IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

ZACHARY HAMMON, et al.,

Plaintiffs,

-vs-

JUDGE POKORNY
CASE NO. 209957

MARYMOUNT HOSPITAL, et al.,

Defendants.

Doc. 456

- - - -

Deposition of MAX WIZNITZER, M.D., taken as if upon direct examination before Lynn D. Thompson, a Notary Public within and for the State of Ohio, at Rainbow Babies & Childrens Hospital, 2101 Adelbert Road, Cleveland, Ohio, at 4:50 p.m. on Friday, January 15, 1993, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants El-Mallawany, Abrams and Brown in this cause.

- - - -

MEHLER & HAGESTROM
Court Reporters
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

APPEARANCES:

Christopher M. Mellino, Esq.
Charles I. Kampinski Co., L.P.A.
1530 Standard Building
Cleveland, Ohio 44113
(216) 781-4110,

On behalf of the Plaintiffs;

Lisa Cerino Cabi, Esq.
Hahn, Loeser & Parks
3300 BP America Building
200 Public Square
Cleveland, Ohio 44114
(216) 621-0150,

On behalf of the Defendant
Marymount Hospital;

Robert C. Seibel, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114-1192
(216) 736-8600,

On behalf of the Defendants
El-Mallawany, Abrams and Brown.

- - - -

MAX WIZNITZER, M.D., of lawful age, called by the Defendants El-Mallawany, Abrams and Brown for the purpose of direct examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION OF MAX WIZNITZER, M.D.

BY MR. SEIBEL:

Q. Would you state your full name for the record, please.

A. Max Wiznitzer.

Q. Doctor, my name is Bob Seibel. We were introduced briefly before, but I am from Jacobson, Maynard, Tuschman & Kalur, and along with Jerry Kalur of our firm, I represent Dr. El-Mallawany and his firm. Dr. El-Mallawany is an obstetrician/gynecologist. I was just curious if you know him at all?

A. No, I don't.

Q. What is your professional address?

A. 2101 Adelbert Road, Cleveland, Ohio 44106.

Q. That's University Hospital?

A. Rainbow Babies & Childrens.

Q. Do you have any other offices?

A. I see outpatients at an office in Beachwood and

at an office in Lakewood on an intermittent basis. I mean this is the home headquarters, if you want to think of it that way.

Q. Those other offices, are they associated with Rainbow Babies & Childrens Hospital?

A. We rent space. Out in Beachwood, it's the Rainbow Subspecialty Center. I've forgotten the exact name.

Q. How about Lakewood?

A. Lakewood just has my name on the door, when I'm there.

Q. What's your date of birth?

A. March 4th, 1953.

Q. And what is your Social Security number?

A. 331-44-4521.

Q. Doctor, you understand that your testimony is being recorded today?

A. Yes.

Q. And you understand that your testimony is also under oath?

A. Yes.

Q. Do you understand that we'll be relying on the answers that you give as we analyze this case and prepare for trial?

A. Yes.

Q. Do you further understand that this is my only opportunity to discover your opinions under oath in this setting?
A. Yes.
Q. And would you agree not to answer any question unless you understand it?
A. Yes.
Q. What is your position here at Rainbow Babies & Childrens Hospital?
A. I'm the chief of child neurology.
Q. How long have you held that position?
A. Since July lst, 1992.
Q. How many other child neurology physicians are there here at Rainbow?
A. One-and-a-half.
Q. Dr. Horwitz is the other?
A. Dr. Horwitz is one, and we have another person who is the head of the division of rehabilitation and developmental disorders, who is also a child neurologist who works with us.
Q. Who is that?
A. Dr. Mark Cohen.
THE WITNESS: I'm going to ask a favor.
MR. SEIBEL: Sure.

- - - -

(Thereupon, a discussion was had off the record,)

- - - -

(Thereupon, Defendants' Exhibit 1, 4-5-91 Wiznitzer letter to Kampinski, was mark'd for purposes of identification.)

- - - -

Q. Would you describe your medical education, training, experience beginning with college?

A. I went to Northwestern University and, first of all, was in Evanston, Illinois in their honors program in medical education. I was entered from 1971 through 1977. The last four years, I was in the medical school there. In 1975, I got a bachelor of science in medicine, and in 1977, I got my M.D.

After that, I did a pediatrics internship and residency at the Children's Hospital & Medical Center in Cincinnati. That was from 1977 to 1980. From 1980 to 1981, I did a developmental pediatrics fellowship at the Cincinnati Center For Developmental Disorders.

From 1981 through 1984, I did my neurology training, which basically is my pediatric

neurology fellowship, although I'm boarded in neurology, at the Children's Hospital of Philadelphia and at the University of Pennsylvania neurology program in Philadelphia. And that went through '84.

From 1984 through 1986, I did a National Institute of Health fellowship in higher cortical functions in children at the Albert Einstein College of Medicine in Bronx, New York.

Q. Where did you go after you finished your fellowship at Albert Einstein?

A. I came here.

Q. Are you employed by University Hospital?

A. No.

Q. So yours is a private practice of pediatric neurology?

A. No. We are employees of Case Western Reserve University School of Medicine.

Q. Do you maintain any private practice at all?

A. No.

Q. Besides the medical training that you just described for me, have you begun any other residencies or fellowships that you didn't ultimately finish?

A. No.
Q. And did you attend any other medical schools, for instance?
A. No.
Q. Are you licensed in any other states besides Ohio?
A. Yes. To be honest with you, I can't remember if my license is inactive or active, but I have licensure in Pennsylvania and in New York.
Q. And how about hospital privileges; anywhere besides University Hospital?
A. I have consultative privileges at Lakewood Hospital and at Geauga Hospital.
Q. Has your license to practice medicine ever been revoked, suspended, modified, restricted in any way?
A. No.
Q. And have your hospital privileges ever been revoked, suspended, modified or restricted in any way?
A. Except for not dictating my charts on time, where you get a death notice. Other than that, the answer is no.
Q. Doctor, I'm going to hand you what we've marked for purposes of this deposition as Defendants'

Exhibit 1 and ask if you would identify it for the record, please.

A. Defendants' Exhibit 1 is a letter dated April 5th, 1991 to Mr. Charles Kampinski from me regarding Zachary Berardinelli,

Q. Have you issued any other reports besides this one to Mr. Kampinski or anyone from his office?

A. Not to my knowledge.

Q. Do you maintain a separate file for these types of reports apart from your patient file?

A. No.

Q. Was this the one and only draft of this report?

A. You want an honest answer?

Q. Sure.

A. I couldn't tell you if it was or if it wasn't.

Q. Well, my question is did you discuss your report with Mr. Kampinski before you put it in final form?

A. No. I mean the only other drafts that I can think of would have been with typos or I wasn't happy with the grammatical structure of sentences.

Q. What issues did Mr. Kampinski ask you to address that led you to writing this report to him dated April 5th, 1991?

A. Maybe I don't understand the question.
Q. Sure. Well, something had to happen to prompt you to write this report.
A. Yes.
Q. And I assume that it was some discussion with Mr. Kampinski about Zachary?
A. Yes.
Q. So getting back to the question then, what issues did Mr. Kampinski want you to address in report form to him which led to your creation of this April 5th, 1991 report?
A. I can only, you know, guess from the letter. Basically, it was, number one, what kind of neurologic deficits does Zachary Berardinelli have and, number two, when did they occur.
Q. And does your report here address those two issues to the best of your abilities as a specialist in pediatric neurology?
A. It addressed it to the best of my ability at the time that I wrote the letter.
Q. Do you now have information available to you that affects your statements in this letter one way or the other?
A. No, not really.
Q. So have your views changed at all since

April 5th, 1991?
A. They've only been more refined.
Q. We'll get into those in more detail.
Do you know when your first contact was with Mr. Kampinski or someone from his office?
A. To be honest with you, no. I can guesstimate for you.
Q. All right. What's your best guess?
A. 1990.
Q. Why do you say that?
A. Because I have a letter in my file asking for my records in 1990.
Q. What's the date of the letter asking for your records?
A. March 13th, 1990.
Q. That's from Mr. Kampinski?
A. Yes. He also asked to meet with me at the time.
Q. Did you meet with him?
A. Yes.
Q. Do you know when?
A. No. It was between March and April of 1990.
Q. Do you remember what you discussed?
A. Probably the same things that are in the letter. I have no independent recollection of the conversation, but I'll make that

assumption.
Q. Have you given deposition testimony before?
A. Yes.
Q. About how many times?
A. Ten. I'll be honest with you. That's a guess. I really don't keep a count,
Q. How many times have you given a deposition as an expert witness?
A. Define "expert witness" for me.
Q. Well, from your position as a pediatric neurologist rendering opinions about any aspect of a case.
A. See, I see "expert witness" more as a person when I'm not involved in the child's care but someone asks for my opinion.
Q. All right, fine.
A. In those situations, for depositions? Six, seven.
Q. Now, you've been deposed six times in cases where you have not been involved with the patient?
A. Where I was not involved in treatment or the care of the child.
Q. Where you've just looked at the records independently and drawn certain conclusions?

A. Yes.
Q. And so then approximately four other times where you actually have had involvement with the patient?
A, Yes.
Q. Like this case?
A. Yes. And I'm -- to be very honest with you, these are wild guesses, because I really just don't keep a count on depositions. My business is the practice of medicine, not to give depositions.
Q. In those cases where you testified having not been involved with the patient's care, on whose behalf did you render opinions?
A. Primarily defense.
Q. And how would that break down in terms of percentages?
A. Oh, at least -- at least 65, 70 percent defense.
Q. Describe your current practice, if you would.
A. I'm an academic physician, and as an academic physician, I have responsibilities in three areas. Area number one is clinical care of children, since I'm obviously a pediatric neurologist. And that subsumes the greatest amount of my time. Both on an inpatient basis

as well as on an outpatient basis.

