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State of Ohio,)
) ss:
County of Mahoning.)

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IN THE COURT OF COMMON PLEAS

- - -

Chelsea A. Davis, a minor, et al.,)
)
Plaintiffs,)
)
vs.) Case No. 94-CV-3168
)
Howard Kramer, M.D., et al.,)
)
Defendants.)

- - -

Deposition of Max Wiznitzer, M.D., a witness herein, called by the defendants for oral examination, pursuant to the Ohio Rules of Civil Procedure, taken before George J. Staiduhar, Notary Public in for the State of Ohio, pursuant to notice, at the offices of Max Wiznitzer, M.D., 5860 Landerbrook Drive, Mayfield Hts., Ohio 44124, on Thursday, October 10th, 1996, commencing at 6:30 p.m.

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I N D E X

APPEARANCES:

On behalf of the Plaintiffs:

John G. Lancione, Esq.
1300 East Ninth Street
1717 Bond Court Building
Cleveland, Ohio 44114

On behalf of the Defendants:

Thomas J. Travers, Jr., Esq.
Manchester, Bennett, Powers & Ulman
Atrium Level Two
The Commerce Building
Youngstown, Ohio 44503-1641

Max Wiznitzer, M.D.

of lawful age, being first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

By Mr. Travers:

Q. Dr. Wiznitzer, my name is Tom Travers, the attorney in this case representing Dr. Kramer who has been sued by the Davis family in the Mahoning County Court.

We are here to take your discovery deposition, which is an opportunity €or me to ask you some questions concerning information that you may know or opinions that you may hold pertinent to the issues in this lawsuit.

Have you had your deposition taken before?

A. Yes.

Q. So you have some idea what we are trying to accomplish today.

A. Yes.

Q. Would you state your full name, please?

A. Maximum Wiznitzer.

Q. And you are a pediatric neurologist. Is that correct?

A. Yes.
Q. I meant to ask you before we went on the record, you don't happen to have a CV that I could peruse at some point.
A. No. I would be happy to provide you with anything you want.
Q. Give me a thumbnail sketch of your medical education?
A. I went to undergraduate school and to medical school at Northwestern University. I attended the honors program in medical education there from 1971 through 1977, graduating in 1975 with a Bachelor of Science in Medicine and with my M.D. degree in 1977. And from 1977 through 1980, I did a pediatrics residency at the Children's Hospital Medical Center in Cincinnati, Ohio. From 1980 through 1981, I did a fellowship in developmental disabilities at the Cincinnati Center for Developmental Disabilities. 1981 through 1984, I did my pediatric neurology fellowship at the Children's Hospital *of* Philadelphia. And from 1984 through 1986, I was a National Institutes of Health fellow in disorders of higher cognitive dysfunction of children at the Albert

Einstein Medical College in the Bronx, in New York.

Q. And since that time, you have been in private practice?

A. Since that time, I have been on the full-time faculty at Case Western Reserve University School of Medicine.

Q. You have a clinical practice --

A. Yes.

Q. -- in that role?

A. Yes.

Q. Can you give me just a brief description of what types of things you do from a clinical standpoint?

A. I do everything a child neurologist does. Child neurology is a specialty that deals with disorders of the nervous system in children, medical, the medical treatment. So I take care of seizures, headaches, mental retardation, cerebral palsy, stroke, learning disabilities, autism; probably name a section of child neurology, I have taken care of patients in.

Q. You don't have a particular subspecialty in that?

A. Yes, I do.

Q. What would that be?
A. I specialize in disorders of higher cognitive dysfunction, primarily autistic, and attention deficit hyperactivity disorder. I also have an interest in stroke in childhood and the neuroimaging of stroke and cerebral vascular disorders of childhood.
Q. This has taken advantage of some of your very specialized training at the NIH?
A. The NIH paid for me to be at the Albert Einstein College of Medicine, yes.
Q. Do you consider yourself competent to interpret plain films of children, I guess?
A. What kind of plain films?
Q. Well, plain films.

In this case, we are talking about CT scans and MRIs, and I guess plain films don't come into play. Do you have a substantial degree of competency in the interpretation of those types of studies?

A. Yes.
Q. Would you think that your level of expertise there is the equivalent of someone who specializes only in pediatric neuroradiology?
A. Very well may be.

Q. Can you tell me how it was, if you know, that Chelsea Davis came under your care?
A. Mr. Lancione called me and asked me to look at her.
Q. What would you describe as the relationship you have had with her? Are you her primary treating neurologist?
A. No.
Q. What was the purpose for your examination of her? Was it to render medical care, or was it to ascertain her status?
A. To ascertain her status.
Q. How many times have you seen her, do you know?
A. Once.
Q. That was prior to the time that the MRI study was done?
A. Yes.
Q. You have not seen her since then?
A. No.
Q. You have seen that study, though?
A. Yes.
Q. Do you know how you were selected by Mr. Lancione to serve in that role?
A. No.
Q. Have you had any relationship with him in other

litigative matters or with other patients of yours?

A. I have had a relationship with many, with other patients of mine, and in one -- I served as an expert on one case if I am not mistaken. That was not a patient of mine.

Q. Have you served in the role of a medical consultant in litigative matters for other lawyers in his present or previous law firm?

A. No.

Q. Have you ever undertaken medical-legal consultation on behalf of a defendant who is a defendant in a lawsuit?

A. Excuse me? I don't understand the question. It is too complicated.

Q. What I am trying to find out is whether you have ever acted as an expert in a lawsuit having been retained by the defendant physician as opposed to the patient?

A. I have never been retained by a physician. I have been retained by defendant lawyers.

Is that what you mean?

Q. I suspect so.

You have testified as an expert for defendant doctors?

A. On behalf of?
Q. Yes.
A. Yes.
Q. Any idea of the number of times you have acted as a medical legal consultant?
A. People always ask me that question. My primary job is my research and my clinical care of patients. I may do this on a 10, 15 times a year basis. That's it.
Q. Okay. I would like to ascertain your specific role in this case. You have been identified as an expert on behalf of Chelsea Davis. You understand that to be true?
A. Yes.
Q. Would I be correct in assuming that it is not your intention to offer any opinions concerning the obstetrical management of this patient and whether or not it was in accordance with accepted obstetrical opinions?
A. I have no opinion about the obstetrical care.
Q. Do you have any opinions concerning whether different management of the patient during labor and delivery by Dr. Kramer may have resulted in a different outcome as far as Chelsea is concerned?

