, correct?

A Correct, because nobody tested her.

Q Okay. Did you see in any of the records that you reviewed, prior to the carbon monoxide poisoning, any seizure activity?

A Just one kind of obscure thing on a radiology request.

Q Tell me about that.

A There's a CT -- it's in my report. There's a CT that was ordered' and the diagnosis on the CT was written as, "Patient with convulsions."

Q Okay. You mean in your report, on page 2 of your second report when you say that, dated 1-18-96?

A My first report -- wait a minute.

Q Down at the bottom there?

A Yes.

Q Okay.

A I wouldn't necessarily say that's meaningful. It's hard to know where that came from in terms of the radiologist who wrote it, or whoever wrote it.

Q Okay. Any other references to any seizures prior to the carbon monoxide poisoning?

A Not that I noted.
Q Do you know of any literature that would say that the risk factors, the perinatal risk factors that you were talking about, can lead to seizures occurring after 34 years?
A Oh, certainly.
Q Can a person have no seizure activity at all and then these perinatal risk factors kick in at 34 years?
A Well, they usually kick in a little earlier, but it's not that unusual to have them kick in in adult years.
Q Really. There's literature to that effect?
A I think if you look at the epilepsy surgical literature, you'll find that.
Q And what about for the cognitive impairments? Is there literature to support these perinatal risk factors causing cognitive impairments to occur suddenly at 34 years?
A I don't know of any, no.
Q You don't know of any single case in which that has happened, do you?
A It's not something I have searched for.
Q Okay. Let me ask you about, we talked a little bit last time about the exam that you performed

on Veronica, and we talked at least about the cognitive part of the test that she did.

Do you recall us talking about that?

A Yes.

Q You also did a physical exam; is that right?

A Neurologic exam.

Q Neurologic exam.

And how long did that, the neurologic exam, take, that part of the exam?

A I did not time it, as we've already established.

Q Okay. By the way, how is it that Mr. Hentemann's office got ahold of you?

A I don't know.

Q I mean how did they identify you?

A I have no idea. They might have just called the department.

Q You did a motor exam? Is that part of the neurologic --

A That's part of the neurologic exam, correct.

Q And on that you -- page 3 of your first report, I guess. Is that where the motor exam is discussed?

A Yes.

Q And "She had normal bulk, tone, and strength on the right side"?

A Yes.
Q And on the left side she was -- is that "5 of 5 at the biceps"?
A 5 minus.
Q What does that mean?
A Well, we use a 5-point scale, 5 being normal, zero being nothing, and, you know, fill in the in-between numbers. There are standard performance measures for the 5-point scale. Most people find that 5 points is a little crude, so we use pluses and minuses.
Q So she was just slightly --
A Not quite as good as the other side.
Q Not quite as good at the biceps level, 5 minus 5, correct?
A Correct.
Q 4 plus at the triceps, correct?
A Correct.
Q So just slightly below the 5?
A Correct.
Q So a very minor weakness? Is it weakness that you're testing?
A Correct. It says here these were all give-way weakness.
Q 4 plus at the deltoid. So again, just .slightly

below the normal?

A Correct.

Q And by "give-way weakness," what do you mean?

A I mean they're able to exert full power, but they do it only instantaneously and then they give way.

Q What's the significance of that?

A It indicates somebody who's capable of showing normal strength but prefers not to.

Q Prefers not to or doesn't have the stamina?

A No. There's a different type of exam when somebody doesn't have the stamina. Then it's a more gradual overcoming of their course rather than an abrupt giving way.

Actually, I think Dr. Mars describes the same thing.

Q "Finger reflexes were just slightly below normal"?

A Correct.

Q And the "femur" was again "4 of 5"?

A Yes. I'm sorry. That's a typo. The femur is a bone. It should have been either the quads or the femoral nerve group, probably.

Q So pretty much on all the left side you tested --

A Yes.

Q -- she had this very slight weakness?
A Yes.
Q And you test those individually, don't you?
A Correct.
Q And your conclusion is that for each of these she didn't try as hard as she could?
A Correct,
Q And she was able with each of those to come up just below the normal?
A Or even at normal, but then she gave way.
Q In each of the things that you tested on the left side, she was just slightly below getting a 5 of 5, correct?
A Correct.
Q Would that be hard to do, to -- strike that.

Veronica was pleasant and cooperative throughout the exam?
A Correct.
Q You don't say anything about her affect. Dr. Naugle said that it was flat.
A No, she --
Q Do you agree with that?
A No, not when I talked to her. She was quite engaging. She started talking to me about her previous work people that she knew, did I know

them and so on.

And she wasn't flat with my -- she was actually angry at my nurse about the fact that the clerk had asked her about how she was going to pay for the exam and so on. So-she just engaged us spontaneously.

Q Did you tell ner to make sure that Dr. Vargo takes a look at her left leg?

A Dr. Vargo? I didn't know that name at the time.

Q Hadn't she told you about her treatment at Metro?

A Yes. But I didn't know the name of the person doing it.

Q Did you tell her to make sure that somebody looked at her left leg?

A No.

Q Not at all?

A No. I'm sure I wouldn't have said that.

Q A Homans' sign is pain in the calf, isn't it?

A Yes. And I scratched that, too. That's another typo. It's corrected on the final report. That's why I described the actual test on the final report, so you'll know exactly what was done.

Q What final report?

A Well --

MR. HENTEMANN: The second one.

A The second one. The second report.

Q Okay. Well, I have the second report.

A Right. So it's --

MR'. HENTEMANN: Are you working from the second report?

A I'm looking at the first one, but I'm saying that also was a typo. So I described the exact test in the final report so that you'll know exactly what was done.

Q Okay.

A Here, it's, "Because of" -- page 6 of 8, "Because of the discrepancy in her observed and tested gait," I asked her to perform a test in which her leg is raised off the bed and et cetera.

And that has an eponym attached to it. And I can't remember the eponym, so. I remember that Homan's was the other sign, and scratched that.

Q A Homans' sign is pain, isn't it?

A That's why I said I scratched that. So we're not talking about Homans' sign anymore.

Q Well, let me just ask, did she have pain in her leg?

A No.

Q Can you describe how you do this test?
A Yes. It is described there. But as you -- they're lying on their back. You ask them to raise their leg. You have your hands slip beneath the opposite buttocks. They have to stabilize the hip on the bed in order to raise their leg. So if they're actually making a good effort to raise the leg, we'll feel them pressing into your hand on the opposite side.

So she pressed into my hand on the left when she was raising her right but failed to press into my hand when she was raising -- trying to raise her left leg, at least to any great degree. She pressed it a little bit and raised it a little bit.

Q What causes the pressing to occur?
A Contracting --
Q Tightening of the muscle?
A Stabilizing the hip. All of these muscles here stabilize the hip onto the table.
Q I see.

If somebody has pain in one of their legs, does that affect that kind of test?
A If they had pain --
Q Pardon me?

A If they had pain, they might not make an effort. She didn't complain of any pain.

Q So that's another instance of her faking?

A Correct.

Q Let me just ask you, do you think that's a serious charge to make against a person, that they're faking?

A It's not a legal charge.

Q Well, what is it?

A It's just a medical observation.

Q Well, don't you think it's serious?

A It was your -- no. It's just one of -- I'm not making moral judgments about it.

Q Well, do you think a charge like that could hurt a person's reputation?

A No. It's supposed to be confidential.

Q Well, I mean you're testifying to it in a deposition.

A Well, this is an unusual circumstance. I didn't use that term. You used it.

Q Well --

A I used "elaborating" or "malingering" or other terms.

Q Malingering?

A You said specifically "faking."

Q Okay. Well --
A And you seem not to be satisfied with anything else, so I've just decided to go along with that.
Q I'm satisfied with whatever you want to say, Doctor.
A Okay.
Q Believe me, it doesn't matter to me what you say.
A Well, then, all I'm saying is she did not make the adequate effort. She did not make an effort to raise her left leg.
Q All right. Now, on page 7 of 8 you say that she "has a wealth of doctors and emergency room visits for a variety of relative minor complaints both before and after the carbon monoxide exposure."

Do you see that?

A Yes.
Q Then you go on to say, "She even had an abdominal surgery which was not clearly necessary according to the operative report."

What is the significance of what you're saying there about her past medical history, if any, to your opinions in this case?

A It appears that she may have a tendency to be histrionic.

Q Meaning what?
A Meaning more likely to attribute various types of stressors to physical -- to have them manifest as physical manifestations.
Q Is that an emotional condition or a psychiatric condition?
A Well, it's both.
Q Both?
A Yes.
Q Again, that would be a psychiatrist's area of specialty?
A Neurologists have to deal with these problems frequently. So this type of problem I would say also falls under neurologists and general practitioners. It depends what the symptoms are, what system they claim is being affected as to who will deal with it.
Q I'm trying to find out which of these, if we have to go thrcugh them, or if you can tell me which of these, of her past medical history, do you think is histrionic?
A Well, she had several visits for possible facial fractures that she didn't have. She had several visits for pain as a child. As a child she had a history of being already treated with a number of

narcotics; pain in the legs, pain in the back. Where this was coming from is not clear from the notes.

Q Did any of --

A You know, maybe it's the mother who's a worrywart, but...

Q Okay. Did you see in any of the records of any of these visits where any of these doctors that she was going to see thought that Veronica was histrionic?

A I didn't see anybody mention that, no.

Q I mean they're the doctors who were actually there treating her for the complaints that she came in with.

Wouldn't they be in a better position?

A They would just evaluate them, and when they find nothing, they send her out.

Q They didn't --

A A lot of these are emergency room visits. So, no, they're not treating physicians.

Q Well, tell me about -- you said two visits for facial fractures?

A I think she was hit in the face with a basketball as a child, came in, and later she was hit again. That time she was beaten up by her boyfriend, so

it probably would be appropriate to x-ray her at that point.

Q Well, the time she was hit (with a basketball, she actually had a fractured nose, didn't she?

A I don't think it showed on the x-ray. I think that was a query on the x-ray form, was "Rule out fracture."

Q And the time that she got in an altercation with her boyfriend, did you review the records relating to that, to that incident?

A Well, I don't know if I had all of them. I saw the CT report.

MR. HENTEMANN: You're talking about medical records?

MR. LANSDOWNE: Yes.

A And I think I saw Dr. Kimball's note that she had examined her and sent her for a head CT.

Q I think you said in your report that -- let me get this correctly -- you don't believe the incident with the boyfriend --

A I didn't discuss that.

Q -- had anything to do with her problems; is that right?

A No. I didn't discuss that in my -- I don't recall mentioning anything about that.

Q I think --
A I think I mentioned she's had some history of head trauma. Is that what you're talking about?
Q Yes. In the middle of page 7.
A Right.
Q "She has also had several head traumas, although I doubt these were significant since she never lost consciousness"?
A Right. In terms of significant, I mean I'm sure they were significant to you. I'm talking about risk for seizures. We were talking about seizures at that point in time.
Q Okay. And you were including in these traumas the altercation with the boyfriend?
A Yes, it would have been included, but I didn't mention it specifically.
Q Okay. And the other head trauma was getting hit by the basketball?
A And it seems like there was one other one in there as well, but I'd have to look it up.
Q Okay.
A I didn't pay attention to them. Since she didn't lose consciousness, they didn't pose a significant risk factor in my mind.
Q Whatever they were, they just weren't significant

to the issues in this case, correct?

A I didn't --

MR. HENTEMANN: Of the seizures?

A Of the seizures.

Q Okay.

A We're talking about risk factors for seizures.

Q Well, they weren't significant to the seizures, then, right?

A No, I didn't think so.

Q And they weren't significant to the cognitive problems either, correct?

A Well, I'd say probably not, since she wasn't knocked out.

Q So they're not significant to anything in the case, correct?

A Well, I think, as I said, they're significant to her, I'm sure. But they're not necessarily -- they may have relevance to this case, but they're not significant to --

Q They're not significant to you medically?

A The two issues we're talking about, no.

Q Okay.

A You know, I think -- well, I shouldn't volunteer things. But you're asking me if the other doctors had ever said anything about her behavior

or questioned her complaints. That's why it's always useful to have all of the records.

You know, in medical school. they always tell us to make sure you look at all the records before you make a diagnosis. And I don't think any of these people ever did have all the records at their disposal.

Q only you have had all the records?

A Well, I think everybody in this case has now had access to all of them.

Q So just so I know what records you have and what hospitalizations, when you talk about these several hospitalizations and ***so*** forth that lead you to believe that she might be histrionic, the first one would be **1967**, when she had bloody diarrhea. Is that --

A Yes. She was three then.

Q Do you believe she was histrionic at three?

A Obviously not.

Q And then she had urinary tract infections at age 11 and a half and 12 and a half.

She wasn't, you know, feigning urinary tract infections, you wouldn't think, would you?

A No. I don't know how those diagnoses were made.

Q Then she had a bruised kneecap.

Did you see that?

A A bruised kneecap.

Q And they actually diagnosed some chondromalacia there, didn't they?

A But that doesn't result in bruising.

Q I'm just saying they did diagnose some chondromalacia, 'correct?

A It's just coincident.

Q All right. But chondromalacia could be a significant medical condition?

A But that's not what she came to -- that's not what her complaint was.

Q So what? What's the difference? She came with a sore knee.

A Well, the difference is her mother is taking her to the emergency room whenever she bruises her kneecap, --

Q Okay.

A -- whenever she has a little back pain. I think she has a source for learning these behavior patterns.

Q Then she had the fractured nose, or at least there was a suspicion of fractured nose.

A Well, we could look it up if you want. I'm not sure if it was actually fractured.

Q I just think, Doctor, if you're going to say she may be histrionic, you ought to know what these things are. So maybe you better look at that.
A Well, based on my exam, I could say that.
Q Just based on her exam, you could tell she was histrionic?
A Yes. She was faking, in your term, neurologic symptoms and signs.
Q Okay. And you think that's a lifelong behavior?
A It may be.
Q Maybe learned from her mother?
A Well, I'm not going --
Q Is that what you said?
A I won't speculate on that.
Q Okay. And she had cancer.

You don't think she was faking that in any way, do you?

A No. It's related to the DES.
Q She had lower-quadrant pain and had an appendectomy?
A Correct.
Q Do you think that she somehow faked appendectomy symptoms, --
A She didn't have --
Q -- or appendicitis symptoms?

A She didn't actually have those symptoms. She had lower-quadrant pain. What I recall from reading the notes is that she didn't have rebound and the other things you associate with actual appendicitis. She had a number of normal tests.

She persisted in having pain, and they finally did one more test and thought they saw some fluid. And based on that they took her to the operating room, and it was a normal appendix.

Q So what's the significance there?

A I think she had some pain that was not related to appendicitis that she elaborated on. She was in the hospital for quite a while about it.

Q And that was at University Hospitals here, right?

A I don't remember where it was.

Q Well, it was --

A Fine.

Q That's what the records say.

So are you saying that the doctors at University Hospital here did an unnecessary surgery on her?

A The surgeons always say, "If you think appendicitis, you should do the surgery." So you'll have to ask them about that.

Q I'm asking you. Do you think they did an

unnecessary surgery?

A I wouldn't want to speculate on that.

Q Sinusitis. She's also had sinusitis problems?

A Correct.

Q Do you think those are real?

A I wouldn't want to speculate on that either. I'm sure some of them are real. She's had procedures to deal with them. And sinusitis can cause a lot of the problems that she complains of: headache, dizziness.

Q Carbon monoxide would be more likely to cause those kinds of things?

A Acutely. And statistically, no, sinusitis would be more likely, because it's more common.

Q Sinusitis would be what?

A Sinusitis is more common than carbon monoxide poisoning, so that would be more likely to cause those symptoms.

Q Oh. I thought you were saying the symptoms didn't match up with sinusitis?

A No.

Q Okay. Page 7 of 8 at the bottom there. **Is** this last paragraph part of your medical opinions or is it just a -- I don't know what. I'm not sure what it is. Is this part of your medical

opinions, this last paragraph?

A Well, let me read it. It's part of the summary. It's part of my summary of her cognitive and emotional status.

Q I mean does it form the basis of any of your opinions in the case?

A Which opinions? It doesn't form the basis of my opinion about her seizures. It does not form the basis of my opinion about her neurologic deficits. And it probably contributes to -- in my opinion, contributes to her current behavior.

Q "Current behavior" meaning what?

A Vis-a-vis her cognitive testing.

Q Oh. You mean the scoring poorly on the cognitive tests?

A Correct.

Q And that's as a result of an emotional problem; is that what you're trying to convey here?

A I think I convey that it's a combination of things. She's somebody that was not -- didn't have good mechanisms for dealing with, you know, any additional stressors in her life.

Q And that's based on your review of --

A It's based on all of the notes, from her psychologist, from her other doctors, and her

MMPI in '93.