I also do things. I read EEG's, and I run the evoked potentials lab at University Hospitals. That's number one.

Number two, I have a responsibility for the education of medical students and of residents as well as of my colleagues in various aspects of medicine. In terms of continuing education programs.

And number three are my endeavors in research. And, unfortunately, I would say the latter is not as much time as I would like it to be.

In addition to that, I also lecture to parents groups and things like that when the request arises, because I think it's important to have a well-informed public.

Q. So all your compensation for the clinical care of patients comes from Case Western Reserve University?

A. Yes. Yes. I mean there's -- I have grants for my research, if that's what you mean.

Q. Not necessarily.

A. But I do not -- no, I don't have a private practice set up on the side where I see patients

in the evening or on weekends, No, I don't do that.

Q. Why did you choose this particular specialty?

A. Why did you choose to be a lawyer?

Q. I asked you first,

A. Okay. Then I'll wait for an answer from you afterwards.

Q. Yes, all right.

A. I chose pediatrics because I enjoy working with children. If you want the story, I'll give it to you.

Q. I do.

A. I don't mind giving it to you.

When I did my pediatrics training, I was interested in going into developmental pediatrics. I always had an interest in learning disabilities and developmental disorders in children, and my mentors at the Cincinnati Center For Developmental Disorders told me that you're not going to get any respect unless you're trained not only in developmental pediatrics but also in pediatric neurology. And I took their advice seriously, and I went into pediatric neurology with -- as you will notice, with my NIH fellowship, which was in higher

cortical functions in children.

I'm interested in you might want to say the cognitive aspects of my subspecialty. I mean I have a wide range of interests, but that's one of them. And I hate to say it. It's fun. I enjoy my work, And I enjoy my research and things like that.

Q. What is your fee for giving a deposition?

A. $350 an hour.

Q. What is your fee for reviewing a case?

A. $250 an hour.

Q. And how about for testifying at trial?

A. $350 an hour. Including transit time.

Q. Do you intend to testify live at the trial of this case?

A. If I'm requested to.

Q. And I say live at trial in contrast to videotape.

A. I understand.

Q. All right. Still if you're requested to testify live at trial, you will come down to court?

A. And if I'm around.

Q. What materials did you review before you wrote your report on April 5th, 1991?

A. I reviewed Zachary Berardinelli's hospital chart

and my records, my office records, to that time,
Q. When you say "hospital chart," what do you mean?
A. He was admitted to the hospital. He was a newborn. So his newborn records.
Q. "Hospital" meaning University Hospital?
A. Yes, University Hospital of Cleveland records.
Q. So before you wrote your report -- I just want to summarize, make sure we have a clear record.

Before you wrote your report, you reviewed the University Hospital/Rainbow Babies & Childrens records for Zachary and his September, '88 admission and then the records you had available in your own office up to that point, April 5th, 1991?

A. Yes.
Q. Any other records that you had reviewed before your wrote your report?
A. Whatever was in the University Hospitals records up to that point in time.
Q. Do you have a copy of those records in your office here today?
A. Not here, but I have the original records right here to refer to in case I need to.
Q. When was the last time you looked at those?
A. Earlier this week.

Q. Have you reviewed any further material since you wrote your report?

A. Only whatever has been clinically relevant. I think that's the best way of saying it. Maybe I don't understand what you mean. I've also looked at -- I have seen some expert reports. Let me think if I have this right. From Dr. Chalhub, Dr. Redline, Dr. -- there's a doctor at Metro --

Q. Dierker?

A. -- Health Hospital. Yes. That's right. It would be Dr. Dierker. And I looked at Dr. Edelberg's deposition.

Q. Do you have copies of those documents here in your office?

A. Not here, no.

Q. Where are they?

A. In my home.

Q. Any other further materials?

MR. MELLINO: I don't understand what you're asking him. If he's looked -- what he's looked at since he's written his report?

MR. SEIBEL: Yes.

A. Let me think. Rita Berardinelli's deposition I

briefly glanced through. But other than those papers which have to do with the legal aspect, the only things that I have looked at were any reports that had to do with Zachary's medical or neurologic care, That's it.

Q. What about the records of his pediatricians?

A. No. I haven't seen those.

Q. What about any Marymount Hospital records?

A. If there were any records from Marymount Hospital that were in the University Hospitals of Cleveland chart, I would have seen them.

Q. Have you developed any new opinions since you wrote your report in April of 1991?

A. In what way?

Q. Any opinions that you didn't have in April of '91 that you do have now relative to this case.

A. As I said, I've refined my opinions as to, you know, what I wrote there. To be getting more specific.

Q. When did you first see Zachary?

A. I saw Zachary in September of '88.

Q. What date?

A. Oh, I'll be honest with you. It had to be the same date that the child neurology note was put in the chart.

Q. Why do you say that?
A. Because a note wouldn't get put in the chart without me seeing the child. More important question is did I sign anything? The answer was probably not. My first written note in the chart is from September 19th, 1988.
Q. That's in the progress notes?
A. Yes. That I can find.
Q. That would be the first progress note on September 19th, 1988?
A. Yes.
Q. Begins "Zachary is awake but not totally alert"?
A. Yes.
Q. That's your first entry in this chart, doctor?
A. That's the first entry in my handwriting, yes.
Q. Who wrote the September 6, 1988 child neurology consult note?
A. Had to be one of my residents.
Q. Can you find it and tell me specifically.
A. I think the name is Neger, N-e-g-e-r. And I just don't have any independent recollection of who this person is.
Q. You don't know Dr. Neger?
A. I can't remember. I am sure I know Dr. Neger, but you know how many people come through here

all the time?
Q. No, I don't.
A, I mean I have on the average two to six residents on service with me, or medical students, at any one time. We've had a lot of trainees. We have 20 trainees, 20 residents per year. Most of whom rotate through our service. So that means since I've been here, which is six-and-a-half years, we've just -- you know, in and of itself, we've had 10 trainees that I've known, minimum. Plus the neurology residents, of which there's six per clinical year. So there's 18 altogether. And they also rotate through. So there's a large number of people that come through.
Q. Do you know what level of training Dr. Neger had reached by the time he or she wrote this September 6th --
A. It has to be at least a second-year resident. It has to be.
Q. In neurology? Second-year neurology resident?
A. I just can't tell you, sir. **I** just don't remember. I'll be happy to find out if you'd like. I mean **I** have access to those records.
Q. Your September 19th progress note, was that the

first progress note written by a pediatric neurology attending physician?

A. The first note that I can see, yes.

Q. You actually have very legible handwriting, but just in the chance that I'm misreading it, would you go ahead and read your handwritten note for September 19th, please.

A. Sure.

Q. And if you've used abbreviations, go ahead and tell me what those abbreviations stand for.

A. The note says "Neurology. Zachary is awake but not totally alert. Extraocular movements full. Follows face/voice with his eyes." Or "with eyes. Preference for head turn to right. Moving right arm/hand better although tone and grasp still low. Deep tendon reflexes brisk with five to six beat right ankle clonus. Gag intact. Suck moderately abnormal. No prolonged effort. Question mark, increased lower extremity tone, especially in hips. Poor cry.

"Impression. Exam, including brachial plexus injury, is improved. Right arm movements suggests good recovery potential. Central nervous system exam still abnormal and outcome still not clear. Will follow. M. Wiznitzer,

M.D."

Q. When's the next note in this record by either you or another pediatric neurology attending physician?

A. September 26th, 1988.

Q. That's you again?

A. Yes.

Q. Would you read your note, please?

A. "Neurology. Zachary is feeding better, having taken 70 cc today, although he still does not have a strong suck. Gag intact. Has sleep-wake cycles.

"Physical examination. Head circumference equals 37.4 centimeters. Positive moro. Negative asymmetric tonic neck reflex. Trunk tone decreased. Moves all extremities well with normal tone. Opens and closes hands.

"Deep tendon reflexes 3/4 with unsustained ankle clonus. Briefly visually fixates and tracks other 45-60 degrees.

"Impression. Improved but still not functioning at age-expected level. Will follow. M. Wiznitzer, M.D."

Q. And that's the last note by a pediatric neurology attending in this record?

A. Yes, it is.
Q. Do you remember Dr. Wolff, W-o-l-f-f? First name initial D.?
A. Dr. Wolff is listed here as a pediatric surgeon. No, I wouldn't know him.
Q. What role did you play in the review or approval of the discharge summary for Zachary's admission?
A. I had no role.
Q. Did you review it?
A. Recently. The only person who has a role in that is the attending physician who dictates it.
Q. In going through the progress notes, do you recall the names of any of the pediatric neurology residents that might have been involved in Zachary's admission?
A. There are no names of any of my residents in here. First of all, I don't think I had any of my trainees writing this note. And any neurology note would be labeled "neurology." It just wouldn't be written.
Q. That's really why I asked. Is it fair to assume that the other residents who have written notes in the progress notes are not involved with the

pediatric neurological aspects of Zachary's care?

A. Not unless I was walking through the nursery and they asked me to look at him with them. We discussed it a bit, and then I walked on. That happens many a time, and I don't write an independent note, but then they'll write down what we went over together.

Q. Did it happen here?

A. I couldn't tell you yes or no.

Q. Doctor, could you give me -- you have your original records for Zachary here in front of you. Could you hand them to me, and we're just going to mark them as an exhibit.

A. You can't take the originals. You know that.

Q. Oh, I don't intend to take them.

A. Oh, okay.

- - - -

(Thereupon, Defendants' Exhibit 2, child neurology office chart, was mark'd for purposes of identification.)

- - - -

Q. Doctor, I'm going to hand you what's been marked as Defendants' Exhibit 2 and ask whether you would identify it for the record, please.