A. If you are talking about obstetrical decision-making --
Q. Yes.
A. -- I have no opinions in terms of making comments in that area.
Q. Will you be rendering any opinions concerning the timing of the onset of Chelsea's brain lesion?
A. Yes.
Q. Will you be rendering opinions concerning her medical prognosis?
A. Yes.
Q. And I suspect you will be testifying concerning the findings of your examination of her?
A. Yes.
Q. Will you render opinions concerning the etiology of the medical problems that she presented with?
A. Yes.
Q. We are obviously speaking just in general terms, and we have some more detailed questions in 'chose areas. Are there any other general areas that you anticipate that you will be rendering opinions in?
A. No. Not at least that I can recollect.

Q. You have authored a report to Mr. Lancione, correct?
A. Yes.
Q. Is that the only report that you have prepared in this case?
A. Yes.
Q. You conclude in that report -- my notes may not have the exact language. I think it is accurate -- that you talked about the intercranial injury occurring as a result of her perinatal encephalopathy?
A. Yes.
Q. That is your opinion, that her intercranial injury was the result of perinatal encephalopathy?
A. Yes.
Q. Can you define €or me, Doctor, what you mean by perinatal?
A. At the time that I wrote this or at the present time?
I am very serious about my question.
Q. Well, how about both?
A. At that time, we had two issues. There was no doubt that according to the medical records, this child had had a hypoxic ischemic

encephalopathy. However, I had a report here -- that report -- that I had a CT scan that showed calcification in the basal ganglia. I needed to delineate better in my own mind what that meant.

As a consequence, I needed to determine, one, was that calcium or was it not, and, number two, if it was not calcium and we noted the child with neurologic dysfunction, what pattern of brain injury was present on neuroimaging study, which is why I asked for the MRI.

Because of the fact there might have been calcium, I basically used the term "perinatal" to include the time prior to onset of labor since I was not sure of what was happening until we could better delineate things through neuroimaging studies.

Q. My perception was that was your opinion then. Since then you reviewed the MRI and have a more closely defined opinion of the onset of the encephalopathy?

A. Yes.

Q. And what is that opinion?

A. The onset of the encephalopathy was during the

course of labor.

Q. When you wrote your report and included the adjective "perinatal," what did you mean by that?

A. I just answered. What I was saying was that I was not -- at that time, I was not certain if the problem had happened right at the time, because of the CT report of what was written there, that the problem --

Q. Can I interrupt? Here is all I am trying to find out. When you say "perinatal," how far prior to delivery were you contemplating that term to represent?

A. Could be a few months.

Q. When you say now that you believe that it was during the course of labor when the onset occurred, my perception of that is that it is your opinion that this happened subsequent to the beginning of her induction on the morning of the 23rd.

A. Yes.

Q. This is probably too broad a question. I am going to try it anyhow, Doctor: Can you explain for me your rationale in determining that any intercranial injury had no earlier

onset than that point in time?
A. I guess it is not too broad a question.
MR. LANCIONE: As long as you think the question is okay, that's fine. I mean, I am not --
Q. I am sure it would require a lengthy answer, and I don't have a problem with that.
A. Okay. What you are asking is that in my opinion, the irreversible insult to her brain occurred during the course of labor.
Q. Right.
A. Okay. Number one, we subsequently repeated a head CT scan.
Q. That was in '95, correct?
A. Yes. The head CT scan showed no evidence of calcification. That meant that the initial findings or the findings on the initial CT scan of 5-5-92 did not represent calcium. It either represented blood or represented acute ischemic changes in the basal ganglia.
Number two, her clinical course after birth is consistent with an acute hypoxic ischemic event.
Number three, findings on MRI are consistent with an event that would have

occurred, that would have occurred at her age of gestation.

Q. You are done?

A. I am done.

Q. Number three, when you talk about the MRI findings being consistent with an event at her age of gestation, my perception is they would also be consistent with an event occurring a day before the onset of labor.

A. Yes.

Q. Would the same be true as far as the findings on the '95 scan?

A. Since the '95 scan was normal, the answer is yes.

Q. Are there clinical findings in your opinion that then prompt you to believe that the insult occurred during labor as opposed to a day before the onset of labor?

A. Yes.

Q. And what would they include?

A. Those would include, number one, the timing of her seizures. If she truly had an insult that occurred the day before labor with her -- that would have made her seizures starting at 48 hours after the insult, which would not be the

usual course that I see since they normally happen within the first 24 hours after delivery, which is what her timing was for the onset of seizures.

Q. Do you know whether she may have had seizures in utero?

A. There is no report of seizures in utero. There is no comment of seizures in utero. So I have to assume there were no seizures in utero, and I would expect seizures right after birth, and none were reported. And people were keeping a close eye on her.

Q. Have you answered my question completely concerning the clinical presentation?

A. No.

Number two, she showed several biochemical disturbances, including, according to the medical records, the onset of the -- of SIADH, syndrome of inappropriate ADH, which seems to have been identified -- it was identified for the first time on April 25th, about a day and a half after birth.

If something had happened in utero that was already kicking off that event, I would have expected the timing to have been a little

earlier. In other words, it should have been present from almost after birth.

Number three, if an event had occurred in utero, I would have expected the drop in her calcium level, which occurred -- again which was noted on the 25th, not the 24th, when she was born.

Another point is if a child suffers a significant irreversible brain injury, in my experience, many times when you start the fetal monitoring, abnormalities on fetal monitoring are noted almost from the get-go, especially if it was an insult that occurred the day before. Abnormalities are found quickly when the fetal monitoring are noted. Those are some of the salient features.

Q. What is your understanding of the first abnormalities noted on the monitor tracings?

A. There are two notes in the nursing notes. Some were about 10:30, and there is something about a fetal heart rate acceleration for about two minutes and some were around 11:30. There is a comment of a prolonged fetal heart rate deceleration that lasted for about four minutes.

Q. What is your understanding of when labor was induced?
A. Labor was induced a little after 8:00 o'clock that morning.
Q. And you would have expected abnormalities earlier than two and a half hours after induction?
A. Definitely. I also would have expected somebody to come along and say that there were changes in the variability patterns of the fetal heart tracing, especially if you have an acute brain insult. You can't regulate your autonomic system as well. All the comments made was "Background looks good. There is good variability," and then some of these prolonged decelerations come out of the clear blue sky.
Q. How soon after induction would you anticipate abnormalities in the tracings had there been an earlier insult?
A. In my clinical experience -- and I have seen quite a few of these kids -- within the hour people start reporting. As soon as they put the fetal heart monitor strip on, many times people will notice that. Again, you are giving me the timing the day before, so I am using

your wording.

Q. In your experience, Dr. Wiznitzer, would an infant who had suffered cerebral injury show evidence of edema for some period after the time of that insult?

