BEFORE THE SUPREME COURT OF THE STATE OF NEVADA

ALI PIROOZI, M.D., Petitioner, v. THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK; AND THE HONORABLE JAMES BIXLER, DISTRICT COURT JUDGE, Respondent(s), and TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST; MARTIN BLAHNIK, M.D., Real Party in Interest.	Supreme Court Case No.: EJDC Case No. A-10-616728-C

RESPONDENT ALI PIROOZI, M.D.'S APPENDIX VOL 2

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VOLUME 1

DOCUMENT TITLE **EXHIBIT**

VOLUME 2

VOLUME 3

VOLUME 4

CERTIFICATE OF MAILING

I HEREBY CERTIFY that, on the 4th day of February 2014, and pursuant to NRCP 5(b), I deposited for mailing in the U.S. Mail a true and correct copy of the foregoing **RESPONDENT ALI PIROOZI, M.D.'S APPENDIX**, postage prepaid and addressed to:

The Honorable Judge James Bixler
The Eighth Judicial District Court
Regional Justice Center
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CLERK OF THE COURT

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DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST, Plaintiffs, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC, MARTIN BLAHNICK, M.D., ALI PIROOZI, M.D., RALPH CONTI, M.D. and FOOTHILL PEDIATRICS LLC, Defendants.	CASE NO. A616728 DEPT NO. XXIV

DEFENDANT SUNRISE HOSPITAL AND MEDICAL CENTER, LLC'S MOTION FOR SUMMARY JUDGMENT

COMES NOW, Defendant SUNRISE HOSPITAL AND MEDICAL CENTER, LLC (hereinafter "Sunrise Hospital"), by and through its attorneys, HALL PRANGLE & SCHOONVELD, LLC, and hereby moves this Honorable Court for Summary Judgment.

This Motion is made and based upon the papers and pleadings on file herein, the points and authorities attached hereto and such argument of counsel which may be adduced at the time of hearing such Motion.

DATED this 1st day of October, 2013.

HALL PRANGLE & SCHOONVELD, LLC

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NOTICE OF MOTION

TO: ALL INTERESTED PARTIES AND THEIR COUNSEL OF RECORD

PLEASE TAKE NOTICE that Defendant Sunrise Hospital will bring the foregoing **MOTION FOR SUMMARY JUDGMENT** on for hearing before the above-entitled Court on the 6 day of NOVEMBER, 2013, at the hour of 9 AM a.m. of that day, or as soon thereafter as counsel may be heard.

DATED this 1st day of October, 2013.

HALL PRANGLE & SCHOONVELD, LLC

By: _____

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MEMORANDUM OF POINTS AND AUTHORITIES

I.

STATEMENT OF UNCONTESTED FACTS

The Complaint arises out of medical care provided to MayRose Hurst from March to August 2008, at Sunrise Hospital. On May 14, 2008, MayRose was delivered at Sunrise Hospital. Her mother, Plaintiff Tiffani Hurst, was only at twenty-eight weeks gestation, thus MayRose was over three months premature. MayRose was immediately admitted to the Neonatal Intensive Care Unit ("NICU") under the care of Defendant Dr. Blahnick.

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Over her three month course in the NICU, MayRose had numerous medical issues, including a bowel perforation, internal bleeding, sepsis, numerous surgical procedures, and intubation. *See* Neonatal Discharge Summary, attached hereto as Exhibit A. MayRose also had eleven blood transfusions due to these numerous issues she battled in the NICU.

On August 2, 2008, MayRose was discharged home by Defendant Dr. Piroozi. Her mother was given a copy of the Discharge Summary and promptly made an appointment with MayRose's pediatrician, Defendant Dr. Conti. *Ex. A.* The first appointment with Dr. Conti was on August 5, 2008. *See* Dr. Conti's Note for August 5, 2008, FP00005, attached hereto as Exhibit B. Plaintiffs Tiffani Hurst and Brian Abbington attended this appointment, handed Dr. Conti a copy of the Discharge Summary and discussed MayRose's NICU admission and the follow-up care recommended in the Discharge Summary by the NICU physicians. However, the recommended follow-up blood test in the Discharge Summary of a CBC, Dif and Retic count ("Blood Count") in 30 days was never discussed. Dr. Conti assessed her to be a "well child." *Ex. B.* MayRose returned to Dr. Conti's office for four additional visits over the next three months and the recommended blood test was never ordered. *See* Notes from Foothill Pediatrics for September 9-October 18, 2008, FP00006-9, attached hereto as Exhibit C. In each visit, MayRose is documented as either a "well child" or to have a minor cold. *Ex. C.*

On October 24, 2008, MayRose once again was at Dr. Conti's office for a "sick visit". *See* Note from Foothills Pediatrics for October 24, 2008, FP00010, attached hereto as Exhibit D. Dr. Weber, another practitioner at Dr. Conti's office, examined MayRose and ordered a Blood Count to rule out a viral infection. *Ex. D.* MayRose had this lab drawn four days later on October 28, 2008. On October 29, 2008, MayRose went into anemic shock and was taken to

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Summerlin Hospital. It was later determined that MayRose had suffered a significant brain injury due to the anemic shock.