A. Defendants' Exhibit 2 is the office chart in child neurology for Zachary Berardinelli, later Zachary Hammon.
Q. Have you removed anything from that record?
A. No.
Q. When was the last time you saw Zachary?
A. The last time I saw Zachary was November 2nd, 1992.
Q. What was his condition at that time?
A. In what way?
Q. From a neurological standpoint.
A. He had an abnormal neurologic exam.
Q. What was abnormal about his neurological exam?
A. He had I guess what could be summarized as an ataxic cerebral palsy with increased deep tendon reflexes in the legs,
Q. I want you to list specifically all the abnormal neurological findings that you detected at that November, 1992 visit.
A. Well, I would say it's not only detected but also elicited from history.
Q. Well, I want to know all the ones that you were able to observe during your examination at that time. We're going to go back and talk about the historical features.

A. Okay. Oromotor movements are slow. This is both jaw and tongue movements. He has mild weakness in the shoulder girdle. He walks with hip and knee flexion, which is abnormal. He has adduction, or the knees coming close together. He has ataxia, both of his arms and/or of his extremities and his trunk. He has a tremor. His speech is ataxic. His deep tendon reflexes are brisk with three beats of clonus at the ankle, and he has a mildly hyperactive jaw jerk.

Q. Any others?

A. That's all that's in my note for that date.

Q. From the time of Zachary's birth, what has been the progress of his neurological problems?

A. Why don't you be specific. I mean that's a very broad question.

Q. All right. Well, let's go back then and examine his neurological status by the time of his discharge from University Hospital in September of '88. Do you know what it was?

A. Whatever I wrote in the chart at that time.

Q. Did that change?

A. Yes.

Tell me how it changed and when it changed.

A. Going through my records, I next saw him in followup on January 9th, 1989.
Q. What was his condition at that time?
A. His truncal tone was decreased. He had brisk deep tendon reflexes. He had persistent asymmetric tonic neck reflex. Especially with rightward gaze. He had some problems with truncal tone. And he had some delay in his motor development with a functional level of approximately three months.
Q. What treatment did you provide to him while he was a patient at University Hospital in September of 1988?
A. I just monitored his neurologic status.
Q. Did you prescribe any treatment for him in between his discharge in September of '88 and your next visit with him in January of 1989?
A. No.
Q. What was the purpose of your visit with him in January of 1989?
A. To see how he was doing.
Q. And how was he doing?
A. He was -- he had a neurologic problem.
Q. Had it gotten better or worse or changed in any way since his discharge?

A. That's not a good question,
Q. Why is it not a good question?
A. Neurologic status in children is not the same as in adults because the nervous system in children is maturing and developing. So we track the children simply because there may be portions of the nervous system that are supposed to kick in at a certain age that don't, and that's when you're going to start finding problems, even though the injury damage or structural abnormality, whatever it would have to be, occurred a long time in the past.

But as I explain to people, if you cut a wire in the back of a TV set, you're not going to know if the TV set works or doesn't work until you try to flip the switch on. So that's why I'm saying it's not a fair question. The only thing I can tell you with Zachary is there was no obvious regression in skills. I think that's an important point to be brought out here.

Q. Well, one of the reasons I ask is because in your January 26th letter to Dr. Bennet -- is that what you're referring to there in your record?

A. Yes, from the visit of January 9th.
Q. You use the word -- actually, you state the phrase "he has shown developmental progression." What did you mean by that?
A. What it means is that Zachary is continuing to gain developmental milestones. Not to gain developmental milestones either implies a severe neurologic insult or some sort of a progressive neurologic disorder that is making you regress in your skills. Zachary did not show that. But he wasn't showing the developmental progression at the rate that I would expect for a child of his age.
Q. And for a child with severe neurological insult, you would have expected him not to be making the severe milestones that he had made by then?
A. You're talking about severe, really bad ones? Yes. The severe ones don't.
Q. When is it going to be possible to evaluate the prognosis for Zachary over his lifetime?
A. In terms of?
Q. His neurological developmental delays,
A. You can have a problem with cognitive skills, because in my impression, I mean Zachary is not severely delayed cognitively. I thought he's

actually doing pretty well cognitively, but, again, it's a coarse measure of what I see in the office. I don't know what he's going to do in terms of his reading and writing skills, in terms of math skills, in terms of academic skills and things like that.

Q. As of right now, today, do you have any information that he has any cognitive impairment?

A. I stated that I thought that he looked pretty good to me. Now, that was just to me. During the office visit.

Q. I understand.

A. And you have to remember it's a coarse measure. It's a very coarse measure. What I am using that measure to tell me is are there any significant impairments, and there's not. Mild I'm not really there to judge.

Q. But do you have any information that he even has a mild cognitive impairment?

A. I'd have to go check. Hold on one second.

At the present time, I don't have any information to point to anything big time, no.

Q. During the course of your involvement with Zachary, has he continued to make developmental

progression?

A. Sure has.

Q. And has he had any what you call regression?

A. No.

Q. What is the prognosis for his motor problems?

A. In terms of?

Q. Well, are they going to get better, are they going to get worse or are they going to stay the same?

A. They may get somewhat better. His big problem with his motor skills is his ataxia.

Q. What is ataxia?

A. You can think of it coarsely as unsteadiness. And that is what's really interfering mostly with his function.

The second problem with his motor skills is that he also had an underlying element of some spasticity, as shown by how he walks and also by his increased reflexes. That will also interfere with his motor function. But I mean he walks for me, which is good. I like that.

Q. It's an encouraging sign?

A. Of course, it is.

Q. What are Zachary's current needs for special equipment to enable him to function?

A. In terms of?
Q. Anything.
A. I would recommend that you probably talk to the therapists about that.
Q. Well, I need to know, doctor, whether you have an opinion one way or the other whether he --
A. At the present time in terms of what?
Q. Whether he currently needs any sort of special equipment and for how long in the future he's going to need special equipment.
A. He has had appliances in the past in terms of for stabilization. I really can't tell you right now. We'd have to see more **of** where he goes developmentally.

And in terms of his motor skills, to see whether he needs -- you know, whether he'll walk faster using, you know, some sort of supportive device, which he doesn't want to do. But that's typical for children of his age.

Q. When you saw him in November of 1992, was he using any devices?
A. I have no recollection that he was. There may have been an insert in his shoe, but I just didn't mark it.
Q. Now, in terms of whether he will need special

devices of any nature in the future, would that be speculation at this point?

A. We'd have to see how he goes.

Q. Do you have an opinion that he will need such devices?

MR. MELLINO: You already asked him this. He told you that he would defer to the therapist,

A. I would tell you what I'd do here. I can answer your question much better if I can sit with this therapist and sit with the orthopedic surgeon and come up with a common consensus for this kind of help. Then I can answer your question.

Q. Well, what is your role in that meeting?

A. My role in the meeting is partially as a moderator, partially because I have some insight into his neurology in terms of, for instance, what the ataxia will do for him, how much you can give in terms of stabilization and support.

The therapist's role is to make suggestions for various kinds of devices if they are needed. The orthopedic surgeon would be the same way. It's basically a group thing.

Q. Has that taken place?

A. No. I am just saying if that's what you wanted.

MR. MELLINO: Well, he's been given a report from a rehabilitation expert that sets forth what his needs are going to be.

A. Very well may be, I haven't seen that report. If you show me that report, I can comment whether things make sense or not.

Q. Well, doctor, my understanding is in fact this meeting has already taken place, hasn't it?

A. Well --

Q. A meeting with the rehabilitation people?

A. The rehabilitation people asked me general questions.

Q. What did they ask you?

A. I can't remember. That was a long time ago.

Q. How long ago?

A. 1991?

MR. MELLINO: There's a letter I think in there.

A. 1991.

Q. Do you remember who you met with?

A. Two names I have in here. Maureen Van Weenus and George Cyphers.

Q. Do you know those people?

A. I've met them once.

Q. At that meeting?

A. Yes.
Q. Have you had any followup with them at all?
A. No.
Q. Do you remember what input you gave to them during that meeting?
A. They asked me questions. And I have no recollection, no independent recollection whatsoever,
Q. Do you have any notes from that meeting other than a bill for your time?
A. No.
Q. What is ataxic cerebral palsy?
A. Cerebral palsy is a nonprogressive -- actually, that's the wrong word to use. Cerebral palsy is an impairment in tone, strength or coordination that is due to a static process. In other words, it's not due to a progressive neurologic disorder such as an enzyme deficiency that will make you worse over time. Basically, it's like a brain tumor or things like that.

We normally will use words to identify the major component of what we find on examination for the cerebral palsy. So, for instance, the most common type we see is a spastic cerebral palsy in which they have increased tone and they

have spasticity, which is an exaggerated clasp-knife reflex, And there's various forms of that. Then there are --

Q. Those would be the more severe forms of cerebral palsy?

A. No. No. No, those are not. Severity can only be judged on the child's functioning. So, for instance, I have patients with extrapyramidal forms of cerebral palsy like a choreoathetotic form where the movement disorders had so severely impaired them that they can't walk even though they have decent strength, but they are just bedridden because the movements are so severe.

In my opinion, at the time that I saw Zachary last, what he had was he was significantly ataxic. He had truncal instability and extremity instability, or unsteadiness. That was part of this whole picture, which has also been described as ataxic cerebral palsy, if you want to think of it as an ataxic component, because he has increased deep tendon reflexes. And I guess that's what I mean by that.

But it's a nonprogressive neurologic

disorder in that I don't expect him to look horribly worse at age 20 than he does at age 4, unless something else comes up, for instance, and he develops another extrapyramidal quality to his movements that would interfere with his functioning.

Q. Do you anticipate that that will happen?

A. I don't anticipate it, but you can never exclude it. Kids fool me all the time.

Q. So it's a possibility rather than probability?

A. Definitely.

Q. The ataxia of Zachary's cerebral palsy is the chief feature of his neurological problem?

A. It's the major feature. I mean there's other things. There's weakness and everything else. But if you are going to look at Zachary and watch him in movement, you'd say that, you know, you'd be most impressed with the ataxia. But that doesn't mean other things aren't there.