A. Not always.

Q. Generally?

A. No. You can't use the word "generally." Either it happens or it doesn't. It depends on some degree of severity of the injury, the pattern and the cause, in other words, the reason the injury occurred.

I have had patients who we have easily been able to date exactly when the injury occurs, the irreversible HIE and time it. When we follow with CT scans, we see no edema. Yet, when you do an MRI later on, you can see a classic ischemic pattern that would fit with the history. So that's a well known fact.

Q. Is it true that more often than not that infants who sustain cerebral injuries have accompanying cerebral edema?

A. It depends why the insult occurs. I can't play more often than not games here. It is what the kids do. Either they do or they don't. It is

not one way or the other. I understand what you are asking. It is not a simple answer.

Q. You cannot agree then with the general statement that infants with cerebral insults generally show evidence of cerebral edema on subsequent studies. You do not agree with that?

A. I am not saying I don't agree. I am saying it depends on the reason why the insult occurs.

Do you understand what I am answering? Maybe you don't. You are trying to get me to say, "Gee, there should have been cerebral edema" and later on say, "See, Dr. Wiznitzer, you said that." It is not a yes or no answer to your kind of a question.

Q. That's not the question I am asking?

A. It is. If you are going to say my clinical practice and kids that come in with HIE, do I usually see cerebral edema on the screen acutely, the answer would be yes. Do I need to see cerebral edema in order to make the diagnosis of acute HIE, the answer is no.

Q. Doctor, do you view your role in this case as a medical expert to present informed opinions and analysis, or do you view your role here as an

advocate for the patient's position in this lawsuit?

A. You have to ask Mr. Lancione. He asked me to review this as an expert.

Q. Well, I am just asking you: Do you view your role as an advocate for the plaintiff's position?

A. No. I view my role as an expert witness to evaluate the information that is there and to give my opinion.

Q. Good. I am hopeful that that's what your plan was because -- and you can correct me if my perception is incorrect -- I view the role of the expert to answer questions accurately and not to give speeches as to why it is a dumb question or can't answer it that way.

My question is, isn't it generally true that infants who suffer an insult show evidence of edema on radiology studies?

A. I answered that question.

Q. And that answer is yes?

A. Yes. I did answer that question.

Off the record.

(Discussion off the record.)

Q. When you reviewed the scan on May 12th of 1992,

did you see evidence of edema?
A. There was no scan of May 12th, 1992. It was May 5th, 1992.
Q. I am sorry. I thought -- I thought if you added up the 12th day of life is where my confusion rests perhaps. That's the scan I am referring to.
A. The answer is no.
Q. Okay. Were you able to identify the lesion that had been interpreted as a calcification?
A. Yes.
Q. And where did you note that to be?
A. In the Basal ganglia, specifically in the area of the putamen and caudate nucleus.
Q. If you had not had the benefit of subsequent studies, would your interpretation of that film had been the same as it was interpreted at the time?
A. Not necessarily.
Q. Looking at that study independently of any follow-up studies, what was your interpretation of that lesion?
A. I said what we have is an area that is brighter or more hyperintense than the tissue around it, and I mentioned before that there are three

major reasons why things like that can be there. One is calcium, two is blood, and three is changes in the white matter in that matter that basically make it look -- because there is white matter in the basal ganglia that make it brighter than it is.

Q. Without studies you would not be able to distinguish among those three potential causes --

A. You could by some degree perhaps by trying to look at the films and the actual -- the images on the scanner itself and try to modify those settings and see exactly what the density of that hyperintense signal is. In the absence of that, I don't think you can. I don't think you can differentiate.

Q. Did you note any other significant findings on that study?

A. No.

Q. That was the only film available for your review at the time that you examined Chelsea Davis as I understand it?

A. Yes.

Q. Subsequently, you had the benefit of the MRI and the '95 scan?

A. Yes. The '95 CT scan.
Q. Tell me your interpretation of the '95 CT scan.
A. The '95 CT scan basically looked normal.
Q. Were there any evidences at all of abnormalities on that study based on your review?
A. Not to my recollection.
Q. How about the MRI study?
A. The MRI scan was abnormal.
Q. What findings did you note on the MRI?
A. On the T2 weighted imaging study, there was abnormal signal from the left basal ganglia. There was also abnormal signal from the white matter in the upper parietal region, and there was atrophy cortex in the area of that white matter, the abnormal signal from the white matter.
Q. Are any of those findings correlated to the lesion from the 1992 CT scan that had originally been interpreted as a calcification?
A. Yes.
Q. Which?
A. The abnormal signal from the left basal ganglia. If I am not mistaken, it was in the left putamen.

Q. Do you have any explanation for the presence of that finding on the MRI and its absence on the '95 CT scan?
A. Yes.
Q. What would that be?
A. CT was not sufficient or did not have adequate resolution to identify that it is not just something you would see on the CT scan.
Q. You would expect that that evidence would still be there today if an additional MRI were done?
A. Yes.
Q. It is not that that lesion had been there when the MRI was done and had disappeared by the time the '95 scan had come along.
A. Excuse me?
Q. I will withdraw that question.
Q. When you talk about the abnormal signals from the white matter, were you able to go back and compare that to the 1992 CT scan to see whether there was any evidence of that phenomena that was undetected when that first CT scan was interpreted?
A. I did not go back and look. I did not compare after the fact. I would be happy to do that if you would like me to. I have no problem.

Q. Do you have an opinion as to whether or not that finding in '94 -- the MRI was in '94, right?
A. Yes.
Q. -- do you have an opinion as to whether the findings on the '94 MRI concerning the white matter abnormal signal represented a lesion that developed after the time that the '92 CT scan was taken?
A. Yes, I did.
Q. And what is that opinion?
A. This lesion did not develop after the '92 CT scan was taken.
Q. It developed beforehand?
A. It was present before, yes.
Q. And had an MRI been done rather than the CT scan in '92, it probably would have been evidenced at that time as well.
A. It may have been evidenced. It depends on how you did the MRI and everything else.
Q. Tell me your opinions, Doctor, concerning the significance of those findings on MRI.
A. The MRI findings are consistent with an ischemic insult.
Q. Do you believe that they are inconsistent with

the original interpretation of the '92 CT scan as evidencing calcifications?

A. Yes.

Q. Explain for me how you reach that conclusion.

A. The major reason -- there are two major reasons: One is there is no calcium on the CT scan we did in 1995. Once calcium is present in my experience, it stays there, especially that amount of calcium. It doesn't go away. That's probably the main reason.