After several weeks at Summerlin Hospital, MayRose continued her medical care at Denver Children's Hospital. It was not until nearly a year later that doctors were able to confirm MayRose had a very rare form of anemia called Diamond Blackfan Anemia.

It is uncontested that Defendants Drs. Blahnick and Piroozi ("the NICU doctors"), would not be capable of diagnosing MayRose's Diamond Blackfan Anemia during her NICU admission. *See* Stipulation and Order Regarding Certain Trial Evidentiary/Procedural Rulings, attached hereto as Exhibit E. It is also uncontested that MayRose's discharge from the NICU was within the standard of care as she did not require any further hospitalization. *Ex. E.*

However, Plaintiffs' experts argue that the NICU doctors fell below the standard of care by 1) allegedly not investigating a possible pathological reason for MayRose's eleven blood transfusions in the NICU and 2) in the Discharge Summary not emphasizing MayRose's anemia and ordering a Blood Count sooner than 1 month after discharge. *See* Plaintiffs' Expert Report from Dr. Hermansen (NICU doctor), attached as Exhibit F; *See* Plaintiffs' Expert Report from Dr. Strouse (hematologist), attached as Exhibit G. Yet, all the experts agree that had Defendant Dr. Conti ordered the Blood Count as recommended by the NICU doctors in the Discharge Summary that was handed to Dr. Conti at MayRose's initial visit, MayRose's brain injury more likely than not would have been prevented. *Ex. G.*

Despite Plaintiffs' allegations of breaches in the standard of care, Plaintiffs fail to demonstrate that these alleged breaches were the proximate or actual cause of MayRose's brain injury on October 29, 2008, nearly three months after discharge. Further, it is uncontested that the NICU doctors' recommendations, had Dr. Conti followed them, could have prevented this

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injury. Therefore, as there is no issue of fact as to the proximate and actual cause of MayRose's injury, summary judgment is proper and Sunrise Hospital should be dismissed.[1]

II.

STANDARD OF REVIEW

As this Court is aware, "[s]ummary judgment is appropriate and 'shall be rendered forthwith' when the pleadings and other evidence on file demonstrate that no 'genuine issue as to any material fact [remains] and that the moving party is entitled to a judgment as a matter of law.' " *Wood v. Safeway, Inc.*, 121 Nev. 724, 729, 121 P.3d 1026, 1029 (2005) (internal citations omitted). "When a motion for summary judgment is made and supported as required by NRCP 56, the non-moving party may not rest upon general allegations and conclusions, but must, by affidavit or otherwise, set forth specific facts demonstrating the existence of a genuine factual issue. 'The non-moving party's documentation must be admissible evidence,' as 'he or she 'is not entitled to build a case on the gossamer threads of whimsy, speculation and conjecture.' " *Pegasus v. Reno Newspapers, Inc.*, 118 Nev. 706, 713-714, 57 P.3d 82, 87 (2002) (internal citations omitted).

. . .

. . .

. . .

[1] Dr. Conti settled with Plaintiffs and is no longer a defendant in this matter. Further, it is uncontested that the only claim against Sunrise Hospital is for agency/vicarious liability for the conduct of the NICU doctors, Defendants Dr. Blahnick and Dr. Piroozi only, and not for Dr. Conti. *Ex. E*; *See also* the Complaint.

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III.

LEGAL ARGUMENT

A. Plaintiffs' Experts' Opinions as to Causation Are Not Permitted by Nevada Law

Pursuant to NRS 41A.100(1), medical expert testimony is required to establish the accepted standard of care, a breach of that standard and causation. The Nevada Supreme Court in *Banks v. Sunrise Hospital* discussed the requirements for establishing causation:

> Generally, "a medical expert is expected to testify only to matters that conform to the reasonable degree of medical probability standard." [citation omitted] In *United Exposition Service Co. v. SIIS*, we concluded that a finding of negligence in a medical malpractice case "cannot be based solely upon possibilities and speculative testimony." In *United Exposition*, we stated that "[a] testifying **physician must state to a degree of reasonable medical probability that the condition in question was caused by the industrial injury**, or sufficient facts must be shown so that the trier of fact can make the reasonable conclusion that the condition was caused by the industrial injury." We determined that the speculative nature of the expert's opinion that the injury " **'possibly could have been' " a precipitating factor was insufficient to support a finding of causation** between the defendant's negligence and the plaintiff's injuries.

Banks ex rel. Banks, 120 Nev. at 834-835, 102 P.3d at 61 (quoting *United Exposition Service Co. v. SIIS,* 109 Nev. 421, 424, 851 P.2d 423, 425 (1993)) (emphasis added).