Q Are these two reports that we have marked the only two reports you have cr'eated in this case?

A Correct.

Q Did you do any drafts of these?

A Graphs?

Q Yes, drafts of the reports.

A Drafts. No. I mean there were some -- I corrected some typos initially. Unfortunately, I see I didn't get them all. But other than that, no.

Q You referenced you reviewed the Charlie's Crab records?

A Yes. That was sent, too, with the stack.

Q Did you ask for those, or what happened?

A I asked for whatever was available, and I got in addition a bunch of billings and the Charlie's Crab notes.

Q Are the Charlie's Crab records of any significance to you?

A Well, I looked through them, and I noted she was having difficulties at work before the incident requiring counseling, making frequent mistakes and had even requested, I don't know, some kind of leave right before the incident for some

emotional distress or something. It wasn't clear what it was for.

Q Are those the employment records you looked at?

A That's all I had given to me.

Q When you say making frequent errors --

A I think one was, you know, an incorrect adding of the bill. And I forget. One had something to do with a gift certificate. I didn't quite understand what the mistake was there.

Q So what I mean is, when you say "frequent errors," that's two errors?

A I think the person that was her supervisor made some note as to saying, in effect, "This is" -- "I told her this is the last time," or something like that, "I'm going to put up with this."

Q Last time I think you said you do know Susan Redline?

A I know her by name.

Q Did you look at any of her performance evaluations of Veronica Ferrette?

A Nobody gave those to me.

MR. LANSDOWNE: Let's mark this as an exhibit.

- - - - -

(Plaintiff% Exhibits 6 and 7 were marked.)

- - - - -

Q You have an appointment at Case, don't you?
A Yes.
Q Do you do employee evaluations?
A Yes.
Q Does this look like one that you did?
A No. The ones I do are under University Hospitals, so they're not quite the same.
Q Well, this is Dr. Redline's evaluation of Veronica Ferrette?
A Yes.
Q And the position is on the back, "Research Assistant II."

Do you see that at the top?

A Yes".
Q Do you know what that position is?
A No. It's some research assistant, but I'm not sure of the significance of the "II." It's a salary level, I assume.
Q Do you see the categories for the review? For "Initiative" she gets an "outstanding"? Do you see that?
A Well, I see a "1," actually.
Q And the "1" is "outstanding"?
A Okay.

Q You see that?
A I see that at the top.
Q You understand that?
MR. HENTEMANN: I'll object. This is not a document that was prepared by her, prepared by the witness.
Q You said before you would like to have --
A No, I did not. I said I would like to have --
Q Well, let me finish my question, Doctor. Last week you said it would be interesting for you, in trying to assess the whole patient, to have information about how she performed prior to the carbon monoxide exposure; isn't that fair?
A Yes.
Q And this document does relate to a period prior to -- her work performance prior to her carbon monoxide exposure, correct?
A It's dated the 20th of December, '94.
Q And that is prior to her carbon monoxide exposure?
A Yes.
Q And so would you agree with me, then, that this document would be of interest in trying to determine Veronica's premorbid condition, as you call it?

A I would agree that it indicates that she was doing well at that time.

Q It actually indicates she's doing outstanding at that time overall, correct?

MR. HENTEMANN: Objection. It characterizes the document.

Q Well --

A Yes. You would have to talk to Dr. Redline about that.

MR. HENTEMANN: Talk to Dr. Redline. Is she going to testify?

MR. LANSDOWNE: She's on our witness list.

Q The "Supervisor's Overall Rating," "Outstanding." Do you see that?

A I see that she checked that. I wouldn't want to interpret Dr. Redline's evaluations.

Q But you do evaluations of employees, you've said, right?

A Not on that form.

Q Are there categories of "outstanding," "good," "satisfactory," and that kind of thing on yours?

A They're similar. It's not exact. It's not identical.

Q Similar?

A We have a point system rather than descriptors.
Q I would imagine that in a hospital setting, it's important to be accurate and candid in your evaluations of employees?
A I'm not going to comment on that.
Q You're not?
A No.
Q Okay.

MR. HENTEMANN: What was the date of that report?

THE WITNESS: December.

MR. HENTEMANN: 12-20-94.

THE WITNESS: Yes.

Q Did you have an opportunity to read Dr. Felker's report?
A Yes.

MR. HENTEMANN: Excuse me, Dennis. But you had another document identified in conjunction with this.

MR. LANSDOWNE: Yes. I'm going to come back to that one.

MR. HENTEMANN: Okay.

MR. LANSDOWNE: That will be number 7.

MR. HENTEMANN: What is number

7?

MR. LANSDOWNE: It's a description of "Research/Sleep Technician, Technician II."

BY MR. LANSDOWNE:

Q Having read Dr. Felker's report, did it refresh your recollection if you had ever seen this report prior to over the weekend?

A I don't believe I had read the whole report before. I believe I said I remembered seeing the IQs. It may have been included and it got overlooked.

Q What, did you make some notes about the report over the weekend?

A Yes, since I read it on the weekend.

Q All those notes?

A No. I also tried to get some kind of chronology thing going but wasn't very successful. These are mainly Felker's. This is Naugle here. Naugle was the one that was new.

Q You had not seen Dr. Naugle's report before?

A Correct. I had seen it just before we started the deposition. It had been sent to me on the 7th, so I hadn't had a chance to read it carefully.

Q Okay. Are you familiar with the Wechsler Adult Intelligence Scale III?
A Yes.
Q Do you administer those tests or --
A No. Psychometricians or neuropsychologists administer those.
Q Is it a well-recognized test?
A Sure.
Q Do you rely on those kinds of results in your work?
A In our presurgical evaluations, yes.
Q All right.
A It's one of a series of tests; it's not the only one.
Q How would you describe her score, Veronica's score, on that test as given by Dr. Felker?
A Well, she had a difference in her verbal and performance IQs. It would be borderline greater than the performance. Usually you look at 15 points to be significant between verbal and performance IQ. Full-scale IQ of 74 is obviously below average. That's a 100-point scale, 100 being average.
Q It's a hundred-point scale?
A No. It goes up. But 100 is average.

Q Okay. Well, how would you describe 74?
A I said it's obviously below average.
Q Did this appear to you, from your experience and knowledge, to be a full psychological analysis?
A Which, the Wechsler or just the whole report?
Q The whole report. Dr. Felker's whole report.
A I believe it seemed fairly complete. I don't recall all the tests given specifically.
Q Well, do you recall anything missing?
A Let me pull it out. Let me pull it out.

There's always going to be something missing. I mean there are hundreds of tests you can do.

Q But I mean anything that struck you that should have been done that wasn't done?
A I didn't look at it from that point of view.
Q Okay. Well, what point of view did you look at it from?
A I just read it from the general results and to see how it compared with other observations of Ms. Ferrette.
Q And what were your conclusions about that?
A Well, she's obviously performing at a very low level relative to her previous employment record, college record, so on.

I thought it w'as quite interesting that she reports, Dr. Felker reports, her areas of strength are the "knowledge of social norms, knowledge of social practices and common sense judgment."

The reason that's interesting is because common sense is actually a reflection of IQ. The former neuropsychologist that we worked with corrected me on that one time. I remember it very well.

So in her interactions with the psychologist, she impressed her as functioning normally, but she tests very low.

Q Well, where does it say that she interacted normally?

A It says, her areas of strength are, and I just read it. So "knowledge of social norms," "social practices and common sense judgment."

Q Okay. She didn't say anything about being normal, though, did she?

A I made that statement that I thought that was interesting.

Q I see. Okay.

Dr. Felker concludes that Veronica "...shows a primary diagnosis of Organic Brain

Syndrome Secondary to Carbon Monoxide Poisoning," and "Some Depressive Symptomatology is also noted." That's on the basis of the testing that she did, apparently.

Do you agree or disagree?

A I would have to disagree. I think that all that she can say is that she performed poorly on these tests. She can't say what the etiology is. That's not revealed by these scores. These scores are nonspecific for etiology.

Q Do you believe that the scores are valid?

A I don't believe she did a validity test, actually, that I recall. I think they're certainly inconsistent with other aspects of her evaluation.

Q You mean the evaluation that **you** did?

A Correct. Of course, mine was after this one. Maybe she had improved by then.

For instance, if we look at the "Auditory Immediate" memory, she's "Extremely Low" in this test that she took in 19 -- when was it? -- '99.

And her immediate auditory memory was 5 out of 5 with one try. So 100 percent.

Immediate visual memory also "Extremely Low," immediate visual memory in '99.

5 out of 5 with two tries. So not quite as good.

Q Well, you did --

A And so on and so on.

Q Your testing of immediate visual memory was a 5-out-of-5 test, right?

A Correct,, In the office.

Q An office exam, as compared to this much more extensive exam that was done here, correct?

A No. Extensive doesn't make it better. It depends on how the patient is trying to perform.

Q Do you know --

A This doesn't -- you know, her scores are too low to make any sense. Look at her -- you know, she walks in, she has a normal vocabulary, she uses big words.

You look at her descriptions of her own progress and her occupational therapy. She's using words like "eligibilities" correctly. She's interacting in a normal way.

And how can she have a seriously impaired vocabulary when she's speaking so fluently?

Q I guess that would be something that a neuropsychologist would have to answer, don't you think?

A They could answer that. But I think that --
Q And you can't?
A I would not agree to that.
Q You disagree even though that's not really your specialty?
A It's my specialty to the extent that I do a lot of evaluations of people with neurocognitive problems and seizures, and I have to make judgments on those evaluations before taking a person to surgery. So we have to understand very critically if problems are real or not, if those problems are going to get worse with surgery or not.
Q And that's why, when you're doing that, you refer the patient to a neuropsychologist?
A But I don't refer them to a neuropsychologist and take their report as the Bible. The neuropsychologist and I discuss it in light of the exam, the MRI, the EEG, the social factors, et cetera, et cetera. You know, you can't take these documents as an isolated piece of work.
Q Dr. Felker concludes that Veronica is totally disabled.

Do you agree with that?

A I think that's a legal definition.

Q Well, this is a legal case.
A Well, I'm not a lawyer. Sorry. I don't think I'll comment on that.
Q Do you think that Veronica is capable of employment?
A I wouldn't want to comment on that.
Q Okay. You have no opinion one way or the other?
A I think she may be. I think she may not be.
Q Okay.
A I'm not -- it depends on her state at the time.
Q Okay. Well, I just want to make sure. If you're going to not, if you don't have an opinion about it, that's fine. Do you?
A She's certainly not disabled from a neurologic point of view. Whether she's emotionally or mentally disabled, I'm not -- I wouldn't want to comment on.
Q Are you familiar with something called a Mini-Mental State Exam, MMSE?
A It's a screen for dementias.
Q Do you use that test?
A Sometimes. Usually I do more testing than **is** on that screen, so I don't typically use it. It's specifically useful to follow people with dementia due to Alzheimer's or microvascular

dementias to watch, to observe their progression.

Q Let me ask you about Alzheimer's.

Do you do any work with Alzheimer's patients?

A Not a lot. I believe you asked me about my practice the last time.

Q Yes. I didn't remember you saying specifically anything about it, but I thought you might have done some work with it.

Really my question is, in the early stages of Alzheimer's, is it true that MRIs and CAT scans of patients can be entirely normal?

A Well, CT is an insensitive test, so I wouldn't use that to judge anything.

Q So CT you wouldn't use to judge anything in this case or any other case?

A I wouldn't, no. It's too insensitive.

Q Okay.

A It's mainly useful to show bleeds.

Q Right. It's not really sensitive --

A No, it's not.

Q -- for the brain insults, correct?

A It shows gross insults. But if you're looking for a sensitive test, it's not your first choice.

Q Well, MRIs as well, in early-stage Alzheimer's

patients, can be entirely normal, correct?
A They can show atrophy consistent with age. That's frequently how they're read as normal.
Q Right. Well --
A Because people can have atrophy but not particularly show signs of Alzheimer's. So the norm includes significant atrophy.
Q So if you're a certain age group, you're expected to have a certain amount of atrophy, and otherwise --
A And some people don't, so --
Q Some people don't.
But getting back to my question, then, in the early-stage Alzheimer's, frequently MRIs are read as normal, correct?
A I don't know the percentage point, but I wouldn't argue with that.
Q You had recommended a Beck depression test of some sort?
A Depression inventory, yes. I don't --
Q What is that?
A I don't think I had seen these other evaluations at the time.
It's a screen for depression.
Q Why did you recommend that?

A It's just one that we typically use. But there are others, I'm sure, that are useful as well. I don't know all of the depression screens. I should have maybe just said "a depression screen" or "some depression screens" rather than give a specific name.

Q Well, why did you recommend any depression screen?

A Because she appeared to have a history of depression, and depression can significantly impair cognitive function. In effect, there's an etiology called pseudodementia, which is indistinguishable from dementia except that their EEG is normal. So you treat them for depression, and you can cure their dementia.

Q So you were thinking maybe the source of her cognitive difficulties was depression?

A Yes.

Q And you wanted a --

A I was thinking that could be a contributing factor.

Q And you wanted to have a test done to see how she scored on that, correct?

A Correct.

Q And, in fact, you did want know that she had

already had such a test, correct?

A Correct.

Q And, in fact, she scored on that test in such a fashion that you wouldn't expect depression to be having any significant effect on her cognitive function, correct?

A I don't know. Where is that at?

MR. HENTEMANN: Are you referring to Felker's report?

A Is it Felker or is it somebody else?

Q Well, I think it's been performed a couple times. But --

A Well, I think there's been more than one performance. I'm not sure what you're referring to. Affect, mood --

Q Well, do you know how she scored on --

A Her, Dr. Felker's, statement was that she showed some depressive symptomatology. I'm not seeing a score here.

Q Did Dr. Naugle do --

A Let me see if I have his.

Q Page 4 of his report.

A Oh, it's in the -- can I see it? Is it in the exhibits?

Q No. Page 4 of Dr. Naugle's report.

A Oh, I'm trying to find it. I thought it might be in the exhibits.

Q Do you want to just look at this page?

A Yes, I appreciate it. Thanks.

Q Save ourselves some time. It's the second full paragraph.

A Right. I see it.

Q It says, "The Beck Depression Inventory did not suggest significant emotional distress at this time," correct?

A I see that, yes.

Q So that's what I was indicating before, --

A Okay.

Q -- that depression would not account for the type of cognitive scoring that she did for Dr. Felker?

A It doesn't appear that it would, no. She didn't seem clinically depressed to me, but that's always something you have to be cognizant of.

Q Dr. Naugle also ran the same Wechsler Intelligence Test?

A Correct.

Q And again, I can give it to you.

A I have it. It's in here.

Q (Handing.)

A Oh, it's probably in here.

Q One, two, three, four, five, fifth paragraph.
A Yes, I see that.
MR. HENTEMANN: Which page of Naugle?
MR. LANSDOWNE: 3.
THE WITNESS: That's 3.
A Yes, I said I saw it.
Q Okay. She again scored lower on her performance IQ than her verbal IQ, correct?
A True.
Q So that would be consistent with what Dr. Felker found, correct?
A True.
Q And in fact she got the same exact full-scale IQ of 74 as Dr. Felker got, correct?
A Correct.
Q Now, again, do you think she's -- what term do you want to use now? -- malingering or manipulating this Wechsler Adult Intelligence Scale test?
A I don't think she set out to get the exact same score in each test, no.
Q Do you think she's malingering and manipulating the Wechsler Adult Intelligence Scale test that was given by Dr. Naugle and by Dr. Felker?

A I think that it's likely that when she knows she's being tested for cognitive functions, she performs below her abilities.
Q So that's a yes for both of those?
A Yes.
Q Okay. Purposely performs below --
A I said before I wouldn't want to ascribe motive.
Q Okay. Purposely, or because of some emotional deficit, scores poorly, right?
A Well, I don't know about the term "deficit," but people --
Q Well, I don't know what else to say --
A People perform poorly sometimes, as I said before. Sometimes they absolutely know that they're doing it and they just do it for a specific set gain.

But other times -- most times it's not that easy to establish why somebody acts the way they do. Why does somebody take drugs when they know it's bad for them?

Q Well, in any event, she ends up scoring exactly the same on the full-scale IQ for Dr. Naugle as for Dr. Felker, and those tests were performed more than a year apart, right?
A Correct.

Q So if she was manipulating that test, that would be quite a remarkable achievement, to be able to manipulate the exact same full-scale **IQ**, two tests, more than a year apart; wouldn't you agree?

A I don't know that.

Q You're not familiar enough with the test to know that?

A Well, the test consists of many subtests. I think it would be remarkable if she got the same score on every subtest. But to come up with the same average is probably statistically not as difficult as the other problem.

Q But you're just not sure?

A I'm not sure.

Q Okay.

A The scores are plus minus 5 points anyway, in accuracy.

Q That would be more -- you would expect a neuropsychologist would have more information about whether that would be a --

A Hopefully.