Number two, you have already made the inherited assumption that that was calcium in the 1992 scan, and I already argued there were several options, and the calcium option is obviously discredited by the subsequent findings on the '95 CT. So since there was no calcium there to start with, it was an abnormal signal from other reasons.

Q. Have you reached a conclusion as to what you believe the reason was for the abnormal signal in the '92 scan?

A. Yes.

Q. And what is that?

A. That was due to an ischemic insult. If you want to use the broader terms, hypoxic ischemic

insult to the brain.

Q. What specifically do you think you were viewing on that scan, hemorrhage to the brain?

A. It is hard to say. More than likely hemorrhage. If you came and said, "Could it be the ischemic insult to the putamen and the globus pallidus," I wouldn't argue with you. Do you understand what I am answering?

Q. Yes.

Q. Do you hold any opinions as to the timing of the onset of that insult?

A. Yes.

Q. More specifically than post induction?

A. Yes.

Q. Tell me those opinions, please.

A. You are talking about the hypoxic ischemic insult?

Q. Right.

A. The timing more likely than not occurred after about 1:05, 1:15 in the afternoon. There was a second prolonged deceleration at that time, and then subsequently, there were other changes that occurred on the fetal heart rate monitoring strips that were suggestive of ongoing problems in terms of how the child was

able to regulate the autonomic nervous function, which were not present beforehand. Beforehand was a clean tracing except for these areas of deceleration, so it had to have happened after that event.

Q. That event being the event at 1:05 you noted?

A. Yes.

Q. Do you know how long after 1:05?

A. Probably at least an hour after, hour and a half at the minimum.

Q. Would it be a correct statement that Chelsea suffers from cerebral palsy?

A. Yes.

Q. Do you believe that that medical condition is secondary to that lesion that we have been discussing?

A. To the insult that occurred or the abnormalities under neuroimaging?

Q. Yes.

A. Yes.

Q. Is the one abnormality that I am talking about in the basal ganglia because I am going to then ask you about the other abnormalities on the 1994 MRI, or can you make that determination?

A. If you came to me and showed me a child who had

definite abnormalities of the basal ganglia of that type and showed me the physical examination, I would argue that, yes, that can be associated with it. I know you don't want me to give lectures. I have to qualify my answer. Very simply, the MRI doesn't show everything that is wrong with the brain.

Q. Are you speaking generally or in this instance?

A. Generally. Also in this instance because you see abnormal signal from white matter in one area, some areas of cortical atrophy, some abnormal signal from the basal ganglia.

It doesn't mean that's the only areas that aren't working right. That just means that's the only area that the neuroimaging area is demonstrating. I would argue that there is probably something more diffuse, so I just can't play pure basal ganglia games or pure white matter games or comments just like that. You have to take the picture as a whole.

Q. Have you also reviewed the child's EEGs?

A. Yes.

Q. And they have been interpreted as being normal. Do you agree with that assessment?

A. No.

Q. Tell me, how many EEGs have you seen?
A. Excuse me?
Q. How many EEGs have you seen?
A. Per year?
Q. No, no. Of Chelsea Davis.
A. One.
Q. Do you know the date of that?
A. 4-27-92.
Q. You have not seen any since that time?
A. No.
Q. What is your interpretation of the 4-27-92 EEG?
A. It is abnormal.
Q. In what respect?
A. I think the background is too slow. I think that we would not expect to see the normal physiologic changes in background activity that children of her age should manifest. In other words, I don't see real well-defined identifiable sleep states in the way that we define new born child or new born baby sleep states.

It shows some relative invariance because most of it looks about the same. It shows about the same kind of patterns, little burrs of some moderate amplitude activity

followed by some lowering of the background amplitude, which in my opinion was too low for a child of this age.

Q. Do you find the EEG findings consistent with the imaging studies?

A. In what way? I mean, this is definitely not a yes-no question. The only way they are consistent with the imaging studies is that the abnormalities on the imaging studies are due to HIE. The abnormality on the EEG can be seen in children with HIE.

Q. I guess what I am wondering is whether or not children showing the type of lesion indicated on the MRI study in this case customarily present with general category of EEG tracings.

A. No. You can't be that specific.

Q. Is there anything about your interpretive findings of the EEG that are inconsistent with the conclusions you have reached concerning the imaging studies?

A. I really don't understand. I am sorry. I am not playing games. I don't understand your question,

Q. When you look at the EEG, is there anything about it that you find unexpected because of

what you know of the condition of the patient's brain from the imaging study?

A. Are you talking about from the MRI that I looked at subsequently?

Q. Correct.

A. No.

Q. You don't believe that a patient with the degree of lesion that you have talked about on MRI would present with more of an abnormal finding on EEG?

A. That's a good question. It is a good question, and I asked myself that same question. In my clinical experience, just to answer your question, which is really the only way I can do it, it has been variable. I really -- the only real way I can answer your question is sometimes yes and sometimes no. And I am not playing games with you.

Q. I assume you would decline to answer a more-often-than-not question.

All I am trying to find out, Doctor, isn't it surprising that this EEG would be as close to normal as it is compared to the lesions that you have identified on your subsequent imaging studies?

A. May I answer -- no lecture, a quick answer -- I will not answer that exact question. The EEG was consistent with the child's clinical picture. I thought the EEG was moderately abnormal. At the time, I thought the child had a moderate encephalopathy, so it fit quite consistently in that regard.

The findings on the imaging study are just evidence of some ischemia, nothing more, and it doesn't tell you the severity if that's what you are asking, the severity of what had been going on.

Unfortunately, what I don't have and I would loved to have -- and I normally would have done it -- is an EEG done the day of birth or the day after birth. I would then be able to answer your question.

Q. I believe that I had digressed a little and had exhausted my questions on the basal ganglia lesion. Do you hold any opinions concerning the abnormal signals from the white matter? Is there anything about them inconsistent with your HIE theory?

A. No.

Q. Do you believe they are secondary to an

encephalopathy?

A. They are secondary to a hypoxic ischemic insult, yes.

Q. Is it your opinion that they developed in the same manner as the basal ganglia lesion?

A. Yes.

Q. We have talked about attempting to time the insult here. Are you familiar with any studies that attempt to accomplish that through an analysis of blood studies?

A. Yes.

Q. Have you made any independent attempt to investigate the timing of the issue through -- down that avenue?

A. I try. There is not enough information regarding blood tests that really would help me in this regard. That's number one.

Number two -- and what kind of blood studies are we talking about by the way? Let's be exact. There are different kinds of blood studies.

Q. You tell me your opinion concerning whether or not findings in the following areas can be pertinent to the timing of an event: Number of norrnoblasts.