In the present case, Plaintiffs offer two experts to testify that the alleged breaches in the standard of care by the NICU doctor caused MayRose's injury. However, both expert opinions are based on an inaccurate assumption that is completely contrary to the facts and sworn testimony. As such, this testimony should be stricken and summary judgment granted.

1. The Plaintiffs' Experts' opinions are based on false assumptions and should be stricken.

NRS 50.275. Testimony by Experts

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as

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> an expert by special knowledge, skill, experience, training or education may testify to matters within the scope of such knowledge

The admissibility of expert opinions was discussed in detail in *Hallmark v. Eldridge*. The Nevada Supreme Court produced the following criteria for the Court to analyze when determining whether an expert's opinion should be admitted:

> To testify as an expert witness under NRS 50.275, the witness must satisfy the following three requirements: (1) he or she must be qualified in an area of "scientific, technical or other specialized knowledge" (the qualification requirement); **(2) his or her specialized knowledge must "assist the trier of fact to understand the evidence or to determine a fact in issue" (the assistance requirement)**; and (3) his or her testimony must be limited "to matters within the scope of [his or her specialized] knowledge" (the limited scope requirement).

Hallmark v. Eldridge, 124 Nev. 492, 498, 189 P.3d 646, 650 (Nev. 2008) (emphasis added). In the instant case, "the assistance requirement" is being called into question. The Nevada Supreme Court provided the following factors to analyze this prong of the test:

> In determining whether an expert's opinion is based upon reliable methodology, a district court should consider whether the opinion is (1) within a recognized field of expertise; (2) testable and has been tested; (3) published and subjected to peer review; (4) generally accepted in the scientific community (not always determinative); and **(5) based more on particularized facts rather than assumption, conjecture, or generalization**.

Id., 124 Nev. at 500-502, 189 P.3d at 651 – 652 (emphasis added).

In this case, Dr. Hermansen's and Dr. Strouse's opinions will not assist the trier of fact because their opinions are based upon a false assumption. "Just because a witness may be qualified as an expert does not automatically qualify him to give an opinion necessarily based on facts beyond his knowledge even though the opinion may be within the range of his expertise." *Choat v. McDorman*, 86 Nev. 332, 335 (1970). Opinion testimony should not be received if shown to rest upon assumptions rather than facts. *Wrenn v. State*, 89 Nev. 71, 506 P.2d. 418 (1973); citing *Choat v. McDorman*, 86 Nev. 332, 335, 468 P.2d. 354 (1970). Such expert

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opinions may not be the result of guesswork or conjecture. *Id.*, citing *Beasley v. State*, 81 Nev. 431, 436, 404 P.2d. 911 (1965).

In *Wrenn*, the District Court precluded engineers from offering expert opinions where the validity of their opinions rested upon several assumed facts which were not established to have been the actual facts of the alleged homicide. The Supreme Court affirmed; since the probative value of the engineering calculations and resulting conclusions depended upon the accuracy of the facts they ***had assumed to be true***, the trial judge properly precluded their opinion testimony. *Id.*, citing *Levine v. Remolif*, 80 Nev. 168, 390 P.2d. 718 (1964); *Choat v. McDorman*, 86 Nev. 332, 468 P.2d. 354 (1970); and *Beasley v. State*, 81 Nev. 431, 404 P.2d. 911 (1965).

When the opinion of an expert is based on erroneous assumptions of fact or law, the evidence is insufficient to support a verdict. *United States v. 319.88 Acres of Land*, 498 F.Supp. 763, 766 (Nevada 1980). Moreover, the Nevada Supreme Court has noted that if a medical expert cannot form an opinion with sufficient certainty as to make a medical judgment, there is nothing on the record with which a jury can make a decision with sufficient certainty so as to make a legal judgment. *Morsicato v. Sav-On Drug Stores, Inc.*, 121 Nev. 153, 158, 111 P.3d. 1112, 1116 (2005). Medical expert testimony regarding the standard of care and causation must be stated to a reasonable degree of medical probability. *Id.* Expert testimony on causation or standard of care which is speculation and conjecture fail to meet the requisite standard of care for expert testimony. *Id.*

In this case, the Court must preclude Dr. Hermansen and Dr. Strouse from misleading the jury with an opinion that the alleged breaches in the standard of care by the NICU doctors would have changed the outcome when it is based upon the false assumption that Dr. Conti would have followed the NICU doctors' recommendations. Dr. Conti specifically stated that it would not

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have mattered what the NICU doctors recommended in the Discharge Summary, he would have done what he felt best.

> Q: In any event, whether you read [the Discharge Summary] or whether you didn't, you did not comply with the NICU doctors' request that you draw a [Blood Count] 30 days after discharge. Correct?
>
> ...
>
> A: I did not order [the Blood Count] at the time. We order what the child needs and nothing more.
>
> Q: And it was your opinion, based on your examination of MayRose, that she did not require a follow-up [Blood Count]. Correct?
>
> A: Yes.