Q -- significant finding? Hopefully? Okay.

Let me ask if you agree with this from Dr. Naugle's report.

MR. HENTEMANN: What page?

MR. LANSDOWNE: The last page, 5.

Q This is getting into his summary of his conclusions here.

And you have had a chance to read the whole report, right?

A Yes, I've read it.

Q And he's referring to the test results he got. And he says, "Such a neuropsychological profile is typically indicative of generalized cerebral dysfunction and would be consistent with the type of compromise resulting from extensive CO exposure."

Do you agree with that?

A Yes', it could be consistent with extensive CO exposure.

Q Okay.

A That's different than saying, "This is clearly due to carbon monoxide."

Q I understand.

A It's just saying it's consistent with it.

Q "The neuropsychological profile would be consistent with this type of compromise."

Okay. You agree with that?

A I just did.

Q Second sentence: "If her test performance were presumed to be a valid indication of her ability, the fact that there is no other known event or illness before or since her CO exposure that would account for the severity and extent of her compromise would suggest that her CO exposure was responsible for her cognitive decline."

Do you agree with that?

A Yes. If it were presumed to be valid and if she had no other risk factors, is basically what he's saying.

Q He says the fact that there is no other known event or illness before or since her CO exposure, that would account for the severity and extent of her compromise?

A If her performance is presumed to be valid, yes.

Q So you would agree that if the test that Dr. Naugle performed, Dr. Felker performed, and Dr. Layton performed were valid, then that would suggest that her CO exposure was responsible for her cognitive decline?

A There's a lot of ifs there. It's just too much of a strung-on sentence. If you can break it down, you know, into individual components.

Q All right. Well, if **Dr**. Naugle's tests are a

valid indication of her ability, you would agree that her CO -- it would suggest that her CO exposure was responsible for her cognitive decline?

A That would. be suggestive, yes.

Q And you would agree that if her performances on the tests performed by Dr. Layton were a valid indication of her ability, that would also suggest that her CO exposure was responsible for her cognitive decline?

A It could suggest that.

Q Okay. And you would agree that if Dr. Felker's test performances were a valid indication of her ability, that would also suggest that her CO exposure was responsible for her cognitive dec1ine?

A Yes, that could be a suggestion.

Q With the cognitive impairments that you identified, could Veronica work as a sleep technician? Do you think she could organize and run her own business with the cognitive impairments that you found?

A Yes. But I didn't specifically test business organizational skills. So just within the limits of what I tested is how I understand the

question.

Q I'm just asking based upon the impairments that you found, that's all, because that's all I can ask you about.

A Right. She had minor impairments, so I'm sure she could be a tech. Maybe she could run a business. I'm not as sure about that.

Q Why aren't you as sure about that?

A Well, because that involves a lot of other skills. Being a tech is, basically you're taught to do a certain type of testing, usually not a whole lot of different types of testing. And you do that repeatedly, and you can get to be a very good performer at that.

Running a business involves a lot of flexibility. And I don't know if she has that or not.

Q Because you didn't test for it?

A No. No, I think Dr. McPherson noted that she was not flexible but -- actually, I think what you just showed me said that she was not flexible. But whether that relates to business skills or not, I'm not sure.

Q The thing I just showed you, you mean her --

A Her evaluation.

Q -- her evaluation?
A Right. Dr. Redline, which is a different kind of a function.
Q I have to ask you about this, because it's in your report. You note a discrepancy or some kind of finding with the left labial fold?
A This is the labial fold. It was a little bit flatter on one side than the other.
Q On the left side?
A Yes.
Q What's the significance of that?
A Most neurologists would say it doesn't have any significance, because a lot of us have an asymmetric face. It's one part of the test we do to put together with the whole rest of the examination.
Q Well, I mean you noted it in your report. That's why I'm asking you about it.
A Yes. I always note that.
Q So the reason that you look for it is that --
A It could be a subtle sign of some facial weakness. But then when I tested her strength in her face, she didn't have weakness. But it's something we report on exam.
Q Because it can indicate --

A What I just said.
Q -- some kind of damage to the nerves or to the brain?
A It could represent a small -- yes, like a tiny stroke or birth injury or something like that.
Q Or brain damage from a toxic substance?
A Not typically focal, no.
Q You can have focal deficits from toxic substances?
A If you have a secondary event, like a bleed or a stroke.
Q Not unless that --
A Correct.
Q Never?
A Correct. You don't have to necessarily see it on an MRI. Rut if you have a focal finding, you have a focal lesion. That's the essence of the neurologic exam.
Q Okay. And you can have a focal deficit and a focal finding and not see it on MRI?
A Correct.
Q Okay.
A The exam is more sensitive than the MRI.
Q And a left labial fold discrepancy could be an example of a focal deficit?

A It could be.
Q Okay. You say in your report, page 7 of 8, "I recognize that some of her deficits were in the area of more complex operations..."?
A Yes, we discussed that before. I was quoting Dr. Layton's evaluation, I believe, wasn't I, at the time?
Q Well, you quoted Dr. -- you said it was Dr. McPherson.
A Okay. Dr. McPherson, then, but yes.
Q I think we established Dr. McPherson did not do a neuropsychological exam?
A Because she was earlier, no.
Q So this is another error in your report?
A It's one error in my report.
Q Well, we've seen some other ones.
So people do makes errors?
A Typographical errors.
Q So even waitresses at Charlie's Crab make errors?
MR. HENTEMANN: And even lawyers, too.
Q Even lawyers.
You did not test for complex operations, correct?
A Well, I think we went over this before. Do we

want to go over it again? I can be here until --

Q Did you test for --

A Off the record.

I can be here until about 3:30. I have a patient to admit here today.

Q Okay. Go ahead. I'm just asking one question. Did you test for complex operations?

A Certainly.

MR. HENTEMANN: I'm going to object. It was asked and answered.

A We did answer it before.

THE WITNESS: Off the record.

(Discussion held off the record.)

BY MR. LANSDOWNE:

Q Your answer was that you thought you had tested for some?

A I said there's a whole realm of complex operations. Some of what I did would fall in the more complex arena, others wouldn't.

Q Okay.

A I mean that's not the same as some other evaluations. Like paragraph recall I specifically mentioned, which I didn't test.

Q All right.

A I think that's one of the things I was referring

to. She had been shown deficient in paragraph recall by probably Dr. Layton.

Q Okay. You found some end gaze nystagmus?

A Yes.

Q What is the significance of that?

A AED levels, the levels of her carbamazepine and Neurontin.

Q Pardon me?

A That would reflect the blood levels of her carbamazepine and Neurontin.

Q Oh.

A Specifically the carbamazepine.

Q The medications that she's on?

A Correct.

Q Let me ask you about that.

She is on antiseizure medication --

A Correct.

Q -- prescribed by Dr. Mars, correct?

A Correct.

Q Is Dr. Mars giving her medication that she doesn't need?

A I'm certainly not going to answer that.

Q Okay.

A I believe I specified the evaluation that I would have recommended already.

Q Yes. You said you would have recommended a --
A Video EEG in the hospital, off medications.
Q Okay. And you would be looking for what?
A Seizure focus.
Q And she might have that? You might find that?
A If she did not have it after being off AEVS's and sleep deprived for over a week, the probability of her having a focus would be less than 1 percent.
Q If it didn't show up on --
A Correct.
Q If you didn't have a finding on the video EEG, correct?
A Correct.
Q But I mean let's assume she had the test -- this is an evaluation that you would recommend for her?
A Correct.
Q And what you'd be looking for **is** some evidence of seizure activity?
A Correct.
Q And if you found that, how would that change your opinions in this case?
A If I found that, I would leave her on medication.
Q How would it change your opinions in this case?

A Then I would think that she had seizures, and that was not one of the areas of contention.

Q What do you mean, it was not one of the areas of contention?

A I wouldn't be doubting that she had seizures.

Q Oh.

A I'd still be dou'btingher exam.

Q Okay. So if this video EEG or a PET scan showed evidence of some focal --

A Abnormality.

Q -- abnormality, you would then just realize that, yes, she does have seizures, but it wouldn't change your opinion as to her neurologic deficits?

A The deficits on her exam, no.

Q Okay. And as to the cause of the seizures?

A Well, I don't think we would know the cause of the seizures.

Q Okay. You wouldn't know one way or the other what was the cause **of** the seizures? You wouldn't have an opinion about it?

A Well, I think I stated my opinion would be it would be more likely to be a focal seizure from a perinatal injury than from carbon monoxide poisoning, and which, if they have seizures,

they're -- typically, generalized focal seizures are rare.

Q That's your opinion as it relates to carbon monoxide?

A Correct. Or any toxin. Toxins produce generalized insults. The whole brain is affected at the same time.

Q And you said the basal ganglia is the most common place to be affected?

A Well, that's one of the most common. It affects the cerebral cortex, too.

Q With carbon monoxide?

A Correct. That's what we're talking about.

Q Can you cite me to any literature that says the basal ganglia is a common source of damage from carbon monoxide?

A I think if you look through the literature on carbon monoxide, you'll see a lot of reports of neuroimaging shows basal ganglia damage. In terms of one unique reference, no. There's a lot of them.

Q You think that because you've read it or just think that?

A Well, I was taught that. I trained at Columbia Presbyterian, which involved training at Harlem

Hospital, where there were a lot of cases of carbon monoxide poisoning. And, yes, we were taught that this is a diffuse process that typically will involve the basal ganglia.

Q And that's --

A And the cases that I said I followed myself indeed did have that disorder.

Actually, too -- you said I could add to my testimony at a later point.

Q Sure.

A I remembered I do have other exposure, other work with, experience with carbon monoxide poisoning from working in the respiratory intensive care unit at UCLA. All the firemen that had a PC02 of a certain level, I think it wa's probably like above 25 -- I mean a carboxyhemoglobin level -- were admitted to the respiratory intensive care unit.

So when I was working there, I saw quite a few of them coming in. They'd get their nasal 02 and they'd go out and go back to the fire.

Q What was your involvement?

A I was working as a medical resident in the pulmonary intensive care unit.

Q For what period of time?

A A couple months. I think one of the months there there were a lot of those California brush fires, so we had a lot of them coming in.

Q That did not involve neuroimaging of these people who had been exposed?

A Sometimes it may have. But these people were -- they came in, basically they're neurologically intact, and they're treated until their levels are okay, and then they go home or they ***go*** back to the fire.

Q They're not people who were found unconscious from carbon monoxide poisoning?

A Well, some would have been unconscious, but most of them probably were not. They'd just come in and get tested after a significant smoke inhalation and exposure.

Q What were their levels, did you say?

A I think they had to be about 25 to be brought in. You know, I'd have to check back. It's **a** long time ago to remember the exact levels.

Q Levels as high as 40?

A Yeah, sure. Higher.

Q As high as 40, these firemen?

MR. HENTEMANN: Did you say "higher"?

A I think higher.
Q And they'd come in perfectly normal, neurologically intact, and you'd give them some oxygen and send them back to the fire?
A Correct. They'd usually stay about 24 hours' I guess. A little longer than she stayed in the hospital.
Q Did you do any follow-up work with these people?
A No. I'm sure they followed up with the pulmonologist.
Q So you don't know?
A As I said, I was working as a resident.
Q So you don't know what their neuropsychological result was?
A Well, I know they were good enough -- they felt themselves they were good enough to go back to work, so I think that was their choice.
Q You don't know ultimately what their neuropsychological deficits might have been?
A No. But I'm sure there's a lot of literature on firemen.
Q Okay. Have you read any of it?
A No. Have you?
Q Yes.
So what are we talking about? You saw

two, three fireman?

A Well, you asked what my experience was.

Q I understand. I'm just following up.

A I told I told you my experience with two cases that were neurologically impaired. Then I remembered over the weekend, we saw quite a few firemen coming into the pulmonary ICU.

Q You can't remember how many and you can't really remember the levels that they had?

A Well, they wouldn't be admitted for, you know, a level that was not significant to an ICU setting.

Q I know, Doctor. But --

A And there were about six of them. Probably about half a dozen.

Q If you're going to testify that this somehow qualifies you to give --

A No, I didn't say it qualified me as an expert. You asked what my experience was. I was telling you what it was.

Q I know. And I'm just following up on it.

And all I'm asking is, currently what the levels were. And, you know, this is a long time ago. Can you remember what the levels were?

A I reported to you that they would not be admitted to an ICU if they did not have significant

levels.

Q Give me a number.

A That's obvious.

Q Give me a number.

A I said probably over 25.

Q Do you remember or are you guessing?

A I'm guessing.

Q Okay.

A I guarantee you the third-party payers don't guess. They wouldn't be in an ICU unless their levels were higher.

Q I'm sure. Here is Exhibit 7.

A Okay. What is this?

Q This is a description of a "Research Sleep/Technician, Technician II."

It's actually a requisition for the position, but it describes what the position entails?

A Yes.

Q Have you ever seen that before?

A No.

Q This is the job that Veronica Ferrette held?

A Was this at the VA?

Q Actually, it was when she moved from the VA -- well in part.

MR. HENTEMANN: I'm going to object to the questioning on that document without any proper foundation.

Go ahead.

Q Do you think, given this brief job description, that Veronica Ferrette could perform those functions today?

A I wouldn't want to comment on that.

Q Can I see your file there, Doctor?

A Sure. (Handing.)

Q These notes, did you make all these over the weekend or --

A Yes.

Q Okay. This "Toxic Smoke Compounds and Inhalation Injury, A Review," that's the only article that you have in your file here?

A Correct.

Q And what did you get this for?

A When I heard I was going to see a case of carbon monoxide poisoning, I just looked for a general review article. Actually, I was hoping for more of a neurologic review article, but I didn't find one.

Q Let me just make sure I understand your role here, Doctor.

You're scheduled to testify on videotape, what, next week?

MR. HENTEMANM: Boy, I don't know.

THE WITNESS: I'm not sure what the date is.

MR. HENTEMANN: We were working on that this morning. The 20-something.

Q You're going to do a videotape deposition, I understand?

A That's what I understand, yes.

Q And your essential opinion will be that Ms. Ferrette does not have a neurologic impairment, correct?

A Correct.

Q And that she may have some slight cognitive impairments, correct?

A Correct.

Q And to the extent she does have these cognitive impairments, they were probably caused by the perinatal issues we talked about before, right?

A I think I would say there's no way of knowing whether they were present beforehand.

Q Okay. You're just going to say that -- well, is it possible they were caused by the carbon

monoxide poisoning?

A It's possible.

Q Okay. And it's possible they were there before?

A Yes.

Q And the two are just equally as possible?

A Yes, I believe so.

Q And then any other opinion that you're going to offer in this case?

A Regarding the seizures?

Q Oh, the seizures. Seizures, you're going to say that -- your opinion is going to be that she probably has pseudoseizures?

A That's a term we often use. It's kind of being replaced by "nonepileptiform seizures." But either term.

Q Yes. Can you tell me what that means, that "nonepi1eptic"?

A Yes. That means that people have behavioral manifestations that appear similar to seizures, but there's no abnormal electrical activity in the brain.

Q And you think that the seizures that Veronica is having are caused by what, her emotional problems?

A I think it's likely to be caused by her stress

over this whole situation, her desire to have her needs attended to, and to get attention for whatever problem she sees in'herself.

Q Stress, desire to have needs attended to. And what was the third one? I'm sorry.

A I think that was essentially it.

Q Okay. So an emotional or psychiatric condition?

A Psychological, yes.

Q Did you suggest that Veronica be evaluated by a psychiatrist or a psychologist?

A I suggested the neuropsych testing.

Q Oh, okay.

A And I knew that she was seeing a psychologist already.

Q Okay. What else? Is there another opinion, or is that it?

A That's pretty much it.

MR. LANSDOWNE: Let me take a minute.

(Recess taken.)

BY MR. LANSDOWNE:

Q Doctor, I'm going to ask you to read a couple things, if you would, from your notes.

A Yes. That's why I usually dictate them.

Q Yes. What is that?

A Yes. That was when she was admitted. I went over the admission note. That's her ABG, arterial blood gas --

Q Oh, okay.

A -- at 3:35 in the morning. That's what that was. It looked like an O.

Q What's this "3 hours" here?

A Well, I was still trying to figure out whether she had the hyperbaric oxygen or not. I didn't see a report in the medical records, and I'm just curious.

I don't know that it changes the whole picture any, except that somebody mentioned she had it. I didn't find a report of it from the hospital. But on this one, oxygen, her PO2 was 364, which is really high. So I mean maybe she had it. I don't know.

Q PO2 of 364 would show significant anoxia?

A No, no, no. That's really high. That's much higher than normal.

Q Oh, you mean -- I'm sorry. I'm thinking .3.

A 364, yes.

Q So that would indicate that she had been --

A Possibly she did have the hyperbaric oxygen.