Q. In your report to Mr. Kampinski on April 5th, 1991, you say that "Zachary's most recent exam is consistent with an ataxic cerebral palsy." Is that still the case today?

A. Yes,

Q. What do you mean by "consistent with"?

A. That's what he has,
Q. Is it consistent with anything else?
A. No. That's what he has.
Q. What is encephalopathy?
A. Encephalopathy is dysfunction of the brain.
Q. What is the relationship between the term "encepha1opathy" and "ataxic cerebra1 pa1Sy"?
A. By definition, ataxic cerebral palsy is an encephalopathy. It's a chronic encephalopathy.
Q. What area of Zachary's brain is affected?
A. Good question. Thalamus. Definitely.
Q. Why do you say "definitely"?
A. Because it's shown on neuroimaging studies as being abnormal.
Q. Which ones?
A. His MRI.
Q. Do you have a copy of that in your file?
A. Which?
Q. The report, the MRI that shows the thalamus dysfunction?
A. No. I'll be honest with you. I'd have to go -- let me see what the report says.

I don't have a copy of it there. I know I've reviewed the MRI.

Q. When was that MRI taken?

A. If I am not mistaken, it was taken about 1990.
Q. Was it taken here?
A. Yes.
10-16-90.
Q. Well, don't put it away. I want you to read me what the report says.
A. Be more than happy to.
Q. All right.
A. MRI of head, clinical data two-year old male with developmental delay. There's clinical concern for abnormal myelination. Multiecho -- that's one word -- images of the head were obtained in the axial projection. Additional T1 weighted images were obtained in the coronal projection. There was normal myelination for a two-year-old infant. No mass effect or shift is identified, No extra axial collections are seen. Impression, normal MRI of the head.
Q. Why does that lead you to conclude that there are some abnormalities of his thalamus?
A. Because it was misread. I've reviewed it subsequently with the neuroradiologists, who agree that there's an abnormality in the thalamus.
Q. Which neuroradiologist?

A. Both the man who read it, Charles Lanciery as well as Alison. Smith.
Q. And when did you review that study with them?
A. I've reviewed it several times. Most recently today.
Q. You actually looked at the film itself?
A. Yes, I did.
Q. Who did you review it with today?
A. Dr. Smith.
Q. And it's a she?
A. Yes.
Q. What's her first name?
A. Allison.
Q. And she's a neuroradiologist here at University Hospital?
A. Yes, she is,
Q. Tell me about your conversation with Dr. Smith today.
A. That's just it. I put the films up, and I said "What do you think?"
Q. And what did she think?
A. And she says increased signal in the thalami. There may be something in the centrum semiovale bilaterally. And we do not have adequate projections to be consistent with -- to try to

identify certain other areas of the brain. I mean when the study was done, it was done in a certain way.

And then I said to her, "It's not worth it to put him through the study again just to get this information."

And then we went off and discussed various and sundry topics which have little pertinence to you.

Q. Did she give you any explanation as to why this was not reported back in October of 1990?

A. No.

Q. What specifically about the film that you discussed today with the neuroradiologist leads you to conclude that there's an abnormality in the thalamus?

A. I just told you.

Q. Tell me again.

A. There is abnormal signal from the thalamus.

Q. To what extent is it abnormal?

A. In what way? You can see it. I mean I can bring the films into this room, show you what a normal MRI looks like, show you what this MRI looks like, and you'd see the abnormality.

Q. Tell me is there a difference in quality of the

signal?

A. That's what I said. There's increased signal intensity. I can't remember, to be honest with you, if it was a T1 or T2 weighted study. It was probably the T2 weighted study. Because if I'm not mistaken in this situation, the white matter was dark, which is what you get in T2 weighted studies.

Q. Did Dr. Smith say that it may be present or that it probably is present?

A. Dr. Smith said it is present.

MR. SEIBEL: Do you need to get that?

THE WITNESS: Yes.

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

Q. When was your first discussion with the neuroradiologist about the October, '90 MRI?

A. Had to be sometime after the October, '90 MRI was done. Because I usually try to look at all neuroimaging studies that are done on patients of mine.

Q. Is it your testimony, sir, that they have agreed

that their report showing no abnormalities has been in error from the first time you reviewed the actual MRI film with them?

A. Yes.

Q. Does the abnormality in the thalamus that you believe was evidenced by the October, '90 MRI explain Zachary's neurological problems?

A. It is associated with it. Is that what you mean? I don't think it explains everything, no.

Q. Which problems does it explain?

A. I don't know which problems it explains. I will be honest with you. I've seen scans like this of this in the past with the children with extrapyramidal cerebral palsy, of which he has one type, the ataxic. So I've seen lesions of this type before.

Is it associated with his ataxia? It could be. What we might be doing is catching fibers that are coming from the cerebellum and are on their way up somewhere else, and they could have been interdicted, if you want to think of it that way. So it can explain that. If there are abnormalities in the white matter, and it looks like there are, then that could explain his motor weakness and increased deep tendon

reflexes.

Q. Well, do you have an opinion to a reasonable medical certainty as to whether the abnormality that you say is present on this MRI explains Zachary's neurological problems?

A. It's the other way around. That's not a fair question. What you're saying is that one little area, does that explain everything. I couldn't say yes or no. Is it part of the picture? The answer is yes.

Q. So if --

A. It is not a coincidental finding that has nothing to do with Zachary.

Q. But it doesn't alone explain what his problems were?

A. Maybe it does.

Q. But you can't say one way or another whether it does or doesn't?

A. I just know it's associated with his problems.

Q. Were there any other abnormalities that you believe are present on that October, '90 MRI?

A. Nothing other than what I've just told you.

Q. Are you aware of any other imaging tests or objective test that would suggest that Zachary has a problem with a specific area in his brain?

A. No.
Q. And by that, I mean EEG, CAT scan?
A. EEG would be useless in this situation. CAT scans that have been done have not shown these abnormalities, which is not unusual for his type of cerebral palsy,
Q. Or any other laboratory data, anything that --
A. All the other laboratory data that has been done has been to look for alternate causes, and all of them have come back negative.
Q. What are some of those other alternate causes that you were looking for?
A. Looking for an underlying metabolic disorder, which was not there. Looking for a disorder known as ataxia telangiectasia.

But the tests that we did, which were immunoglobulins and an Alpha fetal protein, were both normal, which basically excludes that disorder. And there may have been some other tests that we have sent off in the past. I know when he was in Health Hill Hospital, I had conversations with the doctors taking care of him there to look for any alternate reasons for his problem, and any of the other tests that we did could not identify any alternate reasons.

Q. Do you believe that any other parts of Zachary's brain are affected besides this area in the thalamus?

A. There may be. But if you're really asking me short of doing an autopsy, I mean I couldn't put it down on a piece of paper. I mean he may have injury or damage to the Purkinje cells in the cerebellum, but you'd never see that in a million years on the scan, There may be small little areas perhaps in the basal ganglia or other nuclei, deep nuclei of the brain that may be dysfunctional, but we just don't have the resolution to see those. But you're just asking me.

Q. Right.

A. And that's what I'm saying. That that would just be, you know, guesswork on my part.

Q. Tell me, if you would, the areas of the brain that you feel are likely to be affected and causing Zachary's problems.

A. Areas of the brain that are definitely affected are if you want to call it the motor coordination centers, which means either the cerebellum or outflow or inflow tracts going into the cerebellum, which is what leads to his

ataxia. There are also probably white matter tracts that are affected because of his weakness, as well as his increased deep tendon reflexes.

Q. Now, are you able to specifically identify those areas other than generically that are damaged in Zachary's brain?

A. Just from what I've told you before in terms of what **I** see in the MRI. Unfortunately, I have patients with other types of cerebral palsy who have normal-looking MRI, CT scans and as such, but they still have the neurologic deficit, which means there has to be dysfunctional parts of the brain. We are just not sophisticated enough to identify where it is.

Q. What is the perinatal period?

A. You know, everyone asks me that, and I always forget. It goes through portions of the pregnancy through the beginnings of after birth, and I'll be honest with you, I can't remember the exact demarcations of when they are. I can look it up and give you a number.

Q. Well, you put it in your report. That's why I asked.

A. I know that. I know that. But that basically

meant -- I was talking about an abnormality in the brain close to -- you know, close to around the time of birth.

Q. Why did you characterize Zachary's encephalopathy as due to problems in and around the time of birth'!

A. In what way?

Q. Well, put it in your report.

A. Right. You want me to expand on that?

Q. I do.

A. At the time that I wrote the letter, I knew definitely in my mind that his brachial plexus problem was due to, if you want to say it, a birth event. I had major suspicions that his other neurologic problems were due to events that occurred at the time of birth.

Unfortunately, I don't speculate and I hate to speculate so I had to be a bit vague in my letter, and that's why I was saying I've refined my opinion later on as new medical information has come available to make me much more comfortable in my view that his problems occurred as a consequence of events during the birth process.

Q. What information has come to your attention that

allows you to make that -- to have confidence now in that conclusion?

A. Well, it's more of just my generic reading, and I really can't tell you from where I pulled things out.

Q. Not reading anything about this case?

A. No. No. I mean I read all the time. I just try to keep up, Most of it's garbage. Some of it's pearls.

Q. Can you remember any specific publication or piece of medical literature that you read that gives you confidence now to say that this encephalopathy occurred during the perinatal period?

A. No. As I said, I already said that if there -- to start with, remember what I said here was that -- just now that it was occurring during the birth process. And it's more of my accumulated knowledge.

Q. Well, what records have you reviewed that lead you to conclude that Zachary's encephalopathy occurred during the birth process?