See Deposition Transcript of Dr. Conti, attached hereto as Exhibit H, 130:19-131:9. Therefore, the complete assumption by Dr. Hermansen and Dr. Strouse that had the Discharge Summary stated further recommendations regarding MayRose's anemia would have changed the later outcome, is not based on facts and should not be permitted. Further, this assumption is blatantly false in that the recommendations regarding MayRose's anemia that ***were in*** the Discharge Summary were ignored. The NICU doctors recommended a Blood Count that Dr. Conti testified he purposefully chose not to order because he did not feel she "needed" it. *Id.*

Please note, Dr. Conti has since passed away. All parties have stipulated to using his deposition transcript at trial. *Ex. E.* Therefore, Dr. Conti's testimony **will not change**.

Therefore, the purpose of an expert at trial is to assist the jury in explaining the facts or an issue. NRS 50.275. *Hallmark* states these opinions **may not** be based on assumptions or conjecture. *Hallmark,* 124 Nev. at 500-502, 189 P.3d at 651–652. In this instance, Plaintiffs' experts will mislead the jury by stating that the NICU doctors caused this injury. This opinion is misleading because Plaintiffs' experts causation opinion relies on the false assumption that Dr. Conti's actions could have been changed. Dr. Conti specifically testified that he did not follow the Discharge Summary, regardless of what it recommended. In fact, he ignored the

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recommendations that were in the Discharge Summary. As Plaintiffs' experts' causation opinion relies entirely on a false assumption, that is not an issue of fact, their opinions should be stricken.

2. Summary Judgment is proper as Plaintiffs lack the necessary causation element to sustain a claim against the NICU doctors.

As previously stated, NRS 41A.100(1) requires medical expert testimony to establish causation. Plaintiffs' experts' opinions should be stricken as based on false assumptions and misleading. Therefore, Plaintiffs cannot establish the necessary element of causation linking the NICU doctors to MayRose's injury.

Summary judgment is proper and this matter should be dismissed with prejudice.

B. The Alleged Breaches in the Standard of Care by the NICU Doctors were Not the Actual or Proximate Cause of MayRose's Injury.

"To prevail in a medical malpractice action, the plaintiff must establish the following: (1) that the doctor's conduct departed from the accepted standard of medical care or practice; (2) that the doctor's conduct was both the actual and proximate cause of the plaintiff's injury; and (3) that the plaintiff suffered damages." *Prabhu v. Levine*, 112 Nev. 1538, 1543, 930 P.2d 103, 107 (1996) (emphasis added). Actual cause is not merely the existence of an injury, nor the existence of breaches in the standard of care:

> To show that the actual cause of death was colon cancer, the heirs produced the death certificate, which listed colon cancer as the cause of death. However, **a prima facie case of medical malpractice is not demonstrated upon the presentation of evidence that a patient died after a doctor breached an established standard of care.** The heirs also had to show that Dr. Daines' conduct was the legal cause of Fernandez's death. In *Sims v. General Telephone & Electronics*, 107 Nev. 516, 524-25, 815 P.2d 151, 156 (1991), this court stated that **"[e]ven where it has been established that defendant's conduct has been one of the causes of plaintiff's injury, there remains the question of whether defendant will be legally responsible for the injury,"** the main consideration in such circumstances being foreseeability. The standard in a medical case concerning the causation of death is "reasonable medical probability." *Perez v. Las Vegas Medical Center*, 107 Nev. 1, 6, 805 P.2d 589, 592 (1991). *See Brown v. Capanna*, 105 Nev. 665, 671-72, 782 P.2d 1299, 1304 (1989).

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Fernandez v. Admirand, 108 Nev. 963, 972-973, 843 P.2d 354, 360 - 361 (1992) (emphasis added). Thus, Plaintiffs must link a deviation in the standard of care by the NICU doctors to MayRose's injury. *See Perez v. Las Vegas Medical Center,* 107 Nev. 1, 4, 805 P.2d 589, 591 (1991) ("that the alleged medical malpractice actually caused the harm complained of.")

In this instance, Plaintiffs' experts state that the NICU doctors breached the standard of care by 1) allegedly not investigating a possible pathological reason for MayRose's eleven blood transfusions and 2) in the Discharge Summary, not emphasizing MayRose's anemia and ordering a Blood Count sooner. *Exs. C* and *D.* However, these alleged breaches in the standard of care were not the actual or proximate cause of MayRose's brain injury.