Q Right. Because that would raise her oxygen?

A I don't know how high you can get up with a nasal cannula. You'd have to ask a pulmonologist.
Q You did look at Dr. McPherson's material?
A Yes. It's in there'.
Q And my reading of that was that Dr. McPherson, at the end of her -- she did two evaluations.
Is that what you understood?
A Yes, I believe I remember that.
Q And at the end of the second one, she had indicated that she didn't expect Veronica would need any further treatment?
A Yes, she thought she was over her acute problem.
Q I have it in here.
A That's my recollection.
Q My copy didn't come out that well.
A Here it is.
Q Do you have it? would you turn to the last page of her report.
A The second report --
Q Yes.
A -- or this big, long one?
Q The second report.
A Yes, this is 12-22. January 7, is that the second one?
Q 1-7-95, yes.

A Okay. Which page did you want, second page?
Q Last page.
A Oh, last page.
Q 6.
A Yes.
Q It indicates there in that first paragraph, "It would be expected that the residual symptomatology currently in evidence would itself remit as a function of completely ending her need to deal with aspects of this situation."
Do you see that?
MR. HENTEMANN: I'm going to note an objection to this interrogation about this report.
A It doesn't sound like what you said. "Adjustment disorder of anxiety"? Is that where you are?
Q The next sentence.
A Oh, okay. Yes.
Q "It would..."
A Yes.
Q Would that indicate to you that Dr. McPherson is saying that she expects Veronica to be fully functioning, and any problems with whatever the previous situation was would not cause her any further difficulties?

MR. HENTEMANN: Objection. I mean --

A Speculating on what Dr. McPherson thinks?

MR. HENTEMANN: Yes, you're asking her --

Q Well, let me just ask this --

A She states that in this paragraph, and in the next paragraph she says something else. So --

Q Does Dr. McPherson's report play any role in your opinions in this case?

A Well, I made my opinion of the exam results before reading it. Subsequently it played a small role in that she had had some situation in which she became completely distraught over some altercation and sought legal attention for that and tested very poorly at that time in terms of her emotional, psychological aspects, but when it was over, recovered.

She said, "I would not be expected" -- "It would not be expected that Ms. Ferrette would need any further psychotherapy or mental health assistance unless under conditions of prolonged legal involvement."

So she's not saying she's completely out of the woods, she's just saying as long as

there's no other similar stress.

Q Do you know what Veronica was doing at this time, where she was working?

A No. I would have to check on that. I don't remember exactly where she was working, if she was in school in '93.

MR. HENTEMANN: Don't guess.

A I won't guess. Dr. McPherson probably says that somewhere in her report.

Q Well, if she was working all throughout this period as a sleep technician, would that indicate that she was able to cope with whatever stress that was?

A I'm not going to comment. You know, we're just reading Dr. McPherson's statement.

Q Well, to the statistician you say this forms part of the basis of your opinion. I have to ask you about it.

A Well, you can look at Dr. McPherson's report.

Q All right.

A She clearly was performing very poorly at the first evaluation. And as you yourself just quoted, she then seemed to get better.

Q And when you say "performing poorly," that was not on a cognitive level, it was on --

A No. I mentioned it was on an emotional-psychological level.
Q She tested high on anxiety, fear, paranoia?
A Among other things, yes.
Q Do you know anything about the assault or anything that led to this?
A Just what was in these notes.
Q Okay.
A Actually, I think she had a deposition in there that I looked through. That was probably the main description of it that I saw.
Q A deposition?
A I think she had a deposition.
MR. HENTEMANN: Who?
Q Veronica.
A Veronica. I think she had a deposition.
Q That would have been the deposition that's in here.
MR. HENTEMANN: That's in her records.
Q That would be the deposition from this case correct?
A Oh, she didn't have a deposition on the first case?
Q If she did, we don't have it in these records in

front of you.

MR. HENTEMANN: No.

A Okay. Then it was just from the doctor's notes.

Q Let me see your notes again.

A Go ahead. That'one note on the yellow sheet, if you want to ask about that, actually in the same article.there.

Q Yes.

A You had asked me before, if she had been removed from the carbon monoxide, wouldn't 1 have expected the level to go down.

Q Right.

A The half-life for carboxyhemoglobin decreasing in the blood is on the order of five hours at room air.

So I would amend my answer to say, no, I wouldn't have expected it to have dropped significantly in the 10 to 15 minutes it took the EMS to get there.

Q That's on room air?

A Room air, right, which she was on.

Q She was on oxygen?

A She was on room air before the EMS got there. I thought that was the question.

Q The question was, between the time that she was

removed from the room and the time that the blood was drawn, she had had oxygen prior to her blood being drawn.

A I thought you were asking by the time EMS got there.

Q No. So do you want to unamend your answer?

A On 100 percent O2, it's about one and a half hours half-life, which means half would be gone in one and a half to two hours.

That's in that article there, if you want to check that.

Q Okay. Well, in any event, I guess the question is, would you expect that her actual level was higher than what they got when they did the blood draw?

A Yes. And I think I answered before, I would expect it to be higher with -- I don't know that it would be significantly higher, because it kind of depends on how quickly the blood was drawn.

MR. LANSDOWNE: Where is that letter?

MR. HENTEMANN: The article?

MR. LANSDOWNE: No. The letter.

A The letter? It's either in "Miscellaneous" or "Communications," if there's a "Communication"

section. Otherwise it's in "Miscellaneous."

Q There's a "Correspondence" section.

A "Correspondence." It should be in there.

Q That doesn't have it.

A All right. Then "Miscellaneous."

Q Here it is.

Is this your handwriting on this letter from Mr. Hentemann's office?

A Yes.

Q What does that say, your writing?

A "What did call say," question mark. "Seizure," question mark. "Mars said saw patient at Meridia ER, no note."

Q What is the seizure question?

A I wondered if the EMS witnessed a seizure. There was no indication that they had. So that's what I was asking, if there were any other notes that I was missing.

Q Okay. And did you receive information about what the boyfriend had witnessed in terms of seizures?

A No, I have not seen that. If that was a deposition or whatever, I haven't been given that information.

Q Would that be significant, if the boyfriend told you that at the scene he was awakened by her

seizing?

MR. HENTEMANN: Wait a second. By her what?

MR. LANSDOWNE: Seizing.

A If it could be established that she was in fact having a convulsion. I think you asked me that question before.

Q And that would indicate?

A It would indicate a certain result of the toxicity.

Q And that would, of course, as you said, put you at higher risk for seizures, once you've had a seizure?

A I don't know that that's the case.

Q Didn't you say that last week, that if you have seizure, you have high --

A It could it could, yes. There are a lot of instances of acute seizures that don't predispose to later seizures in an arena of metabolic imbalance or even acute head trauma. So it may, but it's not a hundred percent.

Q In any event, that would be significant, if --

A In the evaluation of the seizure disorder, yes.

Q If she in fact did have a seizure at the time of the exposure, correct?

A Yes.
Q The letter asked you whether any conditions that she has are permanent. That's one of the questions that you were asked by Mr. Hentemann.
With respect to the cognitive impairments that Ms. Ferrette has, do you have an opinion whether or not they are permanent?
A The ones that I observed in my evaluation?
Q The only ones that you can talk about, the ones that you observed.
A I think, yes, those minor changes may be permanent. They may have been lifelong, as I indicated before.
Q All right. You did get the life care plan?
A It's in here, yes.
Q Did you ask for that, or was it just provided to you?
A It was just included in all the records.
Q What did you do with it? Did you make any notes on it? Did you --
A No. I just read it.
Q Okay. Do you have any familiarity with life care plans?
A Not in that context specifically.
Q In what context?

A In the context of cognitive rehabilitation. I don't know that I've seen life care plans specifically.

Q Are you going to offer any opinions about the life care plan?'

A About the plan itself?

Q Yes.

A No.

Q Okay. Are you going to offer any opinions about Veronica's needs for the future?

A You know, I wasn't specifically planning to. If somebody asks me about it, I might give my opinion.

Q Okay. Well, I guess --

A It wasn't in my report, so it wasn't something that was in my mind.

Q If you're not going to be offering opinions about something, I don't want to waste our time on it. But I don't want to be surprised, either, when you testify at your video deposition. So if you're going to offer an opinion --

A Well, I would assume that I might be asked some questions that weren't asked here, and I'll have to answer them.

Q Well, I'm asking you about opinions that you have

with respect to her needs for the future.

Do you have such opinions?

A It's kind of speculative.

MR. HENTEMANN: She's testified about what she feels the condition is that the plaintiff has. Now, whether they need a life care plan is right at the root of that.

Q Well, do you have opinions with respect to what Veronica's needs are for the future?

A Oh, I think she's going to need a lot of help. Whether the type of help she needs would be one thing or the other, I don't know if I want to comment on it at this time. I mean I think she needs a lot of --

Well, I'll say this much: I think she needs a lot of neuropsychological help and psychiatric help. I don't know that she needs any seizure help. I doubt it, as I've testified.

But if she were my patient, I would certainly evaluate her for that.

Q If she were your patient, you would do further tests to determine whether or not she did in fact have seizures?

A Correct.

Q And if you found that she did, you would keep her

on the same medication she's on?

A Well, if she says she's still having seizures and you can document that, then you'd want to stop the medicine or do something to stop that, to try to optimize the management.

Q I think her testimony was that while she's been on medication she hasn't had any seizures.

A Not exactly. She said she hadn't had any major seizures, but she also has spells of feeling cold, not feeling this or that, that are variously described as seizures. So those you would want to record also.

Q You'd want to further examine that as well?

A To see if that was related to any seizure activity..

Q You think Dr. Mars ought to do that stuff? He's her neurologist.

A Well, I'm not here to tell Dr. Mars what to do. I'm saying, if she were my patient, this is how I would evaluate her.

Q And then based upon the results, you would act accordingly, treat her accordingly?

A To give her the best possible management.

Q And the neuropsychological help that she will need, I guess, because you said the problems are

permanent, I guess the help that she'll need is going to be permanent as well?

A Well, I don't think she needs as much -- by "neuropsychological help" I meant like therapy, psychotherapy.

Q You're aware she's receiving psychotherapy?

A I didn't read the life care plan that thoroughly. I hope she is receiving it.

Q You read Dr. Iahn's records?

A But those were old. Those were quite old.

Q You're not aware that she is continuing to see a psychiatrist?

A Do I have anybody -- I don't think I have anybody's notes on ongoing visits.

MR. HENTEMANN: Did we get those?

MR. LANSDOWNE: Sure.

MR. HENTEMANN: Then she's got those.

A I have them somewhere.

Q Dr. Merod's notes are in there.

A Are they handwritten?

MR. ARGIE: Yes. And so are Dr. Iahn's notes postexposure.

A I had trouble reading the handwritten notes. I

don't know if I saw them postcarbon monoxide. I saw them back when he started working with her.

All right. If that's -- I'm happy she is receiving psychotherapy.

MR. HENTEMANN: What about Iahn's?

A It's an admission. That was an admission.

Q Doctor, I believe that I'm through, subject to getting copies of some of the materials.

A Sure.

Q This is the deposition you were talking about, Veronica's deposition?

A Well, that wasn't the -- I thought that there was one for the '93 incident, but it may have just been a description that I read about it.

MR. HENTEMANN: I think the only depo was Veronica's.

MR. ARGIE: You're not aware of any depo in the other case, are you? She thought it was in connection with McPherson's report.

THE WITNESS: I thought I saw it, but it may have just been with the doctor's reports.

MR. ARGIE: If you are, we

want a copy of it.

MR. HENTEMANN: You're talking about a deposition taken --

MR. ARGIE: In connection with that litigation.

MR. HENTEMANN: The apartment harassment case?

Q You haven't seen the second deposition that was taken of Veronica in this case, correct?

A I didn't know there were two.

MR. LANSDOWNE: All right. If we could get copies of this.

MR. HENTEMANN: What do **you** want copies of, now?

MR. LANSDOWNE: Copies of these notes, copies of these.

MR. HENTEMANN: Clip what you want copied.

MR. LANSDOWNE: Okay.

(Recess taken.)

MR. LANSDOWNE: Doctor, what do you want to do about signature?

MR. HENTEMANN: We're going to not waive.

- - - - -

THE STATE OF OHIO,) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Charles A. Cady, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, Barbara E. Swartz, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by her was by me reduced to stenotypy in the presence of said witness, afterwards transcribed on a computer/printer, and that the foregoing is a true and correct transcript of the testimony so given by her, as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney of either party, 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 Cleveland, Ohio, on this 16TH day of March 2001.

Charles A. Cady, Notary Public
within and for the State of Ohio
My Commission expires November 3, 2004.

THE STATE OF _____)
) SS:
COUNTY OF _____)

Before me, a Notary Public in and for said state and county, personally appeared the above-named Barbara E. Swartz, M.D., who acknowledged that she did sign the foregoing transcript and that the same is a true and correct transcript of the testimony ***so*** given.

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at _____, this _____ day **of** _____, 2000.

_____
Barbara E. Swartz, M.D.

_____
Notary Public

My Commission expires: _____

ERRATA SHEET

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Barbara E Swartz, Mar, 2000

CURRICULUM VITAE

BARBARA E. SWARTZ SS#: 276-50-1335

University Hospitals of Cleveland
11100 Euclid Avenue
Cleveland, OH 44106
(216) 844-3714

MEDICAL LICENSURE

California license #GO46769 (1981 – present)
DEA #AS 966236
Ohio license #76483 (7/7/9

BOARD CERTIFICATION

Diplomat, American Board of Psychiatry and Neurology (1986)
Diplomat, American Board of Clinical Neurophysiology (1988)

EDUCATION

Chapman College, Orange, California
B.S. Chemistry major, minor Psychology

AWARDS

Honors at Entrance
Full tuition honorary scholarship (four years)
Full tuition honorary scholarship (four years)
Outstanding Freshman Chemistry Award
Honorary student member of A.C.S.
Honors Seminar participant
Outstanding Senior Chemistry Award, A.C.S.
American Institute of Chemists student award
Graduated Magna Cum Laude
Chapman College Grey Key (Kappa, Phi, Delta)

GRADUATE STUDES

1975-79 Graduate school in Pharmacology, UCLA. Ph.D. completed October, 1979. Title:
"The Role of 3', 5'-Gyanosine Monophosphate at Cholinergic Synapses of the Central Nervous System in Cats"
Advisors: Donald J. Jenden, Ph.D., Professor and former Chairman, Dept. Pharmacology, UCLA
Charles D. woody, M.D., Professor, Anatomy and Psychiatry, UCLA

1975-1979 Medical School, UCLA. Degree completed June, 1979

Awards
Stern Scholarship (1976 and 1977)
Eldridge Scholarship (1977 and 1978)

PLAINTIFF'S EXHIBIT

RISK FACTORS: In terms of other risk factors for seizures, she had no major history of head injury. She had a normal spontaneous birth and development and normal developmental milestones. No febrile convulsions or family history of seizures. No history of CNS infections.

SOCIAL HISTORY: She was not employed at the time of the accident. She was formerly a sleep technologist at the VA Wade Park and she said she also did some research at University Hospitals of Cleveland. She had quit her job with the intention of opening her own private sleep lab. Included in the materials for review were two articles published that had her name on them. She was the third author on one and the seventh author on the other. She is not currently employed. She denies alcohol or cigarette use.

PAST MEDICAL HISTORY: She denied any other problems. She currently is taking Pamelor 200mg q hs, Loestrin birth control pills 1 qd.

REVIEW OF SYSTEMS: She said that she's had some headache recently due to a sinus infection and is also taking an antibiotic whose name she doesn't remember, possibly Bactrum, but had no other constitutional complaints. She's had no serious medical illnesses and no significant surgical history. On today's evaluation, the patient complains that she still has problems with her thinking, specifically impaired memory and concentration. She feels unable to express herself and has decreased ability to focus. She said this has been the same since the carbon monoxide poisoning with no plateau or worsening of the effect. Interestingly, when she was asked by my nurse when her first seizure was, she responded either 34 or 35 years old, she was not sure. When I asked her the same question, she said it was 2.5 years ago in May of 1998. The patient has her driver's license but is not driving. She says she does not feel she can concentrate enough.