A. It can be helpful.
Q. Platelet count.
A. It can be helpful.
Q. Lymphocytes.
A. I am not sure about that.
Q. Are you familiar with studies which purpose is to demonstrate that there is that correlation?
A. Yes.
Q. What studies are those that you are familiar with?
A. I have read a paper by Dr. Noya on that subject.
Q. Was that read independently of this litigation?
A. Yes.
Q. Do you find his conclusions to be well documented?
A. No. I have questions about his research.
Q. Explain your answer.
A. In his paper, he doesn't really explain how he gets to the timing of when the events occurred. So what he has is a lot of blood study results, and at the very beginning of the paper, he basically wants us to take us on faith that he is able to time it accurately. I don't take anything to faith when it comes to research. I

want to see everything on the table.
Q. Are you familiar with Dr. Noya and other of his publications?
A. Yes.
Q. Do you find him to be a credible researcher in this area?
A. I know nothing about whether he is credible or not as a researcher.
Q. You read his publications?
A. I have read some of his papers, yes.
Q. How about neutrophils, do you think they are a reliable component with regard to timing of the insults?
A. I don't know.
Q. Nucleated blood cells?
A. It is the same thing as normoblast.
Q. You agree that --
A. So the answer is yes, they can be helpful.
Q. What were your findings concerning the normoblast counts in relationship to trying to time the event?
A. There was one normoblast count that was 18 that was done on the first blood count that was present, and that was it.
Q. Can you draw any conclusions from -- I mean,

that's an abnormally high normoblast level, isn't it?

A. Yes.

Q. Can you draw any conclusions from that concerning the timing of the event?

A. No.

Q. What additional information would you need €or that to be helpful in the timing?

A. If you look at perhaps the sequence of what the normoblast count would be, what it would have been like afterwards, the first blood count that is done is done at 8:30 in the evening of birth. The next one is not done for two and a half days. I would like to know what numbers would fill in the gap.

Q. Do you hold an opinion as to whether or not values for the nucleated red blood cells at the time that it was recorded in the study at 7:30 p.m. was rising or declining?

A. Can't comment. It is only one count.

Q. Well, if you claim to know exactly or approximately when this insult occurred, what would you expect as far as normoblast findings?

A. In terms of the nucleated red blood cells?

Q. Yes.

A. I would probably expect it to keep rising after that time.
Q. Would you hold an opinion as to how high in all likelihood it would have risen?
A. No.
Q. Did you investigate the findings of lymphocytes on that same study?
A. I just saw the lymphocyte count.
Q. Do you attach any significance to that in regard to the timing of the event?
A. No. Not one way or the other, no.
Q. Do you hold any opinions, Dr. Wiznitzer, concerning the etiology of the hypoxic event?
A. As to a more-likely-than-not scenario or just in general?
Q. I am asking whether you hold an opinion.
A. I am serious about my question: Is it one of these things like what do you think the possibilities are, or do I have a definite conclusion as to what it was?
Q. Well, I guess I would like to know both. Do you have a definite conclusion as to what it was?
A. No. I don't think any of us do.
Q. What are the possibilities, the most likely

possibility there would have been some sort of a cord compression? Do you have any idea how mechanically that occurred?

A. The baby got stuck. The cord got between the baby and the bony process, actually the uterine wall, so it got compressed somehow to give you some possibilities.

Q. What other possibilities exist?

A. Those to me are the -- that really is the most likely one. I can't evidence anything else. If someone came along and said to me that this was a grossly abnormal placenta not able to supply oxygenation during labor, I can say that that's a possibility; that it could have been; that the placenta wasn't able to supply adequate nutrients to the baby.

Q. Would you agree that had there been interruption of blood supply to vasoconstriction of umbilical vessels, that the same type of results would be evidenced as if an HIE event occurred secondary to cord compression?

A. Yes. If what you mean is that there wasn't good flow through the umbilical vessels --

Q. Right.

A. -- due to a vasoconstriction, yes.
Q. Would you agree that there is nothing in any of the radiology studies or the patient's clinical presentation that would be inconsistent with her insult having been caused by interruption of umbilical supply? Never mind. I am going to withdraw that question.
You believe the likely scenario is that there was an interruption of umbilical blood supply to the fetus?
A. Interruption of the umbilical blood supply.
Q. The mechanics that would have caused that is not something that you know.
A. No.
Q. That was poorly phrased.
A. To a more likely than not conclusion, no.
Q. My question was not well phrased. I know you mean you agree, you don't know mechanically what caused it.
A. More likely than not, no, I don't know.
Q. Do you know whether meconium can cause vasoconstriction of the umbilical vessels?
A. Yes, I know.
Q. That it does?
A. I know that it does it in an in vitro

preparation.
Q. Do you believe that translates then also to an in vivo?
A. Not necessarily.
Q. Well, the reason we do in vitro studies is to postulate what would happen in vivo. Isn't that right?
A. No doubt. If I can give you a quick example, there was a recent treatment for AIDS that were created in vitro and didn't do diddly in in vivo. Because of one, you don't necessarily get the other.
Q. Would it be a correct statement that you don't know that in vivo can cause any more vasoconstriction?
A. I don't think there is enough research to tell you that, and in my mind, unless you can prove to me that something does do it, I have to assume that it doesn't.
Q. Do you know whether or not there can be an interruption of blood supply through the umbilical cord caused by chorioamnionitis?
A. Are you saying to me if there is an inflammatory process in the chorioamnionic region that includes the amnionic fluid and

involving also the umbilical cord? Is that what you mean?

Q. Well, I am asking -- that's a subpart of my question. I am asking in general whether an infection of that nature can result in a hypoxic ischemic event?

A. Yes, it can.

Q. Do you know whether or not there was evidence of such an infection in this patient?

A. To my knowledge, there was no evidence of such an infection.

Q. If there had been evidence presented to you of such an infection, would that impact upon the opinions that you hold in the case?

A. No.

Q. Okay. Doctor, I really apologize if this is repetitive. I just want to make sure I am thinking clearly here.

As far as the timing of the event, the reason you believe you know that is because of the clinical presentation as opposed to any of the EEG studies, the CT scans, the MRI studies.

A. The clinical presentation and the defined abnormalities as represented on the fetal heart rate monitoring.

Q. Do you interpret fetal heart rate tracings yourself?
A. Not clinically.
Q. Do you believe that you have the capability to interpret them?
A. Can I identify deceleration or something like that? Sure. Do I --
Q. I can even do that?
A. I am serious.
Q. As far as their clinical significance from looking at the tracing, do you have sufficient expertise?
A. No. I leave that up to the obstetricians.
Q. Well, then, what is your basis of understanding concerning the findings of the tracings?
A. My basis of the tracings, the initial tracings as I mentioned appeared normal.
Q. I am sorry to interrupt. I am not ask asking you to repeat again what you understand those tracings to represent; I am asking you how is it that you have that knowledge? Were you told that to be true? Did you study them yourself? Did you rely on the nursing notes, or what is your basis for understanding there was normal tracing upon induction?