1. Dr. Conti was an Intervening Superseding Cause that Cuts Off the Liability for the NICU Doctors and Sunrise Hospital.

The Nevada Supreme Court discussed the application of "intervening superseding cause" in *Bower v. Harrah's Laughlin, Inc.*, 125 Nev. 470, 491-493, 215 P.3d 709, 724 - 725 (2009). In *Bower*, bystanders to a brawl between biker gangs brought claims against Harrah's for the resultant conduct of Metropolitan Police Department ("Metro").

> To prevail on their negligence claims, Garcia and Lewis must prove that Harrah's was the cause in fact and the foreseeable cause of their harm. Harrah's was the **actual cause of appellants' harm if its actions were a substantial factor in bringing about their injury**. On the other hand, foreseeability is a policy concern that limits Harrah's liability to only those harms with a reasonably close connection to its breach. **An intervening act will only be superseding and cut off liability if it is unforeseeable.** Thus, under *Doud*, we must examine whether Metro's acts were foreseeable, such that they were not superseding intervening events that would preclude Harrah's liability.

Id. The Court ultimately held that Metro was an intervening superseding cause applying the definition from the Restatement (Second) of Torts § 442 (1965) and applying the following factors:

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> To determine whether an intervening cause is foreseeable, we consider several factors. These include whether (1) the intervention causes the kind of harm expected to result from the actor's negligence, (2) the intervening event is normal or extraordinary in the circumstances, (3) the intervening source is independent or a normal result of the actor's negligence, (4) the intervening act or omission is that of a third party, (5) the intervening act is a wrongful act of a third party that would subject him to liability, and (6) the culpability of the third person's intervening act. Restatement (Second) of Torts § 442 (1965). When a third party commits an intentional tort or a crime, the act is a superseding cause, even when the negligent party created a situation affording the third party an opportunity to commit the tort or crime. *Id.* § 448. In such a scenario, the negligent party will only be liable if he knew or should have known at the time of the negligent conduct that he was creating such a situation and that a third party "might avail himself of the opportunity to commit such a tort or crime."

Id. The Court determined that Metro's intentional conduct by detaining plaintiff and leaving her breast exposed, was not a foreseeable consequence of Harrah's alleged negligence in keeping its patrons safe from the brawl or having their stay uninterrupted. *Id.*

In this instance, the conduct of Dr. Conti, or lack thereof, in not ordering the Blood Court as recommended by the NICU doctors in the Discharge Summary was an intervening superseding cause. First, Plaintiffs' experts agree that had Dr. Conti followed the NICU doctor's recommendations, to obtain a Blood Count one month following discharge, the injury more likely than not would have been prevented.

> Q: But you agree if the pediatrician in this case had ordered the recommended tests for Mayrose within one month of her discharge that that likely would have shown some anemia?
>
> A: I think it would have almost certainly shown significant anemia.
>
> **Q: And would you agree with me if that pediatrician had ordered those tests and looked at the results that the episode of profound anemia here could have been prevented?**
>
> **A: I do.**
>
> ....
>
> Q: The practical matter is, if once the child's in the pediatrician's hands, whether he had diagnosed it in two weeks or thirty days, still would have had the same outcome here if he doesn't do the test, correct?
>
> A: That is true.

See Plaintiffs' expert hematologist, Dr. Strouse's, deposition transcript, 50:5-15 and 55:12-17, attached hereto as Exhibit I (emphasis added). In fact, Dr. Strouse wrote in his expert report:

> [T]he **episode of profound anemia could also have been prevented if the complete blood count that was recommended at 1 month had been obtained**, because, with a reasonable degree of medical certainty, she would have been anemic one month after discharge given her hematocrit of 30% on 8/1/12 [sic] and a typical rate of decrease in the hematocrit of ~9% per month.

Ex. G (emphasis added).

Second, Plaintiffs' expert testified that it was reasonable for the NICU doctors to rely on the pediatrician to follow through with their recommendations after the pediatrician assumed care:

> Q: Okay. Would you expect – at least, based on the recommendations here – would you expect a competent pediatrician to actually order and assess the complete blood count and retics recommended by Doctor Piroozi within one month post-discharge?
> A: Yes.

Ex. I, 50:21-51:6. Further, Plaintiffs' experts agree that once MayRose was discharged from the NICU, and Dr. Conti had taken over care, the NICU doctors were no longer responsible if Dr. Conti chose to ignore their recommendations:

> ... if I've come up with a good plan [discharge plan] and get that plan into the pediatrician's functions, to get the pediatrician aware of the plan, agreeing to the plan and taking it over, I think the neonatologist is off the care at that point.
> Q: Okay. And once you've done that and gotten the plan into the hands of the pediatrician, if subsequently the pediatrician decides to ignore portions of your plan but doesn't tell you, do you think you're responsible for the conduct?
> A: Not if I've given him a good plan and communicated it. If I've done those then – and – no, I don't feel responsible if they go on their own route.

See Deposition Transcript of Plaintiff's Expert NICU Physician, Dr. Hermansen, 32:14-33:3, attached as Exhibit J.