EXAMINATION: The patient was alert, oriented in all spheres. Speech was fluent, comprehension was intact, and repetition was intact. On **mental status testing**, she performed serial sevens fairly quickly, making one mistake. She performed calculations of (21+36), (100-39), (9x5), (28/5) quickly and correctly in her head, although she says she can't balance her own check book at this time. A Trails B type test was done during the exam. The patient was asked to finish what I started and I connected A to 1, she then connected to 2,3,4 and 5. I asked her about the letters and she started over back on B and connecting to C, D and E. In terms of long term memory, she knew the Presidents' back to Reagan, who she knew was a republican actor but spelled his name with a cue. She knew that Gore and Bush were candidates for the Presidency. In terms of her immediate memory, she had 5/5 pictures with two tries. After five minutes, she obtained 4/5 + 1 with a cue. Her verbal memory was 5/5 at zero minutes with one try. At five minutes, she got 3/5 + 1 with a cue and seemed to perform more slowly. She obtained 2/3 on a test of sequential similarities. She performed a tapping test, which was intact, although I did have to explain it twice. On the "A" test, she performed accurately, raising her right hand when the letter "A" was said and for unclear reason, switched to her left hand at the end. On **cranial nerve evaluation**, extra ocular motility was full with some end gaze nystagmus. She had full fields to confrontation. Sensation was intact over the face. Pupils were equal, round and

reactive to light and accommodation. There was a very slight decrease in the left nasial labial fold. On cranial nerve 8, hearing was intact. Air was greater than bone conduction bilaterally. The tongue extended in the midline with good articulation. The uvula was in the midline, the palate elevated symmetrically. Sternocleidomastoids and trapezius were 5/5. On **motor examination**, she had normal bulk, tone and strength on the right side. On the left side, she was 5-/5 at the biceps, 4+ at the triceps, 4+ at the deltoids and these all had give-way weakness. Finger flexors were 4+/5, in the lower extremity the femur was 4/5 with giving way and her tibia's were the same, as was the gastroc-soleus. In the supine position, straight leg raising was tested and was negative. She had a 2+ Homan's sign as she made some effort to lift her left leg off the bed but this effort did not equal that involved in the right leg raising. Tone was normal and lacked any cogwheeling. She did not have a masked fascies. Finger tapping was decreased on the left. In the lower extremities, foot tapping was somewhat slower on the left foot than the right. I should note that she actually had not volunteered any information about the left hemiparesis and when I saw her walk in, she did not appear to be weak on that side but when I started the exam and noted the weakness, she explained it. On the Luria test of sequential hand motion, she performed fare on the left, actually somewhat decreased on the right, being slower but accurate. **Cerebellar testing** revealed intact heal knee shin and finger nose finger. Rapid alternating movements were intact in the upper extremities. **Gait** was performed on a narrow base with actually an increase in her left arm swing. Tandem was performed accurately, but on heal walk, she shuffled her left leg in and out and on toe walking, she performed with some up/down movement. On **sensory examination**, she reported an increase in light touch in the left arm and leg, decrease in pin in the left leg, position sense was intact, vibratory sense was intact. On **cortical sensory testing**, she had no right/left confusion and no extinction on double simultaneous stimulation. On stereognosis testing, she got 3/3 on the right hand and 1/3 on the left. Deep tendon reflexes were 3/5 and symmetric in the upper extremities, 2+-3 at the knees, 2 at the ankles. Plantar response was flexor. There was no Myerson's sign, no Hoffman's sign, no cross adductors and jaw jerk was 1+. I noted that throughout the exam, the patient was cooperative and pleasant, although she had expressed a lot of anger at my nurse over the bill, which the clerk had asked her to pay. We explained to her that the clerk probably didn't know that she was an IME and this seemed to quiet her down.

I also note the patient filled out a QOLIE-10, which is a routine part of our evaluation. Her score was 27, which is fairly high, indicating a good deal of dissatisfaction with her current lifestyle and on a scale of 1/5, she circled 5 corresponding to her life being "very bad, could hardly be worse". The only thing she did not complain about was physical effects of medicine, mental effects of medicine or the fear of having a seizure and effects of medicine of driving.

IMPRESSION: The patient is a 36-year-old right handed female with a history of exposure to carbon monoxide poisoning in May of 1998. She complains of secondary seizures, hemiparesis, and impaired cognitive function since then. The seizures she reported were of a focal nature as well as the hemiparesis. It's noted that the level of carboxy hemoglobin reported did not appear to correlate clinically a severe intoxication and she did not require extreme measures to be revived. However, it's pointed out that there is some discrepancy in the reporting of this

between the patient and her chart, which should be clarified. As a source of coma, carbon monoxide does not produce focal neurologic signs, but rather a generalized depression and one would not expect hemiparesis, which would presumably due to a stroke, but her MRI show any evidence of a stroke. She does not appear to have any risk factors for stroke and the nature of the hemiparesis involving give-way phenomena, absence of cortical spinal tract signs that correspond to the right hemisphere, and abnormal movement of the leg during walking that does not correspond to any neurologic syndrome would lead one to suspect that this portion of the exam represented a conversion or a factitious disorder. There was a slight flattening of the left nasial labial fold. One would have to compare her pre-accident pictures with the present to determine whether that was new. Two normal EEGs does not rule out a clinical diagnosis of seizures, however, and to make a definitive diagnosis, she should have had inpatient video-EEG monitoring with reduction of medication or even cessation of medications to determine whether a real seizure focus exists. It would be unusual to show a significant amount of cognitive impairment with two normal EEGs. On her exam today, she does not show significant cognitive impairment. She has some decrease in her delayed recall of words, although registration was intact. Delayed recall of pictures was better, although, she took 2 trials to register them. This doesn't point to many consistent lateralizing lesions. Tests of attention were relatively intact. These included the "A" test, the finger tapping test and serial sevens. Her sensory exam was also somewhat incongruent, reporting a decrease in one limb on the left, with an increase in the other limb on the left. She did not, however, split the midline or report changes on the face. In terms of her weakness, again, it appears to be of the give-way type. Testing her leg elevation while supine, with the right leg elevating, there was a full extension pressure of the left leg.

Pre-motor function was intact, as evidenced by the Luria test but she did fail to perform one prefrontal test accurately, that being the "trails B test" and she did similarly miss one on the sequential similarities test, which is a sorting task. To evaluate her cognitive function, a full neuropsychological battery should be performed and including a MMPI and a Beck Depression Inventory.

In terms of expected long term quality of life after carbon monoxide poisoning, one can have seizures that are generalized, as opposed to focal, and cognition can certainly be impaired. Wha would be expected is the subcortical dementia type as the basal ganglia are the primary site for damage following carbon monoxide poisoning. She shows no other signs of basal ganglia damage such as rigidity, tremor, postural instability or orthostatic hypotension but the neuropsychological testing should also target subcortical and dementia type profile.

Barbara E. Swartz, MD, PhD
Director, Comprehensive Epilepsy Program
University Hospitals of Cleveland

BES/rmk-11/07/00

UniversityHospitals HealthSystem

University Hospitals of Cleveland

INDEPENDENT MEDICAL EXAM

October 26, 2000

RE: Veronica Ferrette, et al v. Theresa Kowalcyk, et al
UH#: 865992
SS#: 285-68-3509

Ms. Ferrette was interviewed and examined. A file from the defense attorney, Harry A. Hentemann, was reviewed prior to seeing her.

HISTORY OF PRESENT ILLNESS: Ms. Ferrette's problem dates back to 05/07/98 when she was asleep upstairs in her aunt's house. Her aunt had evidently left her car parked in the garage with the engine running and the patient was sleeping in a room above the garage. She was found unconscious. At this point, the paramedics note and the patient's story differ. The patient says that when she was found she was jerking and foaming at the mouth. The emergency squad's note says nothing about a seizure but that they were called for a loss of consciousness. The patient said that she did not respond to CPR and that she was told that she had only ten minutes to live when she was taken to Hillcrest Hospital. The paramedics note said that oxygen was given but that the patient had a good blood pressure and pulse and did not require CPR. A carboxyhemoglobin level was measured. It was 300 ppm or 39.9, which was consistent with a moderate-severe level of intoxication. There is no note from a neurologist during that hospital visit. She initially went to Hillcrest Hospital and then was transferred to St. Vincent's Hospital. She said her first memory was at St. Vincent's Hospital. Here she remained an inpatient for an unclear duration but never required ICU, intubation or hyperbaric oxygen. Medical personnel gave no anti-convulsant medications as there was no report of any seizures. The patient was discharged to go home. She had been followed regularly by a psychologist, Dr. McPherson and a psychiatrist, Dr. Lahn, who were treating her for depression and insomnia. Her regular medications were Pamelor 25-75mg, Remeron 1.5mg and Ativan for sleep and/or anxiety, although she would sometime take Ambien. After this, the patient began to complain of seizures. The first one occurred months after the incident and after the seizures began, she said she noted left hemiparesis. Dr. Mars notes "no further seizures" on June 4 and the patient was unsure when they started. The seizures were described as left-sided shaking and they were first treated with Tegretol and then with a combination of Tegretol and Neurontin, which she is still on. She is on 800mg qd Tegretol and 1200mg qd Neurontin and she says her neurologist is checking her levels. She reports to me that her seizures have been controlled for about fourteen months, although she said she may still have some little seizures described as having her coordination go off, having eyelid flutter, having head shaking and having stuttering speech. Dr. Mars evaluated her with an EEG and a MRI scan. Both were normal. The EEG was repeated and was again normal.

Barbara E Swartz, Mar, 2000

UCLA Medical Center Auxiliary Scholarship (1978)
Ruth G. White Scholarship (1978 and 1979)

Extracurricular

Regents Scholarship Committee

PROFESSIONAL APPOINTMENTS

1979 – 1980	NIMH training grant (post doctoral), UCLA Dept. of Pharmacology
1980-1981	Internship, Internal Medicine, UCLA
1981-1984	Residency in Neurology, Columbia University, Neurologic Institute of NY
1984-1987	Post-Doctoral fellowship in Epilepsy and Clinical Neurophysiology with A.V. Delgado-Escueta at UCLA and VAMC Wadsworth
1987– 1995	Assistant Professor of Neurology in Residence, UCLA
1987-1987	Part-time Staff Neurologist, West Los Angeles VA Medical Center
1988-1999	Full-time Neurology Staff, VAMC Wadsworth
1988-1999	Director, Telemetry Unit VA Southwest Regional Epilepsy Center & Comprehensive epilepsy Program, West Los Angeles VA Medical Center
1990-1999	Advancement to Chief Series, VAMC Wadsworth
1989-1999	Co-Director, Epilepsy Surgery Program. VASWREC, Wadsworth
1991-1999	Co-Director of Clinical Neurophysiology, SWR Epilepsy Center, VAMC, WLA
1995-1999	Associate Professor in Residence, UCLA Department of Neurology
1999-Present	Associate Professor, Case Western Reserve University, Cleveland, OH

RESEARCH INTERESTS

Present	1. ^{15}O-H_2O-PET studies of working memory have been completed and results are in preparation to examine potential neurotransmitters which subserve working memory in the dorsolateral frontal lobe using selective catecholaminergic agents. 2. Changes in brain chemistry in the frontal lobes of epilepsy patients studied with MRS.
1990-1994	Working memory in normal and epilepsy subjects studies with ^{18}FDG-PET activation studies. In particular, the role of the dorsal prefrontal cortex and the Possible reorganization of working memory circuitry in subjects with epilepsy has been investigated.
1989 – present	Cognitive reorganization in epilepsy.
1987-1990	Use of ^{18}FDG-PET in the evaluation of intractable epilepsy with emphasis on the frontal lobe.
1984-Present	Presurgical evaluation and management of intractable epilepsy.
1984-1987	GABA mediated single channel function in human hippocampal neurons.
1979-1980	Ach turnover in the hippocampus
1975-1980	Effects of 3'5' cyclic-guanosine monophosphate at central nervous system Synapses.

AWARDS

1997-1999	Bridge funds - $5000 awarded, VAMC West LA Research Committee
1994-1997	VA Merit Review Grant, "Prefrontal Dysfunction in Frontal Lobe Epilepsy". $210,000, 1994-97.

1991-1995 Principal Investigator, "The Sensitivity of Positron Emission Tomography in Epilepsy". Non-funded project at VAMC PET facility.

1991-1994 Renewal of Frontal Lobe Metabolism in Normal Function and Disease, PI., $180,000.

1991-1993 Co-Investigator, "Depression, Epilepsy and Positron Emission Tomography", Funded by VA Research Advisory Group. Principal Investigator: Lori Altschuler, M.D., $75,0000.

1989-1990 Recipient Academic Senate Grant, UCLA. Titled as above. $5,000

1988-1991 Frontal Lobe Metabolism in Normal Function and Disease. Principal Investigator. VA Merit Review Grant Tab. No. 78. Section Neurology, $160,000

1988-1992 Recipient of IDE application by FDA for Chronic Subdural and Epidural Recordings in the Management of Intractable Extratemporal Complex Partial Seizures. No.G870018/A1. (The first such approval issued in U.S.A.) Five year prospective study completed.

1987-1994 Co-Director, Core Unity on Basic Mechanisms of the Epilepsies NINCDS Program, Project of the Comprehensive Epilepsy Program.

1985-1987 EFA Fellowship Grant: "The Mechanisms of GABAergic Synapses in Hippocampal Cells of Normal and Human Epileptic Tissue." $30,000

1984 Recipient BRSG Grant, UCLA. Titled as above. $5,000

1979-1980 Post-doctoral training grant, NIMH, #MH15345. $10,000. "Acetylcholine Metabolism in Hippocampal Slices in Normal and Kindled Rats"

SUBMITTED AWARDS, pending

2000-1980 Is non-temporal epilepsy progressive? VA Merit Continuation (5 yrs., $125.00 per year). To be submitted May 1, 2000

1999 Continuous Quantitative EEG Monitoring by Telemetry in Acute Stroke – NIH BRP application with Cleveland Medical Devices.

POST-DOCTORAL FELLOWS

Jijun Wang, MD awarded William G. Lennox International Research Fellowship to study with B. Swartz, MD, PhD. Start date July, 1994. Topic: Rigidity Phenomenon in Frontal Lobe Epilepsy as Correlated with ^{18}FDG-Positron Emission Tomography. $30,000

PROFESSIONAL AND UNIVERSITY SOCIETY MEMBERSHIPS

1998-Present Member, VA Advisory Panel on Epilepsy Management.

1998 Examiner for ABPN.

1997-Present Member VA Medical Research Advisory Group – reviews career development awards, Merit Review grants and VA Research Prospectus Neural Sensory Disorders.

1989-Present Western EEG Society – Board Member, 1991; Membership Committee Chair, 1992-1993; Secretary Treasurer, 1994; Vice-President, 1995; President, 1996.

1989-1999 Epilepsy Society Serving LA and Orange Counties – Board of Trustees Secretary and Chair, Planning Committee. Professional Advisory Board President, 1992-present.

1984-Present	American Epilepsy Society – Scientific Program Committee, 1991; Clinical Investigator's Workshop, 1998-1999.
1984-Present	New York Academy of Science
1981-Present	American Academy of Neurology; 1998 – fellow status
1978-Present	American Association for the Neurosciences

JOURNAL REVIEWER

Epilepsia, Neurology, J Neuroradiology, J Neurosurg.