A. Zachary showed evidence of an acute neurologic syndrome after birth.

Q. "Acute" meaning what?

A. Something that came on at that point in time. And that was due to some sort of a systemic insult to the body -- I am just using this now in generic terms -- manifested by the facts that he had blood in the urine, he had elevated liver enzymes, he had elevated muscle enzymes. He had a relatively elevated uric acid, which was three to four days after birth, which, if you look at the later numbers, kept falling further down, which makes me think it was on its way down and we just caught it midway on the trip.

So he had had multi-organ system dysfunction. He definitely had neurological dysfunction. Not only with the brachial plexus question but also with his central nervous system. He was classified as a moderate encephalopathy. There's multiple descriptions in the records to go along with that.

Number two, there was an event that could easily be related to this, which is the fact that he was born with low Apgar scores, had an Apgar of zero at one minute and at five minutes and three at ten minutes, if I'm not mistaken.

During his resuscitation, his initial blood gas showed an obvious metabolic acidosis. As

well as it also showed a respiratory acidosis. But that was corrected with the metabolic acidosis still being there, gradually improving.

I think I'll stop there. Those are -- in other words, what I'm saying is something happened acutely. This is not something that happened three weeks prior to birth.

Q. Do you have an opinion as to what the systematic problem was that led to this?

A. I think it was a combination of two factors. I think that he definitely had evidence of a gram-negative infection. If I'm not mistaken -- you'd have to tell me if I'm wrong -- an E. coli infection.

Q. I believe you're correct.

A. And I think of that as having stressed his system. And then he had a cord compression at the time of his delivery that if you want to think of it, led to the acute asphyxial state. He had no energy reserve left or he had very poor energy reserves left because he had already been stressed in utero from the infection and just got pushed over the brink around that time period.

Q. The latter event toward his birth, you're talking about the shoulder dystocia?
A. Yes. Getting stuck, That is the layman's term,
Q. Which was a greater contributing factor to his systematic problems, the E, coli sepsis or the shoulder dystocia?
A. The shoulder dystocia.
Q. Why?
A. That led to what I consider to be the coup de grace. That pushed him over the edge.
Q. Why?
A. If the E. Coli infection was there, and it was there for hours -- maybe you people are arguing about this. I have no idea. But this is my impression from gleaning through the record.

If the E. coli infection had done something to him before that time, he's still sitting there in the milieu of that environment of infection, which means I'm making an inherent assumption here. And speculation, hypothesis, whatever words you want to use.

Let's assume that the E. coli infection started doing something to him four hours before birth, that it would start causing irreversible brain damage at that point in time. Zachary

would not look the way he looks today. He looks too good for a child who has four hours of progressive brain damage. It makes more sense that something happened within that little window of time, half an hour, 45 minutes, and again these are Just round numbers, prior to the time he was actually delivered that would have caused this kind of a picture.

Q. Can brain damage result from E. coli sepsis in utero?

A. If you go shocky, it sure can.

Q. If who goes shocky?

A. If the child. I mean you can have children who get extremely sick and ill, and you can have stillbirths. Whether it's due to the fact -- probably what happens in those situations is you have such a rip-roaring infection in the placenta that there's poor nutrition delivery to the baby. By "nutrition," you know, I mean glucose, oxygen. Doesn't get rid of the carbon dioxide well. So you still end up with a, quote-unquote, "hypoxic ischemic insult" that occurs as a consequence of the infection.

But as I said, I think he looks too good to have that kind of a problem.

Q. Good in what respects?
A. Excuse me.
Q. Good in what respects?
A. If he had been -- I mean if you start -- the example I gave before. If you start having irreversible damage occurring to you hours before birth because you've got this infection, you're going to get a cumulative worsening of your neurologic damage and it's not going to occur at a slow rate. It's going to occur at a good rate. So that I would expect -- again giving a round number of four hours or even two hours prior to birth, I would have expected him to be significantly retarded if this was only due to the infection.

Let's assume he never had a shoulder dystocia at all and he had only had the infection. I would have expected him to be much more severely affected from a neurology standpoint both cognitively as well as motorwise.

Q. Are you convinced that there was evidence when he came under the care of University Hospitals that there was multi-organ system involvement systemically?

A. During the time he was in the hospital, yes. He had blood in his urine.
Q. And you mentioned some other things before?
A. Well, unfortunately, they never checked liver enzymes. They never did a Chem 20 or 23 until several days after birth.

But for instance, his calciums dipped between the first and second day of life, which is an event I see in these -- whatever word you want to use. Asphyxia I think is bandied about too much in an irreverent manner, but we'll say a hypoxic ischemic insult just to make it easier.

That that was there, and all the other numbers suggested something happened, an improvement was occurring. It's not like he has the infection and it's brewing and three days later, you know, it's caused such significant damage that we get problems. Because in that case, I'd expect the numbers to be going up rather than coming down.

Q. Is Zachary's brain damage irreversible?
A. Yes.
Q. Is it your testimony, doctor, that it would be impossible for the E. coli sepsis alone to be

responsible for Zachary's problems?
A. At the state that he's in now, yes,
Q. Why?
A. I think I gave the explanation already.
Q. Give to it me again.
A. Assuming that the E. coli infection did him in, it shouldn't have been a progressive problem.
Q. What do you mean by that, "progressive problem"?
A. Well, I put you in a pot of boiling oil. If you're in a pot of boiling oil for -- I'm making this up obviously,
Q. I hope so.
A. So appease me.

MS. CABI: That's his vision.

THE WITNESS: No, that's not my vision. There are good lawyers and bad lawyers, and I know I'm in the company of good lawyers.

A. If I put an individual in a pot of boiling oil -- or I'll even use hot water. That's probably a better one to use. And I put a baby -- which happens. You know, if a baby gets put in too hot of a bath, the baby gets put in the bath for a very short period of time, under a minute, the child may be mildly scalded

perhaps, You'll see a little redness that fades away by the following morning, But keep that baby in there for a longer period of time, you're going to first get a first-degree burn, and then if you wait longer, you get a second-degree burn. And then if you wait longer, you get a third-degree burn. In other words, it's a progression of severity of the damage.

And it's the same way here by being in an environment with E. coli sepsis. If you're in that environment, it's not like -- you don't get damaged at one point in time. The infection -- I'll say the "infection," which I think is a better word to use here. The infection continues, but no further damage occurs. That does not logically make sense because you are not about to be worse at one second because of the infection and then. without any significant intervention be better at the next.

Also, he had a significant insult. Here he comes into the time of delivery with a measurable heart rate. He comes out with no heart rate whatsoever. He has a good circumstance for cord compression because he has

a nuchal cord wrapped around his neck twice going through the canal, which can easily be compressed as he comes through.

Q. When you talk about this progression of damage, you mean progression in utero or in --

A. In utero.

Q. -- progression as long as the infection is present?

A. I don't think he was sick enough after birth to say that the E. coli did it. He wasn't that sick.

Q. Well, when you talk about --

A. That's what you're asking me I assume.

Q. No, I'm not really asking you that. I'm asking you about a situation where E. coli sepsis causes brain damage.

A. Yes.

Q. In utero?

A. Yes.

Q. You said that you'd expect that damage to be progressive in nature?

A. Yes.

Q. Now, progressive in nature up to the point of delivery?

A. Up to the point of delivery and/or fetal death.

Q. And what is the basis for your testimony that you would have expected Zachary's brain damage to be worse at birth if it had been caused strictly by the E. coli sepsis?

A. Because as I stated, it would have had to have been a progressive process.

Q. What I don't understand, doctor, is why couldn't it have progressed to the point that it did and then Zachary was delivered?

A. Because he had another event that occurred in between. He had a good reason. It took over five minutes to deliver him. He had -- I don't need to postulate an infection to look at the events that occurred to him at the time of delivery. He may have been so bad that he had -- you know, he had a circulatory arrest at the time of delivery. Unless he had overwhelming sepsis to such a degree that would cause that, that would make him not have a heart rate or anything else, I would expect him in that situation to have required major intervention. In terms of the nursery, high doses of presser agents in order to maintain blood pressure, things like that. That was not what was going on.

You've got another event here that can account for where is the difference. And that's the event that occurred at the time of birth.

Q. So since that event occurred, you are discounting E. coli sepsis as the cause?

A. No. No. In fact., the E. coli infection, I already stated I think that stressed him in utero. I think that if the other event had not occurred, Zachary would not look the way he looks now.

Q. How would he look?

A. That's a good question. If you're going to say to me, "Doctor, is it possible that he might have a minor motor impairment," I would say "Yes, it is possible," Then you would say, "Doctor, is it probable that he would have the same motor impairment that he has now?" I would say "No."

Q. Why not?

A. For all the reasons as I've just given you before. He had a two-hit phenomenon. Got stressed by the infection, got finished off, if you want to think of it that way, pushed over the edge by the events that surrounded his immediate birth.

Q. Do you attend deliveries?
A. I used to do so. All the time.
Q. When did you stop?
A. When my last child was born.
Q. Did you attend deliveries in your practice?
A. No. I've had to resuscitate babies unfortunately even as a neurologist when there was no one else around with pediatric expertise.
Q. But you do not as part of your practice attend deliveries?
A. No.
Q. Do you hold opinions to a reasonable medical certainty about the standard of care utilized by my client Dr. El-Mallawany in his delivery of Zachary?
A. I have no opinion whatsoever.
Q. Do you anticipate giving testimony on that issue?
A. No, I don't.

MR. MELLINO: He's not going to be asked any standard of care opinions for -- for either one, the hospital or the doctor.