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Lastly, Dr. Conti testified that he had the Discharge Summary in his possession during the time he treated MayRose prior to her injury.

> Q: And in response to request for admission number two, you acknowledged that your office was provided with the [Discharge Summary], that you did receive those?
> A: Yes.
> ...
> Q: Well, if you had it when you assumed care of MayRose Hurst, you would have seen that you were being asked by the NICU doctors to follow up with her [Blood Count] within 30 days?
> A: Yes.

Ex. H, 118:25-119:22.

Not only did Dr. Conti have the Discharge Summary in his possession, but he actively chose ignore these recommendations:

> Q: In any event, whether you read [the Discharge Summary] or whether you didn't, you did not comply with the NICU doctors' request that you draw a [Blood Count] 30 days after discharge. Correct?
> ...
> A: I did not order [the Blood Count] at the time. We order what the child needs and nothing more.
> **Q: And it was your opinion, based on your examination of MayRose, that she did not require a follow-up [Blood Count]. Correct?**
> **A: Yes.**

Ex. H, 130:19-131:9. Of note, Dr. Conti treated MayRose for nearly **three months** and **six appointments** following her discharge from the care of the NICU doctors and before her injury occurred. Not once in those *three months* and *six* visits, was a Blood Count ordered by Dr. Conti.

Therefore, the Discharge Summary on its own, despite the alleged breaches in the standard of care regarding its content, is uncontested to contain a recommendation that would have **prevented** this injury. It is uncontested that Dr. Conti had this Discharge Summary at the time he cared for MayRose prior to the injury. It is further uncontested that the NICU Doctors

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can rely on the pediatrician to follow these instructions. Lastly, it is uncontested that had Dr. Conti followed the recommendations within the Discharge Summary "the **episode of profound anemia could also have been prevented".** *Ex. G* (emphasis added).

Based on the uncontested facts and testimony of *Plaintiffs'* experts, Dr. Conti was a superseding intervening cause. First, the conduct of the NICU doctors was not a substantial factor in bringing about MayRose's injury, and was in fact, as stated by Plaintiffs' own experts the recommendation that may have **prevented** this injury. Second, all six factors listed in the Restatement (Second) of Torts § 442 (1965) demonstrate this was unforeseeable:

> "(1) the intervention causes the kind of harm expected to result from the actor's negligence," **(It was not expected that Dr. Conti would choose to ignore the recommendations; it was reasonable to rely on Dr. Conti to follow the NICU doctors' recommendations)**
>
> "(2) the intervening event is normal or extraordinary in the circumstances," **(Extraordinary - Plaintiffs' experts testified that the NICU doctors may rely on the pediatrician to follow their recommendations; Dr. Conti failed to follow these recommendations after three months of care and six appointments, and testified he chose to ignore these recommendations)**
>
> "(3) the intervening source is independent or a normal result of the actor's negligence," **(Independent - Dr. Conti's conduct was the direct opposite of the NICU doctors' recommendations)**
>
> "(4) the intervening act or omission is that of a third party," **(It is uncontested that Dr. Conti was not affiliated with the NICU doctors or Sunrise Hospital)**
>
> "(5) the intervening act is a wrongful act of a third party that would subject him to liability, and" **(Dr. Conti was a defendant in this action based on his failure to conduct the follow up testing recommended by the NICU doctors)**
>
> "(6) the culpability of the third person's intervening act." **(Dr. Conti's failure to perform the recommended tests is uncontested to be the primary cause of MayRose's injury)**

Restatement (Second) of Torts § 442 (1965).

Based on the foregoing, the uncontested evidence demonstrates as a matter of law that Dr. Conti was a superseding intervening cause in MayRose's injury. Therefore, the alleged

violations in the standard of care by the NICU doctors were not the actual or proximate cause of MayRose's injuries, and summary judgment is proper.

2. Plaintiffs are Not Claiming Negligence for a Failure to Diagnose Diamond Blackfan Anemia.

Plaintiffs' experts criticize the NICU doctors for not investigating the cause of MayRose's anemia. *Ex. F* and *G.* However, in the same breath, Plaintiffs' experts state that the true cause of her anemia, Diamond Blackfan, could *not* have been diagnosed in the NICU.

> **"Diamond-Blackfan anemia is not something I think would been diagnosed in the initial NICU stay, no matter what the evaluation would have been."**

Ex. I, 53:20-54:2 (emphasis added). In fact, Plaintiffs stipulated that Diamond Blackfan could not have been diagnosed in the NICU. *Ex. E.* Plaintiffs also state that MayRose's underlying condition of Diamond Blackfan caused her brain injury.

Therefore, the breach in the standard of care in allegedly not investigating the cause of MayRose's anemia while in the NICU is not the proximate or actual cause of her injury because it is uncontested that "no matter what the evaluation would have been" the diagnosis would not have been made. *Ex. I,* 53:20-54:2. As such, Plaintiffs cannot establish "that the alleged medical malpractice actually caused the harm complained of". *Perez,* 107 Nev. at 4.