GRANT REVIEWER

NIH, ad hoc

VA Merit and Career Development Awards

REFEREED JOURNAL ARTICLES and ORIGINAL MANUSCRIPTS

1. **Swartz, BE** Torgersen D, Kovalik E, Thomas K, Brown C, Mandelkern MA. The effects of an alpha-2-agonist, guanfacine on rCBF in normal humans and subjects with focal pathology. In Press. 2000 J. Psychopharmacology
2. **Swartz, BE**, Patell A, Thomas K, Khonsari A, Torgersen D, Brown C, Delgado-Escueta AV, Mandelkern, MA. The sensitivity of 18-FDG Positron Emission Tomography in the routine diagnosis of epilepsy: A comparison to a surgical series and other Neurodiagnostic tests. Submitted, Epilepsy Research, Feb 2000.
3. **Swartz, BE**, Thomas K, Simpkins F, Kovalik E, Mandelkern MA. Rapid quantitative analysis of individual FDG-PET scans. J Clinical Positron Imaging,1999;2(1):47-56
4. **Swartz, BE**, Delgado-Escueta AV, Walsh GO, Rich JR, DeSalles, A, Kauffman M. Surgical Outcomes in Pure Frontal Epilepsies and Foci that Mimic Them. Epilepsy Research, 1998; 29:97
5. Cornford EM, Gee MN, **Swartz BE**, et al. Dynamic FDG-PET and hypometabolic zones in seizures: Reduced capillary influx. Annals, Neurology 1998; 43:801-808
6. **Swartz, BE**. The advantages of digital over analog recording techniques. In: B Swartz, Z Koles (eds.) EEG, Past Present and Futures. Electoenceph. Clin. Neurophysiol., 1998; 106(2):113-117.
7. **Swartz, BE**, Goldenshon E. Timeline of the history of EEG and associated fields. In: EEG-Past, Present and Future, Eds. BE Swartz and Z Koles. EEG clin. Neurophysiol. 1998; 106(2):173-177
8. Sander VJ, Felisan SL, Waddell A, Conrad AJ, Schmid P, **Swartz BE**, et al. Presence of Herpes Simplex DNA in Surgical Tissue from Human Epileptic Seizure Foci Detected by Polymerase Chain Reaction. Arch Neurol. 1997; 54:954-960
9. **Swartz BE**, Simpkins F, Halgren E, Mandelkern M, Brown C, Krisdakumtorn T, Gee, M. Visual working memory in primary generalized epilepsy: An ^{18}FDG-PET study. Neurology 1996; 47:1203-1212
10. **Swartz BE**, Halgren E, Simpkins F, Mandelkern M. Studies of working memory using ^{18}FDG-positron emission tomography in normal controls and subjects with epilepsy. Life Sciences 1996; 58(22): 2057-2064
11. **Swartz BE**, Halgren, Simpkins F, Fuster J, Mandelkern M, Krisdakumtorn T, Brown C, Ropchan J, Blahd WH. Primary or working memory in frontal lobe epilepsy: An ^{18}FDG-PET study of dysfunctional zones. Neurology, 1996; 46(3):737-747

Barbara E Swartz, Mar, 2000

12. **Swartz BE**, Rich JR, Dwan P, DeSalles AAF, Kaufman M, Walsh GO, Delgado-Escueta AV. Safety and efficacy of chronic subdural electrodes in intractable epilepsy. Surg Neurology 1996; 46(1): 87-93
13. **Swartz BE**, Halgren E, Fuster JM, Simpkins F, Gee M, Mandelkern M. Cortical metabolic Activation in humans during a visual memory task. Cerebral Cortex 1995; 3:205-214.
14. **Swartz BE**, Khonsari A, Brown C, Mandelkern M, Simpkins F, Krisdakumtorn T. Improved sensitivity of ^{18}FDG-PET scans in frontal and "frontal-plus" epilepsy. Epilepsia 1995; 36(4):388-395
15. **Swartz BE**, Halgren E, Fuster J, Mandelkern M. An ^{18}FDG-PET study of cortical activation During a short-term visual memory task in humans. NeuroReport 1994; 5(8):925-928
16. **Swartz BE**, Halgren E, Simpkins F, Syndulko K. Primary memory in patients with frontal and primary generalized epilepsy. J. Epilepsy 1994; 7(3):232-241
17. DeSalles AAF, **Swartz BE**, Lee T, Delgado-Escueta AV. Subdural recording and electrical Stimulation for cortical mapping and induction of usual seizures. Stereotactic and Functional Neurosurgery 1994; 62:226-231
18. **Swartz BE**. Electrophysiology of bimanual-bipedal automatisms. Epilepsia 1994; 35(2):264-274
19. Comford EM, Hyman S, and **Swartz BE**. The human brain GLUT1 glucose transporter: Ultrastructural localization to the blood-brain barrier endothelia. J. Cereb Blood Flow Metab 1994; 14(1):106-112
20. **Swartz BE**, Tomiyasu U, Delgado-Escueta AV, Walsh GO, Rich JR, Rand RW, Mandelkern M, Gee M, Quinones N, Ropchan J, Blahd WH. Neuroimaging in temporal lobe Epilepsy: test sensitivity and relationships to pathology and postoperative outcome. Epilepsia 1992; 33(4):624-634
21. **Swartz BE**. Pseudo-absence seizures: frontal lobe phenomenon? J. Epilepsy 1992; 5:80-93
22. **Swartz BE**, Theodore WH, Sanabria E, Fisher RS. Positron emission and single photon emission tomographic studies in the frontal lob with emphasis on the relationship to seizure Foci – A multicentered survey. In: P Chauvel, AV Delgado-Escueta, J Bancaud, 57:487-497 Raven Press, NY
23. Houser CR, **Swartz BE**, Walsh GO, Delgado-Escueta AV. Granule cell disorganization in the dentate gyrus. Possible alterations of neuronal migration in human temporal lobe Epilepsy. Epilepsy Research 1992; 7(50):41-49
24. **Swartz BE**, Delgado-Escueta AV, Maldonado HM. A stereoencephalographic study of ictal Propagation producing anisocoria, auras of fear and complex partial seizures of temporal lobe origin. J. Epilepsy 1991; 3(3):149-156
25. **Swartz BE**, Delgado-Escueta AV, Zolo P. Ictal electrographic onsets in frontal vs. temporal lobe epilepsy. Can. J. Neurological Sciences 1991; 18:649-662
26. Houser CR, Miyahiro JE, **Swartz BE**, Walsh GO, Rich JR, Delgado-Escueta AV. Altered patterns of dynorphin immunoreactivity suggest mossy fiber reorganization in human hippocampal epilepsy. J Neuroscience 1990; 10(1):267-282
27. Kaufman M, **Swartz BE**, Mandelkern M, Ropchan J, Gee M, Blahd WH. Diagnosis of Delayed cerebral necrosis following proton-beam therapy. Archives Neurology 1990; 47:474-476
28. **Swartz BE**, Halgren E, Delgado-Escueta AV, Mandelkern M, Feldstein P., Maldonado H, Ropchan J, Blahd W, Walsh GO, Quinones N, Gee M. Multidisciplinary analysis of patients with extratemporal complex partial seizures. Part I: Intertest agreement. Epilepsy Research

1990; 5:61-73
29. **Swartz BE**, Halgren E, Delgado-Escueta AV, Feldstein P, Maldonado HM, Walsh GO. Multidisciplinary analysis of patients with extratemporal complex seizures. Part II: Predictive value of semiology. Epilepsy Research 1990; 15:146-154
30. **Swartz BE**, Halgren E, Delgado-Escueta AV, Mandelkern M, Gee M, Quinones N, Ropchan J, Blahd WH. Neuroimaging in patients with seizures of probable frontal lobe origin. Epilepsia 1989; 30(5):547-558
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Frontal Lobe Function and Dysfunction. HS Levin, HM Eisenberg, AL Benton, eds. For J. Clin. Neurophysiol. 1992, July

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Barbara E Swartz, Mar, 2000

INTIVTED LECTURES/PRESENTATIONS – Last 5 years only

1. UH, May 9, 2000, 12:00pm Epilepsy Mgmt. Lecture for Med. Residents; VA, May 16, 2000, 12:00pm
2. Epilepsy: An Old Disease – What's New? – Westlake, April 13, 2000, 7:00-8:00pm
3. "Status Epilepticus" – Park Davis Symposium/Wyndham Hotel, April 8, 2000
4. Epilepsy: An Old Disease – What's New? – Landerbrook, March 23, 2000, 7:00-8:00pm
5. Grand Rounds Lecture – CCF, Cognitive Reorganization in Epilepsy, March 9, 2000
6. WSET & WCNS – Cognitive Reorganization in Epilepsy, Feb. 26, 9:00am
7. Pre-surgical Evaluation of Refractory Epilepsy – El Paso, TX, Feb. 1, 2000
8. Clerkship Teaching Seminar – Neurology Conf. Room, Jan. 20, 2000, 11:00-1:30pm
9. Problems in Epilepsy Management – Green Road, Jan. 18, 2000, 12:00-1:00pm
10. FLE – Epilepsy Conference, Jan. 10, 2000, 7:30-8:30am
11. TLE – Epilepsy Conference, Dec. 21, 1999, 7:30-8:30am
12. Clinical Investigator's Workshop – Symposium Moderator – AES, Dec. 5, 1999
13. Panel discussion with Devereaux., Dec. 1, 1999
14. Neurology for Non-Neurologist – Epilepsy, Sat., Nov. 6, 1999
15. Talk to QualChoice Management Group, Nov. 2, 1999
16. Modern Seizure Management – at Akron General, Ortho-McNeil, Sept. 23, 1999
17. Trauma and HCS – for Intl Epilepsy Congress, Sept. 12-18, 1999
18. The relationship of trauma to hippocampal sclerosis. Merit Putnam Symposium,
19. Los Angeles, April, 1999
20. Cognitive activation studies in Epilepsy – Neurobehavior Seminar, UCLA, March, 1999
21. Modern diagnosis and management of epilepsy. Phoenix VA, March, 1999
22. Gender Issues in Epilepsy – EFLA symposium, September, 1998
23. Epilepsy and PET: What can cognitive activation studies tell us? Grand rounds at Rutgers/RWJMD, February, 1998
24. Fundamentals of EEG – yearly lecture given to VA West Los Angeles Neurology Residents.
25. Current Management of Epilepsy – Japanese Medical Society of LA, October, 1997 and Epilepsy Foundation of LA – November, 1997
26. Neurology Grand rounds – Functional Studies with PET Scans, April, 1997.
27. Lecture Western EEG Society, February, 1997: "Functional Studies in Epilepsy with
28. Positron Emission Tomography".
29. Lecture "Advances in Seizure Diagnosis and Management" Van Nuys Hospital, Ventura Hospital, July and November, 1996.
30. "Coping with Epilepsy". Organized symposium for the public. November, 1996.
31. Lecture Western EEG society, "EEG-Past, Present and Future", February, 1996
32. Lecture at Western EEG society, February 1995: Ictal Patterns in Temporal and Extratemporal Epilepsy.
33. Lecture for Nuclear medicine Grand Rounds, 1995: Positron Emission Tomography and Epilepsy.
34. Lectures: Grand Rounds, UCLA Neurology Dept. and Memory Research Group, 1995: Working Memory in FLE, JME and normals.
35. Consultant for design of Chronic EEG recording unit. VAMC Portland, January 1994. Course given at 1994, 1995, 1996 AAN Meeting: Seizure Recognitition and Diagnosis.

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PSYCHOLOGICAL REPORT

RE: **Veronica** Serrette DATE **OF** BIRTH: **6-5-64**

A/N: 285-68-3509 CHRONOLOGICAL **AGE:** 34

DATE **OF** EVALUATION: **3-18-99**

TESTS ADMINISTERED:
Wechsler Adult Intelligence Scale-III
WRAT-Reading
Wechsler Memory **Scale**
Clinical **Interview**

WAIS **admfnistered** by **L. Sprouse, M.A., Psychology Assistant.**

CLINICAL **INTERVIEW** - MENTAL STATUS **EXAMINATION**

Identifying **Information**

Veronica Serrette **is** a **34** year old, single **female. She** arrived **on time** accompanied **by her mother.** She **was** cooperative. and provided information **as** well **as she was able. Her** mother **also** offered additional **data.**

Personal History

Veronica Serrette **was** born June **5,** 1964. **Her** parents **are** both alive but **not living** together. **She has** contact **with** both **her** mother and father. She **has** one **sister and a** half-brother **and gets** along with **them well also.** Veronica reports that **she** attended **schools in Cleveland graduating** from Regina High **School. She attended John** Carroll **for** a **period** of **time and then** transferred **to Cleveland State** University. She also **was** doing graduate work **in** biology **at Cleveland State.**

When asked about her work history, she reports that **the** only **employment she remembers is** working **as a** research **assistant** at **Case** Western **Reserve University, sleep** laboratory. Her **last employment was approximately** a **year** ago.

When asked about her **disability, she** reports she **suffered carbon monoxide poisoning.** She described the **incident** no. **doubt as she** had **been** told it occurred, **she was sleeping** *in* **an upstairs** bedroom of her **aunt's** home over the garage **where** her aunt inadvertently left the car running. The **next morning she was unresponsive. She was taken** to **the hospital for emergency treatment.** Since **then she has had very serious memory** problems. She **feels** her **problems are most severe in terms** of short-term memory **but it is obvious that all aspects** *of* **memory** function **have** been **impaired.**

Veronica's mother reports that on the morning of the accident after EMT personnel arrived they felt that Veronica would not survive. She was treated at St. Vincent's Charity Hospital. Her mother indicates that she had very serious problems with memory function. As a result she is not *left* alone. She also has been left with a seizure disorder and what appears to be considerable depression. Veronica's mother reports that she is easily disoriented. She is unable to travel independently and certainly she cannot drfve. Her mother reports that recently she became lost in the area around her apartment complex and had to be escorted back to her building. In ordinary conversation she becomes confused and does not recall information which has been discussed with her moments before. Veronica's physician, Paul Iahn, describes her as experiencing episodic confusion, affective lability, forgetfulness with impaired concentration.

Referral information further indicates that Veronica suffered permanent brain damage as a result of accidental carbon monoxide poisoning. Her doctor describes her as experiencing moderate depression and anxiety at present with a profound sense *of* loss related to her inability to think and *concentrate.* It is noted that she has a superficial ability to relate to others. She cannot focus well in conversations, her physician describes her "unable to connect In counseling." He also notes some affective blunting and indifference in a general day to day presentation but emotional lability even under conditions; of relatively low stress.

Mental Status Examination

Veronica is approximately 5' 2" and weighs about 115 to 120 lbs. She did not know her height or weight. She has blond hair worn in a style which is current and on the day *of* the evaluation was attired in blue jeans, purple sweater and black leather shoes. Her overall appearance was neat. She was cooperative and pleasant in her manner, Motivation *is fair* for the tasks but she acknowledges readily that she had difficulty concentrating and focusing. This was evidenced throughout the interview and throughout the testing. Her conversation was punctuated by interruptions when she would have to ask for clarification regarding the question which had been asked previously or when she did not understand the meaning of a word. She explained that often she will hear what is being said to her but cannot comprehend the meaning of it and *it* is at those times when she needs to ask for clarification.

Affect and Mood

Facial expression was unremarkable. Affect seemed slightly constricted. Veronica responded that she wasn't sure if she was depressed or not. She acknowledged feeling a great sense of loss about her inability to remember and concentrate and about her inability to continue with her former career in sleep research, She maintained good *eye* contact. She seemed relatively calm and relaxed in the interview. She has a good appetite according to her report. Her sleep is interrupted. She admits to having crying spells which she describes as occurring for no reason. She also noted that after she has a seizure *It seems* that she becomes more emotionally labile and will have crying spells for several days afterward. She admits to some vague thoughts

of suicide but expressed no actual intention in that regard, She stated that after she began to recover from the accident she realized her losses and wished that she simply would stop living. Energy level is somewhat restricted. She does not claim a loss of interest in her surroundings but admits that there are many things which she cannot do and she becomes very frustrated by this,

Mental Content

No delusional material was elicited, There was no evidence of paranoid or grandiose thinking. She denies experiencing any form of perceptual distortion.

Sensorium and Cognitive Functioning

Veronica was not oriented fully, She understood that it was March but indfcated that it was 1998 and admftted that she did not know the date. She could not do serial seven subtractions correctly, she could not interpret proverbs, Recall for digits was at the lowest end of the average range,

Insight and Judgment

Insight and judgment are impaired. Veronica gives the impression that she cannot manage very much independently. In *fact,* her mother reports that she lives with a family member who supervises her and takes care of many tasks which she cannot do such as cooking, laundering, etc.

Daily Activities

Veronica reports that she gets up at different times each *day* but usually between 8:00 and 9:00. Sometimes she will have something to eat but other days she will miss breakfast. She reports that she tries to read each morning but becomes frustrated quickly because she cannot understand. She doesn't enjoy watching television very much because it confuses her, however, she does enjoy listening to certain types of music. She reports that are times when she simply doesn't bother answering the phone. Her mother visits her two to three, times a week, her sister comes almost as frequently and helps her manage her funds and shopping. Her niece does the cooking and laundry. She has several friends who stay in touch with her but for the most part her range of activities *is* very limited.

Results of Testing

Results of the Wechsler Adult Intelligence Scale-III show that Veronfca achieved a full scale IQ of 74 with a verbal IQ of 82 and a performance IQ of 68. Scale score distribution is as follows:

Verbal Tests		Performance Tests	
Vocabulary	7	Picture Completion	5
Similarities	5	Coding	2
Arithmetic	6	Block Design	5
Digit Span	7	Matrix Reasoning	5
Information	8	Picture Arrangement	7
Comprehension	9		

Veronica's full scale IQ places her at the lower end of the borderline range of adult intellectual functioning. Her performance IQ is actually at a mildly retarded level. Her verbal intelligence is at a dull-normal level. Her most marked limitation appears to be in the area of psychomotor rate of performance and visual memory. She also shows considerable limitation in the areas of alertness to visual detail and abstract visual problem solving. Logical reasoning is also an area of weakness. Her area of strength appears to be the knowledge of social norms and social practices and commonsense judgment. Overall, however, results of the WAIS-III suggest she functions at a borderline; range of ability.

Veronica was administered the WRAT-Reading test to assess her word recognition skills. She obtained a score which placed her at a 3rd grade level suggesting that her word recognition ability is extremely limited.

Veronica was administered the Wechsler Memory Scale. Results are as follow:

Auditory Immediate	62 - Extremely Low
Visual Immediate	68 - Extremely Low
Immediate Memory	57 - Extremely Low
Auditory Delayed	74 - Borderline
Visual Delayed	56 - Extremely Low
Auditory Recognition Delayed	75 - Borderline
General Memory	62 - Extremely Low
Working Memory	71 - Borderline

Results of the Wechsler Memory Scale show the claimant's memory function to be within the extremely low range overall. This is consistent with self report and observations of her capability made during the evaluation. She shows fairly marked limitation across all aspects of memory function measured.