A. I relied on the nursing notes and the doctor's notes in the medical records.
Q. The timing *of* the seizures was a factor that you cited. Tell me your understanding of the number of and timing of seizures that this child presented with.
A. Chelsea had at least two or three well-defined seizures. There were subsequent events that occurred after the initial presentation of seizures on April 24th that I think are too vague that, from my reading of the medical records, to definitely state that they were or were not seizures.

If you are asking about what were definitely seizures, at least the first two things recorded in the nursing notes describing some generalized convulsive activity were seizure activity. I guess I will keep it at that.

Q. And these were the evening of the 24th?
A. Yes.
Q. Can you tell me what time you believe those to have occurred. The only reason I am asking, Doctor, while you look -- I mean, I can read the nursing notes as well -- it seems to me

they describe events, and I want to make sure which of those events you are interpreting as being true seizures.

A. On the 24th of April at 1920, there is a nursing note that says, "Tonic-clonic movement of upper extremities, accompanied lip smacking, color dusky" and then skipping along "Episode lasted one minute."

Q. I am sorry. What time was that again?

A. That was 1920. At 1937 there is a note that says, "Tonic-clonic movements of both extremities" and then 1940, "Phenobarbital infusion was finished." That was the beginning. I am sorry. I am done.

Q. I am sorry. I didn't understand that. The subsequent tonic-clonic activity may or may not have been true seizures?

A. That's what I am looking for. I can't read some of the notes. I apologize. There are other notes that are written later on describing some episodes. Unless you can read this better than I can, I can only comment on what I can read.

Q. Okay. As a general principle, what is the anticipated timing of seizure activity

intrapartum of a hypoxic ischemic event?
A. Generally, I would say that it starts -- I am trying to think of the right word. I normally would not expect to see a seizure before about six hours after the insult. It is not an inviolate rule.

As a general rule, I normally would expect seizure activity to be present sometime in the next 24 to 48 hours. Numbers quoted are usually within 48 hours after the insult. In my experience, it is closer to 24 hours or 30 hours after the insult.

Q. I don't want to put words in your mouth, Doctor, from what you are telling me, you conclude that based on seizure activity alone, the insult in your judgment occurred within the 30 hours prior to the onset of that activity?
A. Within that time window, yes, the onset of the clinical seizures. That's only one factor that I had mentioned before.
Q. Yes,
A. And that's one of my factors.
Q. The fact of the matter is the patient has remained seizure free to the best of your knowledge.

A. Yes, to the best of my knowledge.
Q. Would it be your feeling that she would remain seizure free?
A. It is too early to tell.
Q. How old would she have to be before you could make that determination?
A. I am going to have to give you a rough number. This is based on clinical experience. Probably I would have more information within the next five, six years.
Q. Do you have any way of predicting whether or not she will ever have to undergo any further regimen of phenobarbital or other medications?
A. Is this a more-likely-than-not question?
Q. Sure.
A. The difficulty here is that numbers that are quoted are about 50 percent of the kids can go on later to develop epilepsy. So we are right smack dab in the middle, and that's what makes it so difficult. You have literally hit one of the few numbers.
Q. It is clear that you would be able to state with reasonable certainty that this child will have further seizure activity.
A. No doubt about that. I agree with that.

Q. Are there other potential causes for seizure activity in a newborn other than an hypoxic ischemic event?
A. Yes.
Q. What would some of those be?
A. Common ones?
Q. Correct.
A. Low blood sugar; brain malformation, infection, and that's central nervous system infection if there is significant marked drop in the sodium levels.
Q. Bulls eye.
A. I knew you were asking that.
Q. Are you familiar with her sodium values?
A. Yes.
Q. In the neonatal period?
A. Yes.
Q. Do you find them to be consistent with the potential cause of seizure activity?
A. With the numbers that are available to me, I would say no.
Q. What numbers are those that you are relying on?
A. The morning of the 24th, we have a sodium of 136. The morning of the 25th, we have a sodium of 125.

Q. Do you consider that to be a precipitous drop?
A. Depends how -- over one day, no. Is it enough to cause seizure activity in this child? I would expect more likely than not.
Q. What do you consider to be normal sodium values for a child of this?
A. 134, 135. It depends what the lab has as its values.
Q. For a baby with a seizure, would it be typical to check her electrolytes?
A. Yes.
Q. Would a serum --
A. Excuse me. Can I qualify that, please?
Q. Sure.
A. Yes and in the appropriate clinical context.
Q. Would a sodium level of 123 or 125 be of concern to you in a newborn as potential cause of seizure activity?
A. Possibly as a cause. If you gave me levels of 110, I would say yes, no doubt about that. This baby had levels of 123 and 128 and in my interpretation of the medical records didn't have obvious clinical seizures of the type that had occurred on April 24th at about 1920.
Since the numbers dropped lower and we

didn't see the same kind of seizures that were really occurring, I would argue that more likely than not this was not the cause.

Q. Can you attribute a cause to the drop in her levels?

A. Levels of --

Q. Sodium?

A. Yes.

Q. What would that be?

A. According to the medical records, the syndrome of inappropriate ADH secretion.

Q. You agree with that?

A. With my quick review of the information that is there, yes.

Q. Is there any distinction of the nature and duration of seizures caused by sodium depletion from those secondary to an HIE insult?

A. Ask that again.

Q. Just looking at the substance of the seizure itself, can you tell a more likely scenario as to its etiology?

A. Not necessarily, no.

Q. If these seizures were the result of low sodium levels -- first of all, are you aware as to whether or not any treatment was effected

because of her sodium values?
A. I can't tell from the notes. I know that -- because I can't read the handwriting -- it looks like there was fluid restriction in terms of how fast they were running the IV.
Q. Did her sodium values return to a normal range?
A. Yes, they did.
Q. Was there any seizure activity of any sort or any tonic or clonic activity noted after her sodium was returned to the normal range?
A. No.
Q. And your opinion is that her sodium values had nothing to do with her seizures or her tonic activity because it wasn't low enough. Is that what I understand you to say?
A. In this whole clinical context, yes.
Q. You commented upon the drop in her calcium levels.
A. Yes.
Q. Tell me why you believe that to be significant in regard to the timing of the event.
A. Calcium levels drop on an acute hypoxic ischemic incident. It is one of the metabolic derangements that will transiently occur.
Q. How often was the calcium level checked

for her?
A. Daily. Sometimes a few times a day.
Q. When did the drop in her levels begin?
A. It looks like the real dropdown occurred into the abnormal range in the labs 4-25-92 at 0620, that blood test.
Q. Yes.
Q. They had already begun to go down before that, hadn't they?
A. How can you tell? They had to have started to go done down before then, yes.
Q. i guess that's all I am trying to find out. When you rely upon this information to support your contention in regard to the timing of the event, how do you know that I guess is my question.
A. Oh, I understand what you mean, sir. Okay. if this child had had an insult, just to use a round number if I may --
Q. Please.
A. -- the day prior to delivery, let's assume it was 24 to 30 hours prior to delivery, more likely than not **I** would have expected the child to have the initial calcium determination to be definitely abnormal by that time in which it

wasn't here.