Q. What does "intrapartum" mean?

A. The definition I know of is during the birth process.
Q. That means what, from the onset of labor?
A. Yes.
Q. You've characterized Zachary's encephalopathy as moderate?
A. Yes.
Q. What are the other gradations of encephalopathy? Is it mild and severe or --
A. Yes.
Q. How would you define a mild encephalopathy?
A. Mild encephalopathy is a child who has a change in his level of consciousness but for the most part, appears hyperalert, not really awake but he's hyperalert, very jittery, can't be consoled easily, can have increased reflexes, have dilated pupils, some increased jitteriness. Lasts for about 24 or 48 hours, goes away, and the baby looks good afterwards.
Q. What about severe?
A. Coma. With seizures. I think that pretty well puts it together.
Q. What is the body's physiological response to asphyxia or hypoxia to the brain?
A. No. No. That doesn't sound right. Your

question doesn't sound right to me.
Q. Why?
What would you expect as the brain's response to hypoxia?
A. In what way?
Q. In a physiological response, In terms of necrosis, in terms of edema, in terms of anything like that,
A. Maybe you're using the wrong words.
Q. Help me then.
A. Are you talking about what anatomic changes would one expect to see?
Q. Yes.
A. If you have a hypoxic ischemic insult?
Q. Sure. Well, you believe that's what happened to Zachary, don't you?
A. Yes.
Q. And what would you as a neurologist expect as the brain's response to that?
A. It depends if you have a partial asphyxia or a total asphyxia.
Q. What was it in this case do you believe?
A. I believe it was a total asphyxia.
Q. So what would you expect the brain's response to be to that?

A. Damage to deep gray matter. Nuclei.
Q. That's from a cellular standpoint?
A. Yes.
Q. What about from an anatomic standpoint?
A. You may not see edema in that situation, It all depends.
Q. I am asking what is the most likely response?
A. Well, if you have a severe insult, I've seen all sorts. How about if I say it that way. I've seen severe insults where there's a little bit of brain edema, yet there's -- and this is with total asphyxia. Yet there's a significant abnormality on later scans.

I've seen some kids who don't show any real evidence of edema, yet are left with neurologic devastation. This is acutely on CT scan. And I've seen kids who have a lot of edema. Especially in the white matter regions.

Q. Again, what is the most likely response?
A. It all depends on how severe the insult is.
Q. How about in an insult as severe as it was in Zachary's case?
A. Well, I can tell you that he had a moderate encephalopathy, so I would expect the brain response to be not as bad as with a severe

encephalopathy.
Q. Would you expect there to be some response?
A. I think if I had done an MRI, yes, I think that this CT technology we had would not have shown abnormalities in the deep gray nuclei.
Q. Would it have shown abnormalities -- or would you have expected it to show abnormalities in any other place?
A. Perhaps in the white matter. But, again, the technology is not all that good to show that with the CT scan. Even with an MRI, in newborn white matter, abnormalities may be difficult because the water content of the brain is increased to start with.
Q. In most cases, do you see neuroimaging results?
A. In the severe encephalopathies, yes, I see abnormalities on neuroimaging studies. In moderate encephalopathies, I see variables. I may see some mild changes on CT scan or I may see none at all.
Q. What are you most likely to see?
A. I'd have to go back and pull charts and tell you that. I really -- I'm talking about a moderate encephalopathy.
Q. Well, a moderate encephalopathy is the result?

A. No. No, no, It's not only the result. It's the clinical expression of what's going on with the brain.
Q. And didn't you tell me that you believe Zachary had a severe asphyxia? Or total asphyxia?
A. He had a total asphyxia.
Q. What does that mean?
A. Total asphyxia means that there basically is no exchange of oxygen, no delivery of nutrients -- we'll think of it that way -- to the baby for a fixed period of time. The most obvious classical example is you clamp the umbilical cord, just totally clamp it. Nothing can go out, nothing can come in.
Q. In most cases, what would you expect to see on neuroimaging studies of children within the days or weeks of that type of total asphyxia?
A. It depends how severe the insult is.
Q. Can you get anything more than a total asphyxia?
A. If you pass out, you will have -- the reason you pass out is there's inadequate nutrients delivered to your brain. If you're that way for 15 seconds, you're not going to be left with any deficit whatsoever. You're going to get right back up and walk away.

If, unfortunately, you pass out because of a heart arrhythmia and you're still kept standing up and you're that way for, let's say, five to seven minutes, you're going to have a severe insult to your brain. But if you're going to have something in between, you know, you're going to bit a point where you're going to get some irreversible injury, which will get worse over time.

What we're dealing with here with Zachary is that inbetween land. I'm not talking about the severe cerebral edema. This would make it an easy type of a picture. That's not what was here because he didn't have a severe encephalopathy. He had a moderate encephalopathy.

Q. Does the absence of CT findings showing cerebral edema, for instance, make it more difficult to conclude that this is a birth asphyxia situation?

A. No. He had an acute neurologic syndrome. He had evidenced multi-organ system dysfunction. There was no doubt about that there was something acutely that occurred there. No doubt about that at all.

The absence of changes on the imaging study basically suggests that whatever happened to his brain was not a severe insult. That's all that I think that it tells you. Unfortunately, when people write articles nowadays, they only describe the most severe form of how kids look. We don't really get into the less severe forms, if you want to think of it that way.

Q. Are you aware of any -- I'm sorry. *Go* ahead.

A. No, you go ahead.

Q. Are you aware of any medical literature that supports your view that Zachary's problems are attributable to a birth asphyxia?

A. There's a whole bunch of articles written about birth asphyxia stating that you've got to have a causation and a clinical picture afterwards. I mean that's just the standard thing.

Q. Let me refine my question a little bit then. Are you aware of any specific medical literature that would support your conclusion that Zachary's problem is more attributed to the cord compression than it was to the E. coli sepsis'?

A. Your question doesn't make -- people don't write articles like that. I don't understand your question, I guess.

Q. Well, are you aware of any commentary in the medical literature, that you read in the pediatric neurological texts or journals that talk about the greater likelihood that problems like Zachary's were attributed to birth asphyxia rather than E, coli sepsis? Or some other systematic problem?

A. I'm just being honest with you. Your question just doesn't make sense to me. First of all, like you have both things going on. That's number one, And, number two, you want to ask how does an in utero infection cause damage. It causes damage because it leads to an asphyxial state.

Q. All right. So that's why -- I guess that's why I don't understand. I accept that.

A. And he never had -- in my opinion, he never reached that point in time from his E. coli infection. While the cord compression in conjunction with depletion of his metabolic reserves from the E. coli infection is more than enough to explain his acute neurologic symptom that occurred afterwards and then his subsequent neurologic picture.

Q. What would Zachary's condition have been had he

been born immediately before the shoulder dystocia took place?

A. How long is "immediately before"?

Q. Well, before there was any --

A. Before he came down the birth canal?

Q. Yes.

A. More likely than not, probably be normal. From a neurology standpoint.

Q. Completely normal?

A. More likely than not, yes.

Q. Why do you say that?

A. Because I don't think that the E. coli infection was severe enough. Now, it's hard -- I'll be honest with you -- really hard -- let me think. Let me back up here.

He had decels, decelerations, from what I remember. And it's too bad I can't remember how long they were. So I still would say probably more likely than not, he would have been normal. But if you're going to say to me does the possibility exist today there could have been some neurological impairment, I would never argue with you. Let's give credit where credit is due. Or I think I've answered before that he might have had a smidgen of some neurologic

dysfunction but nothing as severe as what he had now. It's pure speculation in that regard.

Q. Can encephalopathy or cerebral palsy like Zachary has occur before labor begins?

A. Yes.

Q. What is the mechanism of that?

A. Great question. What's your next one?

Q. You don't know the answer?

A. In utero events can occur -- as a generic term? Let's use generic statements. Could be due to chromosomal abnormalities. Unfortunately, the videotape of a child that I had -- of a child like that that I had on my desk is not here.

It can be due to an in utero infection. Usually a viral infection. It can be due to an in utero hypoxic ischemic event that was self-limited in nature. It can be due to, you know, a malformation of the brain. But that's not what it's due to here.

Q. Why?

A. Because he shows the rest of the signs and symptoms that go along with it. If it quacks like a duck and looks like a duck and walks like a duck, it's a duck.

Q. How is in utero cerebral palsy detected before

birth?
A. I don't know.
Q. Can it be?
A. In what kind?
Q. A kind like Zachary has.
A. No. You can't say hat.
Q. Encephalopathy, ataxic cerebral palsy?
A. No. No. Moderate encephalopathy is what his acute neurologic picture was after birth.
Q. Ataxic cerebral palsy?
A. I don't know how you'd detect it before birth. There are some ways. For instance, if children have big ventricles before birth. Or, God forbid, the child dies right after birth and you do an autopsy study and you find out that there's abnormalities of the brain that by a neuropathologic basis occurred weeks ago and it can be dated that way. I mean things of that nature,

If I have a child who is born full term with no complications whatsoever, looks perfectly fine, normal labor and delivery history and yet has cerebral palsy afterwards, I can basically conjecture, assuming that it's not a progressive neurologic disorder, that it's a

static process. I can conjecture that whatever caused the cerebral palsy, that had to have occurred prior to birth. And I say this in my office all the time to parents.

So in other words, I guess what I'm trying to say to you is you've got to look at the company it keeps in order to come to a conclusion.

Q. You mean the events that surrounded the birth?

A. Yes.

Q. Did you do any investigation to exclude a prenatal cause of Zachary's cerebral palsy?

A. In what way?

Q. In any way.

A. Yes. I looked for definable metabolic disorders. I looked for certain hereditary disorders. Yes,

Q. And you looked at the E. coli sepsis?

A. Yes. Well, that's not -- hold it. E. coli sepsis is not really a true prenatal disorder, I mean this is an intrapartum phenomenon.