Summary and Conclusion

It is the conclusion of the examiner that Veronica Serrette shows a primary diagnosis of Organic Brain Syndrome Secondary to Carbon Monoxide Poisoning. Some Depressive Symptomotology is also noted. Based on information gathered during the assessment, it appears that Veronica shows substantial impairment In her ability to concentrate and attend to tasks. Ability to understand and follow instructions and carry out routine tasks is judged to be substantially Impaired. Ability to relate to others and deal with the general public shows evidence of moderate impairment due to her problems with memory, concentration and ability to sustain attention. Ability to relate to work

peers and supervisors and tolerate the stresses associated with employment is judged to be substantially Impaired. The claimant in her current level of functioning is unable to manage productive employment of any type. She Is unable to function independently at this time.

AXIS III:
AXIS IV: Traumatic Brain Injury and Subsequent Residuals, No. 4, Severe
AXIS V: Global Assessment of Functioning: 35

Signed:

Sally Felker

Sally Felker, Ph.D.
Psychologist

SF:im

NAME Veronica Ferrette

WAIS-III

Verbal IQ 82 Performance Q 68 Full Scale 74

Vocabulary	7	Picture Completion	5
Similarities	5	Coding	2
Arithmetic	6	**Block** Design	5
Digit Span	7	**Matrix Reasoning**	5
Information	8	Picture **Arrangement**	7
comprehension	9		

WRAT-3

	'Raw	Stand.	%i.e	Grade	**Absolute**
Reading					
Spelling					
Arithmetic					

QUALITY OF LIFE IN EPILEPSY INVENTORY: QOLIE-10

Version 1.0

Patient Inventory

Patient's Name: VERONICA FERRETTE Today's Date: 10/26/00

Gender: Male Female Birthdate: 6/5/64

Have you completed this questionnaire prior to today's visit? Yes No Score = 28

MD Name: DR. Swartz

Instructions: Please **circle** one number for each question. If you are unsure about how to answer a question, please give the best answer you can and write a comment or explanation in the margin. Please feel free to ask someone to assist you if you need help reading or marking this form.

HOW MUCH OF THE TIME DURING THE PAST 4 WEEKS . . .

	All of the time	**Most** of the time	**Some** of the time	**A Little** of the time	**None** of the time
1. Have you had a lot of energy?	1	2	3	(4)	5
	None of the time	A **Little** of the time	**Some** of the time	**Most** of the time	**All** of the time
2. Have you felt downhearted and blue?	1	2	3	(4)	5
	Not at all	A **Little**	**Somewhat**	A **Lot**	A **Great Deal**
3. Has your epilepsy or anti-epileptic medication caused trouble with driving?	(1)	2	3	4	5

DURING THE PAST 4 WEEKS, HOW MUCH HAVE YOU BEEN BOTHERED BY . . .

	Not At All Bothered	A **Little**	**Somewhat**	A **Lot**	**Extremely** Bothered
4. Memory difficulties?	1	2	3	4	(5)
5. Work limitations?	1	2	3	4	(5)
6. Social limitations?	1	2	3	4	(5)

PENGAD-Bayonne, N. J.
PLAINTIFF'S EXHIBIT 4
Dr. Swartz

INITIAL ENTRY DATA

DEMOGRAPHICS

Name: Veronica Fournette Date: 10/26/00 Code:

Age: 36 yo. Age of first Seizure: 34 o 35 2 1/2 yrs ago 5/98

Living Situation: Independent X With family ___ Board & Care ___
Indigent ___

Average Annual Income: 0-$5,000 ___ $6-10,000 ___ $11-20,000 ___
$21-$30,000 ___ $31-$50,000 ___ >$50,000 ___

Employed? ___(Yes) X (No)

Driver's License? X (Yes) ___(No) Driving? ___(Yes) X (No)

Health Insurance? ___(Yes) ___(No) Type? N/A

CLINICAL FACTORS

Risk Factors: Head Injury 0 Duration of LOC ___ Date ___
Birth injury 0 Complicated Birth and Delivery ___
Delayed Milestones 0
Family history 0 Which relatives ___
Meningoencephalitis 0 Age ___
Other CNS Infections 0 Age ___

Precipitants: EtOH ___ Other drugs ___ Sleep loss ✓ Stress ___
Certain Foods ___ Lack of food ___ Excercize ___
Other Carbon monoxide exposure.

Types of Seizures: Absence ___ Myoclonic ___ Generalized ✓
Simple Partial ___ Complex Partial ✓
Secondarily Generalized ___ Secondary Generalized ___

Seizure frequency, current, of each TYPE: NUMBER:
Currently 0 sz x 14 mos. ___
___ ___
___ ___

Seizure frequency, best, of each TYPE None.
___ ___
___ ___

CO → GM sz - pt was found having sz
Addl sz occurred foll CO exposure
No sz x 14 mos. because pt on meds

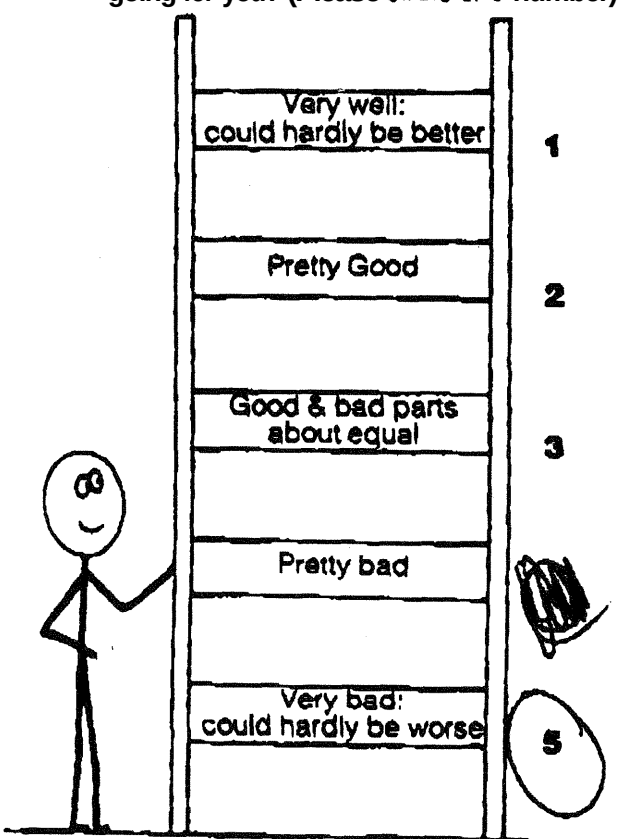
had GTC before paramedics found her
LC ~ 2 Next sz 8 wks later

DURING THE PAST 4 WEEKS, HOW MUCH HAVE YOU BEEN BOTHERED BY . . .

	Not At All Bothered	A Little	Somewhat	A Lot	Extremely Bothered
7. Physical effects of antiepileptic medication?	1	2	3	4	5
8. Mental effects of antiepileptic medication?	1	2	3	4	5

	Not At All Fearful	Mildly Fearful	Moderately Fearful	Very Fearful	Extremely Fearful
9. How fearful are you of having a seizure during the next month?	1	2	3	4	5

10. How has the quality of your life been during the past 4 weeks? That is, how have things been going for you? (Please circle one number)



Patient Nates:

MD Notes:

Medication Notes:

Development of the QOLIE-89, QOLIE-31 AND QOLIE-10 inventories was supported by an unrestricted research grant from Wallace Laboratories, and administered by Professional Postgraduate Services, a division of Physicians World Communications Group.

Table 5, Continued

Seizure frequency, worst, of each TYPE: does not remember how many

Past Medications and highest dosage tried:

1.	hm.	Dose:
2.		Dose:
3.		Dose:
4.		Dose:
5.		Dose:
6.		Dose:

Current Medications and Dosages:

1.	Tegretol	Dose: 800 mg/d (levels checked)
2.	Nitrofurantoin	Dose: 100 mg/d.
3.	Ramipril	Dose: 200 mg q HS
4.	Loestrin (BCP).	Dose: 1/d PO

NEURODIAGNOSTIC TESTS

Examination: Lateralizing ___ Abnormal, non-lateralized ___ Normal ___

Anticonvulsant Levels: 1. ___ 2. ___ 3. ___

EEG: Focal ___ Generalized Epileptiform ___ Diffuse Abnormal ___ Normal ___

Neuroimaging: N/A

CT: Normal ___	Focal, abnormal ___	Diffuse Abnormal ___
MRI: Normal ___	Focal, abnormal ___	Diffuse Abnormal ___
PET: Normal ___	Focal, abnormal ___	Diffuse Abnormal ___

CCTV -EEG (If available) [1]: TLE ___ FLE ___ PLE ___ Primary Generalized ___

Other ___ Non-Diagnostic ___

Neuropsychometric Tests: FSIQ ___ VIQ ___ PIQ ___

Localizing features? Yes ___ No ___

PSYCHOSOCIAL SURVEYS[2]

QOLIE -10 (score) 28

MMPI (number of abnormal categories) N/A

WPSI (" " ") ___

Ab for sinus infection — Dr. Swartz

UniversityHospitals HealthSystem

University Hospitals of Cleveland

January 30, 2001

Mr. Henry A. Hentemann, esq
Davis & Young
700 Midland Building
101 Prospect Avenue West
Cleveland, OH 44115-1027

Ala: **Margaret M. Gardner**

RE: Veronica Ferrette

Dear Sirs:

I previously (Oct 26,2000) sent you an independent medical examination report of Ms. Veronica Ferrette based on her neurologic exam and history derived from her and some medical records. I have recently received numerous other copies of medical records and legal documents and have reviewed those as well. Thus, I am sending an expanded IME in which I will try to incorporate what I feel are the significant sources of information. I have indepen denetly reviewed two EEG's and an MRI scan. These I have returned to the office of Dr. Harold Mars, as requested. Previously, I had faxed to you my Independent Medical Exam of October 26, 2000. Some of the historical comments made in that will have to be amended with the current information.

History of Present Illness: On 5/7/98 the patient was asleep upstairs in her aunt's house. The aunt had left a car running in the garage that was below her bedroom and the patient was found unconscious. There was no note of any seizure activity. The paramedics were called and found the patient breathing with normal vital signs. Given the above-mentioned history of potential carbon monoxide exposure, a blood test for carboxyhemoglobin was drawn at that time. I do no know if it was measured in the field or later in the hospital, but was found to be 300 parts/million or 39.9%, consistent with a moderate to severe level of intoxication. She was taken to Hillcrest Hospital initially and then transferred to St. Vincent's Hospital. A note from Dr. Harold Mars said she had a three hour treatment of hyperbaric oxygen. I could not find a specific description of that in the medical records, but found only a description of 100% O_2 per nasal cannula. I also did not find the pO2 measured at first contact. She did not require intensive care unit or intubation. Again, there was no report of seizures and she was not given anticonvulsants. She was discharged to home.

The next medical treatment she sought was with her regular psychologist, and psychiatrist, Dr. Iahn. She was being treated for both depression and insomnia by them and was taking Pamelor between 25 and 75 mg per night and Rimeron 1.5 mg and Adivan PRN for sleep or anxiety and additionally, sometimes taking Ambiens for sleep. This was all prior to the incident of carbon

monoxide exposure. She had numerous neurologic complaints and was referred to Dr. Harold Mars, whom she saw on 6/4/98. At that time, she complained of blurred vision and episodic loss of vision lasting 10 minutes, headaches, exhaustion, photophobia, impaired concentration, decreased memory, impaired balance and speech. Because her main concern appeared to be her vision, Dr. Mars performed a visual evoked potential study, which was normal. She was also being followed regularly by her osteopath, Dr. Kimball. Dr. Mars had also ordered an EEG, which performed on 6/8/98. His report was normal. My review of the EEG concurs that it was completely normal. This was with hyperventilation photic stimulation. An MRI was obtained on 6/13/98. It was also read as normal. In my review I noted some assymetry in the temporal horns, R > L, which is usually a normal variant. It is a well performed study. She was referred back to Dr. Mars for single episode of left sided jerking followed by weakness of the left side, which persisted. She saw Dr. Morris on 6/22/98 and he began treatment with Tegretol. We saw her again on 7/14/98, at which time she was complaining of being intermittently cold, having problems with hearing, feeling depressed, having difficulties with thinking and intermittent episodes of her left leg giving out.

I noted that in the history that the patient reported to my clinical nurse that she was not sure when the seizures started. However, when I interviewed her she was quite certain that they had started *two* and a half years ago in May of 1998,

The seizures evidently continued, according to her report, although she was never seen in an emergency room to my chart review knowledge. She was given increasing doses of Tegretol and then Neurontin. When I saw her she was taking 800 mg of Tegretol a day and 1200 mg of Neurontin a day and said that her seizures had been under control for over a year. This was confirmed in a note by Dr. Mars. However, she did report "little seizures" described as impaired coordination, eyelid flutter, head shaking and stuttering. A second EEG had been performed on the patient, I believe in July of 1998. This was also read as normal with hyperventilation and photic stimulation. I reviewed it and again concurred.

When I questioned her about other risk factors for seizures, she denied any history of head trauma, any difficulties with birth, and any family history of seizures or history of febrile convulsions, and denied any history of CNS infections. In reviewing her chart, she was born prematurely, weighing four pounds. Her mother's labor was induced and had been confined to bed with bleeding during the pregnancy. She took DES throughout the pregnancy. She, herself, had jaundice and had to be treated in an incubator with lights to lower the bilirubin for two weeks. Instead of no history of head trauma, she has a history of being assaulted with post-concussive type symptoms (dizziness, blurred vision, headache) although the CT was normal (report of 1/12/99). In a previous lawsuit she claimed to be attacked by some maintenance men for her apartment building, but I did not see a clear description of her injuries (August, 1993) There was one or two CT's done prior to the CO exposure, one of them said it was for "Patient with convulsions being evaluated to rule out a fracture of the left orbit" on the requisition (1/18/96). This would indicate a previous assault and possible prior premorbid seizure condition. This was apparently ordered by Dr. Susan Kimball. Although she has no documented CNS infections, she

has had a long history of chronic sinusitis with many, many courses of antibiotics. Thus, if I were to list her risk factors for seizures I would say: 1) perinatal injury 2) head trauma 3) carbon monoxide exposure.

In terms of her **social history**, she was working as a waitress at the time of the accident. She had formerly been a sleep technologist at VA Wade Park. She said she worked as a researcher for Dr. Redline at University Hospitals and at Wade Park. She had quit her job to open her own, private sleep lab, however, there is no mention of her obtaining her Sleep Technology Boards. She had reported to one of the psychological interviewers that she was first author on numerous research articles. Two articles were included for me to review with her name on them. She was third author on one and seventh on the other. This would indicate only a supportive technical role. She attempted to go back to work at Charlie's Crab after the incident. Shortly thereafter, Dr. Mars suggested that she stop working, which she did.

To me, she denied alcohol or cigarette use. However, in reviewing the notes from the ENT physician, one of them strongly suggested that she discontinue smoking to decrease her problems with her sinuses and nasal mucosa. In an MMPI performed as a part of the psychological evaluation in 1995, one of the items that she endorsed was that she had used alcohol excessively.

When I inquired about her **past medical history**, she denied any other medical problems and reported only taking the Pamelor 200 mg at night, low estrogen birth control pills, one per day. She did not tell me that she had also been treated with Paxil and Prozac in the past for depression. Rimeron, ativan, and ambiens for sleep. In reviewing the medical charts, she had a variety of medical problems.

The significant things I noted in the **past medical history** (and this may not be a complete list) dated back to her early childhood at Babies and Rainbow Hospital records. She had been brought in for bloody diarrhea in June of 1967 as a three year old. The symptoms resolved upon stopping oral intake of food and rehydration. At that time, no allergies were noted, but her mother reported a family history of a bleeding disorder. She also reported a history regarding her own pregnancy being difficult, that she was given DES during the pregnancy and that Veronica had two months of bleeding per vaginum as a result of this after birth. However, the patient did have a normal PT and PTT. Between the ages of 11½ and 12½ years she had frequent urinary tract infections. No evident etiologies for those were mentioned. That would have been about 1978. She came in with a knee injury due to rough play and was found to have a bruised kneecap on arthroscopy. She was also brought in as a child with low back pain which resolved with physical therapy and Tylenol. I note on one note regarding the knee pain, someone diagnosed condromalacia femoralis. She came in 1974 with a complaint of a fractured nose when a basketball hit her in the face. The exam sounded unremarkable. At that time she complained of many allergies. She had had a rash to penicillin and noted that she got nausea and vomiting from Morphine, Codeine, Darvon and Percodan. It is not clear why she had been given all of these narcotics as a child. Later notes say she has rashes to these agents as well.