Q. You commented earlier that you believe that it was 4-25 when they first identified the biochemical disturbance, the SIADH. What notes do you base that conclusion on?

A. I base that on the conclusion that that was the first time they identified a low sodium level, and there is a note on 4-26-92 that says she had hyponatremia due to the basis of SIADH. If the sodium was low on 4-26, which it was and they considered that due to SIADH and if it is low on 4-25, that's also due to SIADH.

Q. That's fair enough.

Are there findings in your view, Doctor, that are inconsistent in this baby's presentation from an HIE insult?

A. No.

Q. How many of her organs do you believe sustained some type of damage?

A. Only one organ. I mean, outside of the metabolic derangements that were present, let's ignore those, there was only one real organ that was tested, and that was the kidney, and that showed dysfunction.

Q. What evidences of dysfunction?

A. Two. Number one, initially the baby had decreased urine output despite the fact she was being given sufficient fluids to encourage good urine output.

Number two, for days after delivery, she showed blood -- initially large amounts of blood in terms of the dipstick in her urine. There was also some protein, both of these consistent with an acute renal insult.

Q. In any of the examinations of Chelsea that you are way of, has there ever been demonstration of evidence of injury to any other organ?

A. Can **I** ask you to be more specific? Name the organ, and I can address the issue.

Q. Well, how about the heart?

A. Outside of auscultation and chest X-rays, no other testing was done. What was reported in the medical records reported no abnormality.

Q. And you have no reason to disagree with that. I mean you auscultated, I am sure.

A. Yes. I listen to hearts.

Q. To the best of your knowledge, her heart is fine?

A. Presently?

Q. Right.

A. Yes.
Q. I suppose I could go through organ by organ. Wouldn't you agree generally there has been no evidence of any other organ injury in this?
A. I understand your question, sir. May I rephrase it?
Q. Please.
A. Are you asking me if there is evidence of any other organ system that shows some sort of permanent dysfunction that is clinically evident?
Q. Yes. Thank you.
A. The answer is no. I also wouldn't expect it in the manner of a hypoxic ischemic insult. The hepatic pattern dysfunction is transient. Unfortunately, in this situation, no one ever checked the hepatic dysfunction, and no one commented on it one way or the other.

You can go on with other organ systems. The muscles can show transient dysfunction. No one ever checked and I can't answer that. There is no evidence of any other permanent injury except for what happened to her brain.

Q. Isn't it often true that patients or infants who have suffered brain injury will also suffer

permanent injuries to other organ systems?
A. No.
Q. You are familiar with the term "auto regulation"?
A. Yes.
Q. I am not a doctor. My understanding is that the body's regulatory system will direct the available blood to the brain and deprive other organs before the brain gets deprived because they know the brain is a pretty valuable thing to remain intact. Is that an over simplification of that concept?
A. With enough due warning for the body for the brain, the answer is yes.
Q. Isn't it unusual that the brain would be first injured from lack of blood supply before any other organ system?
A. I am not saying that the brain was first injured, sir.
Q. Well, what do you believe was the first evidence of injury?
A. I think, as I mentioned to you, we have evidence of multi-organ dysfunction. In her situation, we have kidney and brain. Unfortunately, other organ systems weren't

checked. I can't comment on that.
Q. Do you know whether or not auto regulation occurred properly in this infant?
A. No.
Q. No, you do not know, or no, it did not?
A. I don't think anyone knows.
Q. I guess what I am wondering is, was the part of the brain that governs the auto regulatory system damaged?
A. I don't understand your question. I am sorry.
Q. Okay. Well, what part of the brain is important to keep the auto regulation phenomenon appropriately acting?
A. I can't tell you what the deep-seated center ultimately is in the brain itself. It works its way to a large measure of degree through the autonomic nervous system. Is that what you mean?
Q. All I am trying to find out is, is it your contention that this patient's auto regulation was somehow impaired due to some physiologic finding or event, or did she have a normal auto regulation system intact?
A. When? I am sorry. When did she --
Q. At the time of the ongoing stress?

A. I find no evidence that there was something wrong with it beforehand. Is that what you mean?
Q. Exactly.
A. No. I don't find any evidence that there was anything wrong with it beforehand.
Q. Do you know whether the infant's hearing was checked? Well, I am not going to ask you to review. There was hearing checked.
A. I remember that there was a hearing check done, but that's about it. I didn't see any evidence of hearing aids or anything after that fact, so I assume that the hearing was normal.
Q. Is impaired hearing often a secondary finding for someone who has had an HIE insult?
A. It may be present, yes.
Q. Do you know her visual state?
A. Yes.
Q. Satisfactory?
A. Grossly, it seems to be satisfactory, yes.
Q. Would you consider yourself, Doctor, to be an expert on cerebral palsy generally?
A. Yes.
Q. Do you believe that obstetricians can prevent cerebral palsy?

I take that as a no, but you don't like to say it.

A. In a small number, yes. I think that's the best way to answer you.

Q. Are you familiar statistically with how many cerebral palsy patients there are per live birth today in the United States?

A. I don't know the statistics. No, I don't know the exact numbers.

Q. Are you familiar with the etiology of cerebral palsy victims generally?

A. Yes.

Q. Are there -- what is your understanding of the accepted causes of cerebral palsy?

A. About 10 percent are related to the birth process. In other words, they are due to -- I guess the right word would be intrapartum events. Unfortunately, that's the only statistic that sticks in my mind.

There is a percentage that are due to prematurity, percentage that are due to brain malformations, a percentage that are due to in utero vascular events, a percentage that are due to infections, and a sizable percentage that we don't know why it happened.