As the claim is not a failure to diagnose Diamond Blackfan, and Plaintiffs agree that such a diagnosis could not have been made by these NICU doctors, yet Diamond Blackfan was the cause of her injury, Plaintiffs have not met the elements of professional negligence and summary judgment is proper.

. . .

. . .

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IV.

CONCLUSION

It is evident that the NICU doctors are not the actual or proximate cause of MayRose's injuries. First, Plaintiffs' experts' opinions are based on a false assumption. It is uncontested that even with the correct recommendations, which if followed would have prevented this injury, Dr. Conti chose not to follow. As these opinions are based on a false assumption, they must be stricken. Further, Dr. Conti's failure to follow these recommendations despite three months and six appointments with MayRose, is the superseding intervening cause of MayRose's injury. Dr. Conti's failure, not the NICU doctors, is the actual and proximate cause of damages in this case.

Lastly, this is not a failure to diagnose case. Plaintiffs stipulated and their experts agree that the underlying cause of MayRose's anemia **could not** have been diagnosed, "no matter what the evaluation would have been." *Ex. I*, 53:20-54:2. Thus, the failure to evaluate is similarly not the cause of MayRose's injuries.

Based on the foregoing, Sunrise Hospital respectfully requests this Court grant this Motion and issue an Order dismissing Sunrise Hospital with prejudice.

DATED this 1st day of October, 2013.

HALL PRANGLE & SCHOONVELD, LLC

By: _____

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 1st day of October, 2013, I served a true and correct copy of the foregoing **DEFENDANT SUNRISE HOSPITAL AND MEDICAL CENTER, LLC'S MOTION FOR SUMMARY JUDGMENT** in a sealed envelope, via U.S. Mail, first-class postage pre-paid to the following parties at their last known address:

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4850-0841-9350, v. 1

EXHIBIT "A"

8/2/2008 10:06

NEONATAL DISCHARGE SUMMARY

Hurst, baby girl
aka May Hurst
Mother: Tiffani Hurst
Birth weight: **1280 g** **(2 lbs, 13oz)**
Singleton Gestation

Neonatologist: **Martin Blahnik, M.D.**
Follow Up Physician: **Ralph M. Conti, M.D.**
Delivering Obstetrician:
Delivery date: 5/14/2008 time: 00:06
Discharge: 8/2/2008 Time: 12:00 LOS: 80 days

ADMISSION DIAGNOSES
Hypoglycemia (admit), Prematurity (admit), Respiratory distress (admit), Suspected sepsis (admit)

DIAGNOSES
Gastrointestinal perforation, Bowel perforation, Delayed gastric emptying, Slow feeder, pneumoperitoneum, Atelectasis, Germinal matrix bleed (grade 1), Anemia of prematurity, Jaundice due to prematurity, Sepsis suspected (>5 days therapy), Hypoglycemia (<40), Hyperphosphatemia, r/o mastoiditis

PROCEDURES & TREATMENTS
Intravenous fluids, Parenteral nutrition, Umbilical artery line, Umbilical venous line, Central venous line, PICC line, Continuous drip feeds, Gavage feeding, Gastric suction tube, Abdominal radiograph, Ileostomy, Exploratory Laparotomy, Broviac placement, Osteomy takedown, Motility agent(Erythromycin), Ranitidine, Ventilation, Oxygen, Continuous positive airway pressure, High flow nasal cannula oxygen, Chest X-Ray, Intubation, Surfactant, Caffeine, Head ultrasound, ROP screen immature, Red blood cell transfusion, Phototherapy, Platelet transfusion, Transfusion of coagulation factors, Lumbar puncture, Ampicillin and Gentamicin (#1), Antibiotics (1st course), Antibiotics (2nd course), Cefotaxime and Vancomycin (#3), Ampicillin and Cefotaxime (#4), Antibiotics (4th course), Vancomicin and Cefotaxime , Cefotaxime and Vancomycin (#6), Hib Vaccine, Pediatrix (DaPT/Hep B/inactive polio), Pneumococcal vaccine, Antifungal therapy, Analgesia / Sedation, Fentanyl drip, Morphine sulfate

MATERNAL HISTORY
May was born at 28 6/7 weeks (by dates) to a 39 year old woman who was G 3 and P 2 (TAB 1) at the time of delivery.

Prenatal Labs: Blood Type: **O** Rh: **pos** Antibody: **nonrespon** Hepatitis B: **negative**
Rubella status: **immune** RPR: **nonreactive** Length ROM: **Ruptured at delivery.**

GBS Status: **unknown**

Maternal diagnoses and procedures during the pregnancy, labor and delivery included:
Antepartum events: None noted. L&D events: Advanced Maternal Age (multiparous), Preterm labor with delivery, Terbutaline, Indocin, Steroids - complete course
Mom admitted 5/12 to the hospital. PTL w/ FHR decels and non-reassuring strip, AROM at the time of repeat C-section. AFI WNL. Pt admitted for flank pain / then non-reassuring FHR. Meds included PNV, beta-methasone, procardia, terbutaline, indocin, pitocin. Urine tox negative.