Q. Do you know how long the E. coli sepsis had been present?

A. Couldn't have been there that long.

Q. Why?

A. He would have been dead.
Q. You are saying to me it was not there for a week?
A. No. I can tell you it wasn't there for a week.
Q. How long do you think it was there?
A. I have no idea.
Q. You just know it's not there for a week?
A. I know it's not there for a week. I've read the reports of what people have stated. You can put together perhaps a clinical history and everything else like that and say how long was the mother febrile, what else was going on, boom boom, boom, so forth and so on, and put it all together. A more-likely-than-not scenario, it was probably there within the day. And that is just, you know, a first-shot approximation.
Q. At what point did Zachary's brain injury become probable?
A. What, when did it happen? Definitely?
Q. Well, to a probability. If you can say definitely, then fine.
A. Well, I am saying what you are saying is when did it happen more likely than not?
Q. Yes.
A. By the time he was fully delivered. Now, it

could have been a minute before that or two minutes before that. That's also there. If you're saying any type of brain injury, might have been there six minutes before that, eight minutes.

There was no monitoring going on. I have no idea when his pulse fell out. But the probability is that it was definitely there by the time that he was born fully.

Q. Without the E. coli sepsis, would Zachary have been born and been normal?

A. Probably.

By the way, I want to let you know that that's a very difficult question. But that's my viewpoint.

Q. Is there any connection between Zachary's cerebral palsy and his asthma?

A. No.

Q. As of your last encounter with Zachary, did he show any indication of being mentally retarded?

A. That was asked and answered.

Q. I think I asked in terms of cognitive.

A. Well, that's the same thing. What does "cognition" mean?

Q. Well, you're the neurologist. Let me ask you.

A, "Mentally retarded" really means whether you have normal intelligence. "Mentally retarded" means you do not have normal intelligence. I wrote this in my letter. I stated that on my quick screen. "He appears to be functioning adequately in the cognitive domain." Although specific learning arrangements were not assessed. And I felt that he should condition with his therapy and so forth and so on.

Q. Has Zachary recovered from the palsy?

A. Functionally, yes.

Q. What other way is there palsy?

A. I am sure that when he's older, when I test him, I might find some mild dysfunction. But if you're asking me can he use the hand adequately, is it going to interfere with -- you know, from the palsy standpoint, is it got to interfere with how he uses that hand, my answer is 1 don't think so.

Q. Do you deem him to have recovered from the Erb's palsy at this point?

A. Yes. That's what I said. He's functional. If he has 90 percent function but it's enough to make him do what he's supposed to do, that's great. That's why I consider it -- even with my

patients who have a, quotation marks, "recovery,'! end quotation marks, I may find some very mild abnormalities down the road, but what's more important to me is can they do things that children can normally do. And on my most recent examination, I didn't find a major asymmetry of function that would suggest that he has the problem.

Q. What is a Sarnat level?

A. Dr. Sarnat -- actually, there are two Dr. Sarnats, just to be exact -- wrote a paper on this whole subject of neonatal encephalopathy purportedly due to hypoxic ischemic insults, and they had rated their levels as 1, 2 and 3, which are the equivalents of mild, moderate and severe.

Q. Where would I find this article?

A. 1970 about. Oh, the journal. That's a good question. Want me to take a wild guess?

Q. Sure.

A. I can see the article in front of me, and I am trying to remember the journal it was in. It had to be in a pediatrics journal. So I say it was probably in Pediatrics. But, you know, I'll tell you where you can find it. If you want me

to look it up right now, I'll tell you exactly where it's at.

Q. I can find it. What's Dr. Sarnat's first name, the one who wrote this article?

A. Both of them wrote it. There's two of them. And I can't tell you which one it is.

Q. Is that a widely accepted and used standard?

A. No. No. "Standard" is the wrong word. Do people normally score kids with encephalopathy as mild, moderate and severe? The answer is yes.

Q. Using the Sarnat criteria?

A. Using variations on their criteria on what they initially proposed to the medical community.

Q. Would you pull out the 9-6-88 child neurology consult note, please, from the University Hospital records?

A. Got it.

Q. Did you sign this note?

A. No.

Q. Do you remember reading it at the time?

A. I have no independent recollection.

Q. Have you read it recently?

A. Yes.

Q. And do you agree with the conclusions reached in

that note?

A, No.

Q. And to what extent do you disagree?

A. I wouldn't -- for instance, Impression No. 1 says "Hypoxic encephalopathy (Sarnat level 2)."

I would probably put the words "hypoxic ischemic encephalopathy" because I don't believe personally that hypoxia in and of itself is sufficient to cause the majority of the brain damage that we see in newborns. I mean that's a fine point to differentiate, but that's what it is.

Q. Would you contrast "hypoxic" versus "hypoxic ischemic"?

A. It almost never occurs where you have lack of oxygen but still have good circulation. I mean the best model for that would be something like carbon monoxide poisoning. It's a great model for it because the gas displaces the oxygen from its binding on hemoglobin, and so you've got good circulation going on, but you've got poor oxygen delivery going to tissues.

There are other ones that you can give, but in these kinds of situations, you almost have a mixture -- now, I'll give you another example.

If I clamped the cord so there's no -- or I stop your heart -- that's even a better example -- so it doesn't beat. You've got adequate oxygen in your blood. It's just not going anywhere. And the oxygen levels of the blood that's in any organ -- you name the organ -- are going to be rapidly depleted, but there's no circulation going on so the initial event there is ischemia.

Many people believe that you need the ischemic component in order to really cause problems.

Q. Do you?

A. Yes. I'm convinced by the patients that I've followed in some of my own research work.

The second impression, just to continue answering your question, which was a brachial plexopathy, the answer is yes, I agree that the child had a brachial plexopathy.

Q. Reviewing this 9-6-88 child neurology note, what evidence is listed in there that supports the conclusion of hypoxic ischemic encephalopathy?

A. In and of itself? None.

Q. Nothing?

A. No. No. In and of itself, there's information

in here, the description of the child's initial Apgar scores, the description of his clinical picture, but there were other facts that were not put into this note.

Q. What other facts?

A. Like I had mentioned before, the fact that he had multi-organ system dysfunction, More details of the resuscitation, including the presence of metabolic acidosis details if you want to think of the whole picture being put together.

Q. When did you get that information about the resuscitation?

A. I may have reviewed it then. I've reviewed it more recently. That's the only answer I can give you. I can't tell you when. It's in the medical records. It's in the chart. It is part of the University Hospitals chart.

Q. Does the absence of any indication of cognitive impairment or mental retardation in Zachary have a bearing on whether his injuries are due to perinatal asphyxia?

A. No. That just means he wasn't insulted long enough to cause a big-time cognitive loss.

Q. How often do you see brachial plexus injuries in

shoulder dystocia cases?
A. I've never counted. How's that for my answer?
Q. Is it in the greater proportion of shoulder dystocia cases?
A. No. Let's turn around the question.
Q. Fine.
A. How often do I see brachial plexopathy, and what is the most common associated feature with it.
Q. Fine. Tell me.
A. In my experience, most recently, it's usually a big baby who gets stuck. That's not the only cause.
Q. Do you see those types of deliveries right here at University Hospital?
A. Yes.
Q. Would you expect a child born with E. coli sepsis to be depressed at birth?
A. Could very well be, yes.
Q. And difficult to resuscitate?
A. Depends on how severe the sepsis is.
Q. How severe does it have to be to have difficulties resuscitating the infant?
A. The child would have to be in overt shock.
Q. No blood pressure? No heartbeat?
A. No heartbeat.

Q. Anything else?
A. Excuse me. I would consider the resuscitation to be very difficult from that point forward so that if the child was in such severe shock at that point in time, I would expect that the child would have to get more resuscitation, not only that you'd have to intubate and, you know, do bagging, but you'd have to also give major pressers.
Q. Was Zachary's resuscitation difficult?
A. Yes, it was. But after he was resuscitated, the amount of support that he needed was not as much as I would expect for E. coli sepsis.
Q. Would you expect a child born after five minutes of shoulder dystocia to be depressed?
A. Yes.
Q. And would you expect a child born --
A. Let me back up on that. That's not right. The child can be dependent on if the shoulder dystocia is associated with cord compression.
Q. All right. So I'll rephrase my question. Would you expect a child born after five minutes of shoulder dystocia with cord compression to be depressed?
A. Yes.

Q. And would you expect a child born after five minutes of shoulder dystocia with cord compression to be difficult to resuscitate?
A. Dependent on the circumstances.
Q. Did Zachary's brain injury occur in any part during the resuscitation process?
A, That's a good question. And I really don't have an answer for that one. I would feel -- if we were doing a good resuscitation, getting circulation on him, giving him pressers and everything else like that that more likely than not, no, as long as that resuscitation was being done in an adequate fashion.

See, you have to turn the question the other way around and ask if he's difficult to resuscitate because of the events that occurred in utero, can that difficulty lead to further problems, and the answer is yes, it possibly can.

Q. Well, my question was --
A. That's what I'm saying.
Q. I just want to make sure you're answering the question I asked.
A. I already answered the first one, and I just gave you the opposite way around to it. You're

asking if he had further brain damage during the time of his resuscitation,

Q. Exactly.

A. And my real answer to that one is it's always possible, but I don't think that you can give an answer -- it depends on the quality of the resuscitation and, for instance, if you're doing cardiac compression, how good the compression is, how well it's being done, so forth and so on.

Q. Are you involved in teaching residents here at University Hospital about the difference between possibilities and probabilities?

A. No.

Q. Is that something you assume they know?

A, I don't assume it, no, I don't.

Let me back up. Can I ask you when you say "possibility" and "probability," in what context? In the legal context or just in the general, you know, writing notes that this is a possible problem, that's a possible problem, things like.