Q. Well, the number I am most interested in, do you have any idea if there is absolutely no known explanation?
A. It is greater than 50 percent.
Q. Do you agree with that to be an accurate assessment?
A. Presently. Though, I think as we march on with our knowledge base in medicine, that number will diminish.
Q. How is it that you know that cerebral palsy from which this child suffers from cannot be one of the majority of those cases for which there is not an explanation?
A. Because the majority of the causes from which there is no explanation are due to events that occurred during the pregnancy. Here we have a child with an acute neurologic syndrome showing evidence of multi-organ system dysfunction, having an MRI scan that dates the event to have occurred in a term child showing acute abnormalities on EEG. This is not an event that occurred prior to the birth process.

In other words, this is not something that happened at age 28 weeks, 26 weeks, 32 weeks, 36 weeks. It didn't happen then. All

the evidence points to an event that occurred during the birth process.

Q. Or at least by time of full maturation of the fetus?

A. During the birth process.

Q. Well, I am not going to go over that aspect again.

Some questions about Chelsea: Do you claim to be able to predict with any degree of certainty how she will develop starting from an orthopedic standpoint?

A. I think I can address general questions, yes.

Q. Tell me your view of her anticipated course of physical health?

A. She is going to be left with permanent neuromotor abnormalities. In other words, she has evidence of a spastic quadriplegia. That's going to be there even as she gets older. I am concerned if she is going to be able to walk.

Q. Do you know whether she will be able to walk or not?

A. I can't comment at this point in time. If she is not walking now, I would argue more likely than not she won't.

Q. Do you know whether she will be able to be

employed in the future?
A. It depends on her cognition.
Q. Do you have any information concerning her cognition status?
A. General.
Q. And what is your understanding?
A. Her cognition is much better than her motor function.
Q. On what do you base that understanding?
A. When she was younger, she had language evaluations. Round numbers, when she was at about 30 months of age, it was stated that her receptive language skills were approximately at a 20-month level.

Actually, at 30 months of age -- I am sorry -- three years of age, she had receptive language skills of about two years. That's not bad. It is much better than what her motor function was at the time. I don't have any information after that time with any reliable sort. I really can't comment further.

Q. Do you know whether or not her motor behavior has improved since the time that you saw her?
A. Yes.
Q. Yes, you know, or yes, it has improved?

A. To both.
Q. Do you expect that it will continue to improve?
A. Yes.
Q. Would you agree that it is uncertain as to how far she will continue to improve?
A. Could you define "uncertain"?
Q. We don't know.
A. Is she going to walk normally? No.

Might she be able to walk slowly, independently if according to the record from November of '95 she is using a walker and able to ambulate with a walker, the answer is yes.

Will she have a normal gait and be able to run? The answer is no.

Is that the kind of questions you are asking?

Q. She will be able to live by herself as an adult.
A. No. I don't think you can say that at this point in time.
Q. Can you say that she will not be able to?
A. Depends on her level of motor function and her level of self-help skills. So I can't comment at this point in time.
Q. She will be able to have some type of

employment based on your understanding of her cognitive abilities.

A. If she has adequate cognitive abilities, she might be able to do something. Will she be able to do what she was destined to do? I don't know.

Even if her motor function is markedly impaired, she might be able to do some sorting, activities of that type, but I don't -- it is very difficult to make that kind of a statement. I do know she won't be able to hold the job she would have been able to hold if that's what you are asking.

Q. And what job?

A. She doesn't have the motor dexterity or communication abilities. She is at five years talking in phrases when I would expect her to be talking in complete sentences, so, you know, she has impairments of sufficient degree to interfere with her functioning in the future.

Q. Doctor, what have you reviewed in anticipation of your deposition today?

A. The medical records.

Q. I mean, what -- all? You probably don't know if it is all.

A. I will tell you what I did review. I reviewed the obstetrician's office chart on Chelsea's mother. I reviewed the labor and delivery records for Chelsea. I reviewed the 4-23-92 admission to the hospital for Chelsea, including what was provided to me within that grouping. I reviewed Dr. Kolovsky's records from 4-24-92 to 11-6-95. I reviewed Dr. Spirotos' records. And I reviewed my note, and I had previously reviewed the X-ray studies that had been done, the original CT scan that we discussed before, the consent CT scan, and the subsequent MRI.

Q. Did you make any kind of notes or anything when you were reviewing these various records?

A. Yes.

Q. Do you have those with you?

A. Yes.

Q. Could I take a look at them?

A. You are welcome to.

Q. Will I be able to read them?

A. You tell me.

Q. I think they are surprisingly legible.

(Pause.)

Other than those records and these

notes, have you been provided with any other summaries of the case or letters setting forth the facts of the case that you used?

A. None.

Q. Do you have any file in this case other than the notebook with all the records there?

A. I have a hospital chart that contains the letter that you know about --

Q. Your letter?

A. Yes, my letter, the CT scan report from 1995 and the MRI report from 1994.

Q. Have you kept track of how much time you spent reviewing these records or authoring your report?

A. Just broadly.

Q. I mean in writing.

A. No.

Q. How much time would you say you have spent?

A. Total?

Q. Excluding the deposition this evening.

A. In terms of going through the records and everything else like that?

Q. Yes, and formulating your opinions.

A. Formulating, I don't know, four hours.

Q. Have you rendered any billing statements for

the services you have rendered yet in this case?

A. No.

Q. And that will be done on an hourly basis I assume then?

A. Yes.

Q. And I forget, what is your standard charge?

A. You didn't ask.

Q. I think I was told by Mr. Lancione's office.

A. $250 an hour for review of records and $350 an hour for deposition and trial testimony.

Q. I doubt that we are going to have the opportunity to meet to discuss this case again between now and the time that the trial starts.

Would it be a correct statement, Doctor, that we have had the opportunity to discuss those opinions which you will be rendering at this trial during the course of the deposition?

A. Yes.

Q. I mean, are there other things that you anticipate you will be telling the jury about that I have neglected to ask you?

A. Not that I can recollect at this point in time.

Q. Okay. Then I am done. Thank you.

MR. LANCIONE: Do you want to read it?

THE WITNESS: Yes.

(Signature not waived.)

(Deposition concluded at 8:35 p.m.)

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I have read the foregoing transcript from page 1 through 70 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____
Max Wiznitzer, M.D.

Subscribed and sworn to before me this_____day of_____, 1996.

_____
Notary Public

My commission expires: _____

- - -

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

I, George J. Staiduhar, a Court Reporter in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, Max Wiznitzer, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy/computer in the presence of said witness, afterward transcribed by me, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 14th day of October, 1996.

_____
George J. Staiduhar, Notary Public in and for the State of Ohio. My commission expires July 3, 1997.

FINCUN-MANCINI - - THE COURT REPORTERS