In October of 1988, she presented as a twenty-four year old with chronic right lower quadrant pain. She was suspected to have a UTI' based on her history. This was evidently ruled out. She had an ultrasound laproscopy, which was said to be normal. She had an ultrasound, however, with a question of fluid in the abdomen. When her pain did not resolve with antibiotics, she finally ended up going into surgery and having an appendectomy and the dictated report of the appearance was a normal appendix. I did not see any report of pathology.

After this, the majority of notes are with regard to psychologist or psychiatrist visits. However, she did have significant history in 1991 with menorrhalgia, metrorhalgia (excess menstrual pain and bleeding) and an evaluation including endometrial biopsy and hormonal levels. Both were normal. In 1992 she again complained of menstrual abnormalities. She was found to have cervical dysplasia. She underwent a cone biopsy. This revealed stage I - IV dysplasia and she was also treated with 5 FU. It was felt that this was due to the mother's DES therapy.

In 1994 she was seen at UFHC Urgent Care Center complaining about blurred vision, headache and dizziness. It was felt that these symptoms were secondary to her sinusitis. She subsequently had numerous visits to Meridia Health Care system in the past year for the same symptoms, which she now attributes to carbon monoxide poisoning. There are fairly extensive notes from ENT physicians regarding her sinuses. She had acute sinusitis nasal obstruction in 1997. It was thought that this was due to chronic allergies and smoking. She had sinus surgery at this time, including the L middle terbinate of the nose. She saw an ENT physician in October of 2000 regarding the same symptoms. The physician, Dr. David Steptic, noted the patient had an underlying predisposition to sinusitis, potentially because of allergic rhinitis and dry mucus. He recommended conservative therapy. He also said that seizure medications can cause dryness and felt these symptoms could be managed with simple nasal hygiene. (I have never heard of this side effect.)

When I inquired about family history, she also denied any problems. Review of various records reveals that she has an uncle who was psychotic or bipolar and an aunt who was severely depressed. Her mother has had a major problem with gambling and other irresponsible behaviors noted by the psychologist. Veronica told another physician that her mother has had oral cancer surgery.

When I went through a review of systems she did talk about having current sinus problems and taking an antibiotic. She complained of problems with thinking, poor memory and concentration, poor ability to express herself and focus her attention. She said that had been constant since the carbon monoxide poisoning. She did not complain of weakness at first.

In terms of psychiatric history, her first notes date back to 1987 when she was first seen by Dr. Iahn. Significant to the history is that she had a very poor upbringing. Her parents got divorced when she was six months old. The mother was too irresponsible and promiscuous to raise her, so she was raised by her grandmother until the age of six, at which time the mother took over, but was superficial and unavailable. She reported that her father was rich, but cold and manipulative

and that she had had no good male figures in her life. She reported that she floundered in college with a GPA of less than 2.0 for the first two years and with hard work she brought it up to 2.4 total over four years. This is in contrast to other reports in which she stated that she was above a 3.0 in her college years and planned to take the MCAT's and go to medical school. At that time, she also reported that she might be dying of AIDS, although, there was no obvious reason for this statement. Her diagnosis was made first as general anxiety disorder and then amended to major depression. A second psychiatric evaluation was made by Dr. Sandra McPherson in conjunction with a previous law suit that she filed against persons and parties who harassed her regarding the apartment she was living in. At that time, she stated that she had taken the MCAT's and did not do well on them, blaming stress for the poor performance. Dr. McPherson states that she had A 3.6 GPA on Master's studies classes and an undergraduate GPA of 3.2. It is not clear what the source of this information was. The MMPI was administered and showed very high levels of fear, anxiety and depression. It is not clear if Dr. McPherson had access to the previous psychiatrist's notes at that time.

The second neuropsychological evaluation was performed in relationship to the current law suit She reported her seizures as being under control for four months at the time of the testing which was done January, 2000.. You have her long report, basically she was impaired in *every* domain of cognition tested. Most seriously, on executive dysfunction, but also in visual spatial skills. She had poor memory, primarily verbal, which was related to poor attention, organization and more noticeable with difficult material. She still showed serious depression, as she had earlier. Dr. McPherson concluded that all of these symptoms were due to the carbon monoxide poisoning, having she found no indication of cognitive dysfunction before May of 1998. She was entered into an occupational therapy program and, in fact, was still in it, I believe, when I saw her. The reports I have from that program of November, 2000show a very serious and nearly complete problem with things like reading, drawing, paying attention and doing simple calculations with very little ability to improve with practice or focusing. Some later notes io December indicate arriving at appointments late and not doing her homework, although she was able to improve performance with instruction.

I performed a complete **neurologic examination**, which was sent to you earlier. I will point out the pertinent observations. First of all, Ms. Ferrette was spontaneous, and not guarded in her responses to questions. She was cooperative and did not seem hostile. *On* mental status testing, she was normal in terms of speech and language. In testing memory, she registered five out of five pictures with only two tries and after five minutes remembered four out of five spontaneously and one with a cue. In terms of verbal memory, she registered five out of five with only one try and recalled three out of five after five minutes spontaneously and one with a cue. She was a bit slower in her responses to the verbal items. This may indicate some mild impairment in verbal memory, but certainly is consistent with other patients I have who are performing fairly high level jobs and leading normal lives. She knew the presidents down to Reagan, although she needed a cue to get his name. She remembered her previous physicians' names. She was able to do calculations fairly rapidly in her head, including double digit ones and irregular ones. Tests of attention, including the tapping test and the A Test were accurate. Digit span was also intact,

seven numbers forward, five numbers backwards. She did not seem to comprehend the Trails B test. She connected all of the numbers and then connected all of the letters when I asked what she was going to do with the letters. She switched hands in the middle of the A Test, which is not counted as a mistake. It was not clear why she would do this. Overall, to office based testing she had intact attention with a very slight decrease in memory and executive function.

Cranial nerves were basically intact. On motor exam, she had no real weakness on her exam. She gave way on the left upper extremity, which means that rather making a sustained effort, she simply lets the limb go.(Dr. Mars notes had also mentioned "give way" weakness.) I had seen her walk into the examination area and she had a normal gait. However, when I tested her gait, she could toe walk and tandem walk and had normal arm swings, but had a bizarre movement of her left leg when she was heel walking. She would supinate it and pronate it in a shuffling way as she walked. This maneuver requires a good deal more motor control and balance than the test I was asking her to do. So, it does not indicate a true dysfunction. The Luria Test tests looks at premotor function. It is a series of sequential hand movements and she actually performed this better on her "impaired side", the left, than on the right. On the right she was accurate, but a bit slower. She had no cerebellar findings. Sensory exam was inconsistent and nonphysiologic for intracranial pathology. (She said the pin was decreased in the left leg, but increased in the left arm.) Deep tendon reflexes were symmetric. She had flexor plantar responses and no cortical release signs. These findings indicate a lack of one of the types of lesions expected with carbon monoxide intoxication. Also lacking were any extra-pyramidal system (basal ganglia) signs, such as cogwheeling, bradykinesia, masked facies.

Because of the discrepancy in her observed and tested gait, I performed a test in which she is asked to raise her leg off the bed. This requires the effort of extension at the hip opposite the leg that is being raised. She had difficulty raising her left leg although she did do it, She raised her right leg normally. With my hand placed beneath her upper thigh during these maneuvers, I could assess that she made a greater effort to raiser her right leg than her left.

I have been asked to give my opinion as to whether any or all of the patient's current complaints are related to carbon monoxide poisoning. I am quite certain that the "seizures" she complains of are not. In fact, I seriously doubt whether she is having any seizures or whether she ever had any seizures. Carbon monoxide is known to produce diffuse cortical dysfunction, but particularly the basil ganglia are involved. If she were to have carbon monoxide induced seizures, which occasionally happens in very severe cases, two things would be different than her case: 1) She would have generalized (eg. - tonic-clonic) seizures, associated with diffuse cortical damage. 2) There would be clear MRI changes. Neither of these is the case. 3) She would likely have an abnormal EEG, although this would best be determined by prolonged monitoring. Focal onset seizures may rarely be seen in carbon monoxide poisoning, but just as with other diffuse insults, the focal nature of the seizure, indicates that there is a focal component of brain damage that is incidental to the insult in question or only peripherally related. Again, in most cases this would be detected with the MRI or EEG. This should have been tested long ago by bringing the patient in for video-EEG monitoring, taking her off anticonvulsant medications, and seeing if, in fact, any of

these events really are seizures, as it may be harmful to continue her on anti-convulsant medication if she doesn't need them.

In terms of some of her other complaints, I find no objective evidence that she has weakness on the left. The type of weakness she demonstrates was feigned as was the gait. Although the patient complains of a left sided problem, which would indicate some right hemisphere dysfunction, if anything, her right hemisphere functions were more intact than the left with respect to the Luria premotor cortex test, with respect to her associated movements of the arms, and with respect to the memory testing. However, these subtle findings, such as hers, are not unusual in intact individuals. She may have had a slight decrease in her left nasal labial fold, which probably relates to a premorbid facial asymmetry that most of us have.

There is another important point to the history. The patient has presented herself as having no risk factors for any neurologic problems such as seizures, and yet, in fact, she was a premature baby born at four pounds suffering icterus who had to be in an incubator for two weeks. The mother was bed ridden with her pregnancy and was bleeding per vaginum. So, she probably had placenta previa and she was given DES. All of these are risk factors in childhood, teenage and even adult years for the development of seizures, as well as for some cognitive difficulties. Thus, even if she does have seizures, they could just have easily been from prenatal insult, She has also had several head traumas, although I doubt these were significant since she never lost consciousness. So, in my opinion, the most likely diagnosis in this patient is non-epileptic form of seizures or pseudo-seizures, which are produced in a spectrum of disorders ranging from *conversion* to malingering or factitious disorder or hypochondriasis. Although I am not a psychiatrist, the patient certainly has a wealth of doctors and emergency room visits for a variety of relatively minor complaints both before and after the carbon monoxide exposure. She even had an abdominal surgery which was not clearly necessary according to the operative report. She may, therefore, be at risk for the development of additional physical symptoms with any physical or emotional stress.

In terms of her "dementia", she actually performed very well on my testing. I recognize that some of her deficits were in the area of more complex operations according to the testing of Dr. McPherson. Nevertheless, she does not show a consistent pattern of deficits to account for the rather severe and gross problems that have been reported both by her and by the occupational therapist she has been seeing.

When a neurologist tries to assess whether a patient really has neurologic deficits or seizures, we frequently need to make an assessment of the patient's general mental status and emotional state from the history. Clearly by the history, this is somebody who has had ongoing emotional and psychological problems, who has portrayed herself as being a pre-medical student with a GPA of 3.5 to 3.6, although her undergraduate GPA according to a much earlier note said 2.2 to 2.4. I believe she is somebody who has struggled with a bad home environment and a desire to achieve, but never really had the emotional skills to do so. While she says she was preparing to start her own sleep business, no documentation of this, by way of contracts, equipment purchases, investor

inputs, etc, were given in the numerous materials I reviewed. Actually she was working at Charley's Crab, where in 1997, she was making errors requiring counseling by her supervisor. Her ambition may have exceeded her abilities.

The question must always be asked: Can carbon monoxide cause all these symptoms? Since it can cause a plethora of neurologic and psychiatric symptoms, the answer is yes. Did it cause the extreme state of dysfunction that she describes today? I believe the answer is no. It would be very unusual to be so disturbed in her cognitive abilities in the face of two perfectly normal EEGs and a normal MRI. On the other hand, somebody who has a significant psychological and emotional problem will perform very badly on tests that she is given in a cognitive battery. Not to mention, people can perform badly if they want to. Thus, my overall assessment is that the patient does not have a neurologic deficit at all. She probably does not have a seizure disorder. While I am 95% certain of the latter, it is a diagnosis of exclusion and she should have video-EEG monitoring and possibly even a PET scan by now to turn over every stone. She may have some minor neurocognitive problems which do not seem to be enough to account for her extreme level of dysfunction and which could represent a premorbid condition.

If you have further questions, please do not hesitate to call (216-844-3714).

Sincerely yours,

Barbara E Swartz

Barbara E. Swartz, MD, PhD
Director, Comprehensive Epilepsy Program
University Hospitals of Cleveland

ADDITIONAL COMMENTS:
Energetic. Relates superbly to participants. Willing to work unusual hours. Displays caring & concern.

RECEIVED

JAN 0 9 1995

ADMINISTRATIVE SERVICES
SCHOOL OF EDUCATION

BASED ON A REVIEW OF THE EMPLOYEES PERFORMANCE IN RELATION TO THE ATTACHED POSITION DESCRIPTION

1. PLEASE RATE OVERALL PERFORMANCE:

D.O.M. PERSONNEL
RECEIVED
DEC 2 0 1994

SUPERVISOR'S OVERALL RATING

☒ **Outstanding**
Performance is clearly outstanding and results obtained are far in excess of requirements.

☐ **Good**
Performance consistently exceeds the requirements of the position in all respects.

☐ **Satisfactory**
Performance is satisfactory, acceptabie and meets requirements in most respects.

☐ **Improvement Needed**
Performance *is* somewhat below expected levels of accomplishment on one or more major requirements.

☐ **Marginal**
Performance is seriously deficient.

2. Capable of increased responsibility ☐ YES ☐ NO Now ☐ In the future ☐

3. RETAIN AT PRESENT SALARY: ☐ YES

4. PRESENT ANNUAL SALARY $ 25,401 RECOMMENDED INCREASE $ 1270.00 YR. (5 %)
$26,670.00 New Salary

EFFECTIVE DATE 12-1-94

5. I HAVE READ THIS REVIEW FORM AND THE ATTACHED POSITION DESCRIPTION AND MY PERFORMANCE HAS BEEN DISCUSSED WITH ME.

Veronica Gaca Fuentes
EMPLOYEE SIGNATURE
(DOES NOT IMPLY AGREEMENT OR DISAGREEMENT

DEC 2 0 1994
D.O.M. PERSONNEL
RECEIVED

☐ CHECK HERE IF REVISIONS HAVE BEEN MADE TO THE POSITION DESCRIPTION

RATED BY: SUPERVISOR _____ DATE 12/18/94

APPROVALS _____ DATE 12/21/94

_____ DATE _____

HUMAN RESOURCES _____ DATE 1/13/95

SEND THIS FORM WITH THE ATTACHED UPDATED POSITION DESCRIPTION TO THE NEXT PERSON ON THE ROUTING.

NO SALARY CHANGES WILL BE PROCESSED WITHOUT THE EMPLOYEE'S SIGNATURE ON THIS FORM.

PLAINTIFF'S EXHIBIT 6 Dr. Swartz
PENGAD-Bayonne, N. J.

D.O.M. PERSONNEL
RECEIVED

JAN 1 6 1991

RECEIVED JAN 23 1991

Chief Operating Officer
RECEIVED
JAN 18 1991
Department of Medicine

Routing:
1. Department Head
2. Student Employment
3. Human Resources

CASE WESTERN RESERVE UNIVERSITY
TEMPORARY EMPLOYMENT REQUISITION

This form should be routed to Student Employment. If no student is available and qualified to fill the position, this requisition will be forwarded to the Human Resources Department for necessary action.

Department Medicine-UH(PL/CC) Home Dept. 1710 Date 1/10/91

Acct. No. 641-~~[illegible]~~-2426
Acct No # 642-1710-7947 OK to pay a nurse

Job Title Research/Sleep Technician
>Technician II

*Proposed Hourly Rate 10.50

Hours per Week 40

*May not be outside University guidelines

Indicate period of employment and ending date 1/7/91 - 7/1/91

Give brief but specific and complete job description indicating all special requirements (such as clerical or technical skills) and other pertinent facts relative to the job. Additional information may be requested.

To collect a variety of physiological and anthropometric data in a field setting (subject's homes in Greater Cleveland) as to enter these data in a computer file. To oversee 2 overnight polysomnographic sleep studies (in-hospital).
Requires a car ins and driver's license.

Could this position be filled by a student? No If not, explain
The requirement for overnight sleep studies and traveling would make it difficult for a student to fulfill

Do you have a particular person in mind for this job? Yes If so, please give name & social security number. YOU MAY NOT MAKE ANY COMMITTMENT TO THIS INDIVIDUAL WITHOUT APPROVAL FROM STUDENT EMPLOYMENT OR HUMAN RESOURCES.

Veronica Ferrette - 285-68-3509

Requested by: Susan Keller Donald Caplan Extension 844-5367
Employee Supervisor

Approved by: Donald Caplan
Department Head

Student Available (Yes) No

James N. Allaqueo
Student Employment release to hire non-student

Rev. 7/86

fax 368-4678

PLAINTIFF'S EXHIBIT 7
Dr. Swartz
PENGAD-Bayonne, N.J.