Q. Is there a difference?

A. I think there is, yes.

Q. What's the difference?

A. I think you folks use the word "possible" to mean less than 50 percent chance of happening and "probable" meaning more than 50 percent chance of happening,
Q. And how do you folks use the term?
A. I think we don't use it that way. I really don't. That's all I can tell you. And I think if you went out and polled the residents, you'd find out something very similar when they write -- when notes are written.
Q. So when they write "possible," they mean "probable," and when they write "probable," they mean "possible"?
A. No. I don't think they make the fine distinction that you folks make within. the law.
Q. Doctor, through the questions that I've had the opportunity to ask you this afternoon and into this evening, have you had the opportunity to express all your opinions in this case that you expect to testify about at trial?
A. How about saying you've hit the core.
Q. Is that the right way of saying it?
A. I can't tell if it's every single itsy-bitsy last one. There's nothing that I can think of right now. You have to ask me more questions

perhaps -- I mean I could have missed something or there might be something that's lingering back there.

Q. Are you aware of any areas that I have missed in my questions that are relevant to your opinions in this case?

MR. MELLINO: I think he just wants to know if he's covered all the areas that you're going to testify on.

A. I'll tell you something. As far as I know, you've covered the important questions. At this point in time as we're saying it, that's what I would say, that would be my answer.

MR. SEIBEL: Okay. I have nothing further.

MS. CABI: I just have a few real brief questions. Maybe two.

- - - -

CROSS-EXAMINATION OF MAX WIZNITZER, M.D.

BY MS. CABI:

Q. You're aware that the mother in this case was postdate? She was 42 weeks?

A. That's what it says in the records?

Q. Yes.

A. Okay.

Q. You can assume that. If you don't recall that.
A. I will assume that. Okay. What does it mean though?
Q. Would that give you a basis to form an opinion as to the viability of the placenta to support the fetus?
A. You can't say it in that way.
Q. Why?
A. There's a difference between the dates and placental insufficiency, and I'm only telling you this from just my general knowledge. It depends on how the baby looks. If you've got a baby that comes out fat and bustling and looking good and everything else like that, you know the placenta's supporting the child well to the very end. It doesn't matter what dates you've got there. If you've got a baby who comes out scrawny, you know, wasted, decreased subcutaneous tissue, excessive peeling of the skin, things like that, I think you can turn around and say the other way, that yes, that event has already started to occur.

So just fixating on a number is a fatal error in this situation. Again, you're got to look at the company it keeps.

Q. In this case, can you form an opinion as to the placenta's viability to support the fetus?

I thought it would be short.

A. Excuse me?

Q. I thought it would be short,

A. From the information that I have in my University Hospitals of Cleveland record that I'm looking at now, I mean I see no comment by anyone describing -- giving the clinical description of a postdate child. Is that a reasonable answer?

Q. So you don't have an opinion?

A. I just do -- it's not that. I'm just saying to you the opinion I have is I see nothing here in front of me right now that describes a child who is clinically -- clinically postdates, which would mean that there's placental insufficiency that's occurring.

Now, if you have information that you'd want to share with me and that might make me alter my opinion, I'd be happy to look at it. My mind is always wide open for anything that people are going to say.

Q. No. I just wanted to know if you had an opinion.

A. Okay. I tell you that as a pediatrician. We'll say that way, from my pediatric training.

MS. CABI: I don't have any other questions.

MR. SEIBEL: I've just got a couple.

- - - -

FURTHER DIRECT EXAMINATION OF

MAX WIZNITZER, M.D.

BY MR. SEIBEL:

Q. In terms of the prognosis for Zachary's future need, do you have an opinion as to whether -- or how long he will require physical therapy?

A. He is going to require it for the foreseeable future.

Q. How long is that?

A. He very well may require it through adulthood. You know, if you ask me that question in five years, I can answer it better for you. It depends on what his motor progression does and how bad his ataxia is.

Q. What will Zachary's getting older have to do with the effect that his ataxia has? Is there any relationship between his aging and the deficits that he has?

A. I've had some children whose extrapyramidal features tend to get worse over time. I gave you the example before, especially to children with choreoathetotic cerebral palsy, that it may very well take someone and totally physically incapacitate them. More likely than not, I don't think it's going to do that to Zachary.

Q. What about the most likely need into the future for occupational or speech therapy for him as well?

A. For the foreseeable future, and I can't go any further than that, for speech, definitely, he has difficulties with expressive language, predominantly because of the ataxia. Has to work with it and has had some good successes with his therapy. I think it's important to continue through the formative years of language. You know, the peak times are -- the peak times is through age 6 years, but you still have, you know, until you reach adulthood. I mean does he need speech therapy when he's 25 years old? Let's see what his language is like at age 20, and I'll tell you. In all seriousness. I mean I can easily answer the question there.

Occupational therapy. I see that also through adulthood, he's going to have motor difficulty and he's going to need help, alterations, appliances. You know, probably adaptive equipment in terms of spoons and things like that.

If I am not mistaken -- I may be. I can't remember if Zachary was the child who at Health Hill Hospital, they actually weighted him down in order to make his walking better, his ambulation better. This is the kind of strategies that as you're followed longitudinally by therapists, things can be done. He actually moved better. If he's the one, he moved better.

Q. What is the actual mechanism of Zachary's brain injury?

A. Hypoxic ischemic incident.

Q. So lack of blood to the brain?

A. Lack of adequate nutrient delivery to the brain. That's the important word to use.

Q. How do you define "ischemia"?

A. "Ischemia" is an inadequate blood pressure or inadequate delivery of blood in order to support the metabolic functions of the organ.

Q. So he had both hypoxia and ischemia?
A, Assuming he had a total asphyxia. I've seen stated he has a total asphyxia picture. He has no blood flow at all. Technically speaking, he uses up his oxygen reserves. He's then hypoxic. He has no blood flow. He's ischemic because you're not getting nutrient delivery to the area in an adequate fashion.
Q. So that is the description of the mechanism of the actual injury to the brain?
A. Yes.
Q. Have you ever talked to Dr. Redline about this case?
A. No.
Q. Have you ever talked to Dr. Horwitz about this case?
A. From the clinical standpoint? I'm sure we've talked about Zachary in the past. I'm convinced we have. So I guess the answer would be yes.
Q. Do you remember any specific conversation with Dr. Horwitz?
A. No. There's so much going on with Zachary from the very beginning till now. There have been many management issues.
Q. The only other thing before we conclude, doctor,

is I need a copy of your chart,

A. My medical record?

Q. Your medical record, What is the best way to get that?

A. Drop me a note.

Everyone wants the chart?

Q. Yes, I know that Ms. Cabi and I both need a copy.

A. Just do the standard routine.

Q. Which is what?

A. I don't know. Didn't you folks already request a copy of my chart?

Q. Well, if we did, we didn't get one.

A. See, I'm trying to look and see.

Q. I know that Mr. Kampinski did and he has a copy of your records, but I don't have a copy.

A. He has a copy of my records through 1990.

Q. And I need a copy up to the current time.

MR. MELLINO: Can somebody in your office copy those and send them out?

THE WITNESS: Oh, yes. I don't care. Get the right paperwork sent to me, and I'll be more than happy.

Q. It just takes a letter with the address where to send them?

A. And a release, Always got to have a release.
Q. See, that's the problem.
MR. MELLINO: I'll take care of getting you guys copies.
MR. SEIBEL: All right.
MS. CABI: Okay.
A. I've got to do things right. Can't give away patients' charts without a release.
Q. No, and I wouldn't want you to. But it's just that I want to make sure I get a copy as current as it is of every piece of paper that you are maintaining in your records for Zachary.
A. Sure. As long as you tell me we can do that, I can release other people's records. I mean many of the papers in here are other people's records.
Q. I have Dr. Bennet's. I have Dr. McEvoy's record. I have the University Hospitals records.
A. But do you have his therapy records from the achievement center?
Q. Yes.
A. So you really want my records --
Q. I want every piece of paper you have in your chart. Whether it's duplicative of other

records I have already I don't care.

A. Okay. I just want to make sure. One of the other things I worry about is giving away other personnel's records without their permission, but if you folks say that's legally okay, then I'll be happy to do so.

MR. SEIBEL: Okay. We are done.

_____

MAX WIZNITZER, M.D.

C E R T I F I C A T E

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

I, Lynn D. Thompson, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named MAX WIZNITZER, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 ___.

_____

Lynn D. Thompson, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires January 21, 1995

WITNESS INDEX

EXHIBIT INDEX

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

part of Doc. 456

ZACHARY HAMMON, et al.,

Plaintiffs,

-vs-

JUDGE POKORNY
CASE NO. 209957

MARYMOUNT HOSPITAL, et al.,

Defendants.

- - - -

Deposition of MAX WIZNITZER, M.D., taken as if upon direct examination before Lynn D. Thompson, a Notary Public within and for the State of Ohio, at Rainbow Babies & Childrens Hospital, 2101 Adelbert Road, Cleveland, Ohio, at 4:50 p.m. on Friday, January 15, 1993, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants El-Mallawany, Abrams and Brown in this cause.

- - - -

MEHLER & HAGESTROM
Court Reporters
1750 Midland Building
Cleveland, Ohio 44115
216.621.4984
FAX 621.0050
800.822.0650

records I have already I don't care.

A. Okay. I just want to make sure. One of the other things I worry about is giving away other personnel's records without their permission, but if you folks say that's legally okay, then I'll be happy to do so.

MR. SEIBEL: Okay. We are done.

MAX WIZNITZER, M.D.

TO THE WITNESS: DO NOT WRITE IN TRANSCRIPT EXCEPT TO SIGN. Please note any word changes/corrections on this sheet only. Thank you.

TO THE REPORTER: I have read the entire transcript of my deposition taken on the 15th day of January, 1993 or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the signature page, and I authorize you to attach the following changes to the original transcript:

PAGE	LINE	CORRECTION OR CHANGE AND REASON THEREFORE
5	22	Dr. Warren Cohen
36	19	it's not like

2/12/93
Today's date

Signature of Deponent