DELIVERY **Cesarean, unspecified** Apgars 1 min: **03** 5 min: **06** 10 min: **07**
Resuscitation: 02, mask vent
Martin Blahnik, M.D. was called to the delivery room because of Preterm baby. Delivery analgesia used: spinal. Suctioning at delivery: bulb. The respiratory effort at birth was delayed 1 min. Delivery outcome: live birth admitted to ICN.
CPAP given for poor respiratory effort. Pulse ox increase on 60% 02 to low 80s, then higher on CPAP so that 02 was weaned to less than 50% with good sats and improved respiratory effort after 5min.

ADMISSION HISTORY

NEONATAL DISCHARGE SUMMARY

ADMIT EXAM

Weight (g): 1280 (2 lbs, 13 oz) Length (cm): 37 Head circ (cm): 27.5 GA Exam: 28 6/7 wks AGA
VITAL SIGNS: Temperature: 36.8 Heart rate: 150 Respiratory rate: 30 Blood pressure: 40-40 / 18-20 Mean BP: 22-23 Oxygen saturation: 93
GENERAL: CPAP in place, immature infant, exam consistent with dates
SKIN: no icterus or rashes
HEAD: open, flat anterior fontanelle
EYES: normal shape and size
EARS: immature cartilage, normally set, no anomalies
NOSE & MOUTH: nares appear patent, intact palate
NECK & CLAVICLES: no masses, clavicles intact
LUNGS & CHEST: CTA with some grunting
CARDIAC: normal rate and rhythm, no murmurs, pulses equal in all 4 extremities
ABDOMEN & CORD: no hepatomegaly, 3 vessel cord
GENITALIA: immature female external genitalia, appropriate for age
BACK & SPINE: straight spine
LIMBS & HIPS: symmetric, moves all 4 limbs, 10 fingers and toes
NEUROLOGIC: appropriate strength and tone for gestational age

CUMULATIVE SUMMARY

May was cared for in the ICN for 80 days.The hospital course will be summarized by a problem list.

FLUID AND NUTRITION

Her nadir in weight was 1280 grams(2 lbs, 13oz) on 5/14/2008. She gained an average of 18 grams a day to a current weight of 2680 grams. A caloric intake of 80 kcal/kg or more was reached on day 7.
DIAGNOSES:
Hypoglycemia (<40) (5/14/2008 - 5/14/2008)
Gastrointestinal perforation (5/15/2008 - 5/16/2008)
Bowel perforation (5/15/2008 - 5/16/2008)
Hyperphosphatemia (6/16/2008 - 6/29/2008)
Delayed gastric emptying (7/2/2008 - 7/31/2008)
Slow feeder (7/29/2008 - 8/1/2008)

TREATMENTS:
Intravenous fluids (5/14/2008 - 6/18/2008)
Intravenous fluids (6/19/2008 - 6/27/2008)
Intravenous fluids (7/24/2008 - 7/26/2008)
Intravenous fluids (7/31/2008 - 8/1/2008)
Parenteral nutrition (5/14/2008 - 6/19/2008)
Parenteral nutrition (6/27/2008 - 7/6/2008)
Parenteral nutrition (7/25/2008 - 7/31/2008)
Umbilical artery line (5/14/2008 - 5/22/2008)
Umbilical venous line (5/14/2008 - 5/21/2008)
Central venous line (5/21/2008 - 5/27/2008) PICC placed by nursing, tip in subclavian near SVC
PICC line (7/5/2008 - 7/8/2008)
Central venous line (7/29/2008 - 8/1/2008)
Gavage feeding (5/25/2008 - 5/27/2008) Ileus 5/27, made NPO
Gavage feeding (6/10/2008 - 6/29/2008)
Gavage feeding (6/18/2008 - 7/1/2008)
Continuous drip feeds (7/5/2008 - 7/14/2008)
Gastric suction tube (5/15/2008 - 5/18/2008)

NEONATAL DISCHARGE SUMMARY

Abdominal radiograph (7/30/2008 - 7/30/2008)
Ileostomy (5/16/2008 - 7/26/2008)
Exploratory Laparotomy (5/16/2008 - 5/16/2008)
Broviac placement (7/26/2008 - 7/26/2008)
Osteomy takedown (7/24/2008 - 7/24/2008)
Ranitidine (6/29/2008 - 7/31/2008)
Motility agent(Erythromycin) (7/2/2008 - 7/22/2008)

RESPIRATORY

The highest oxygen percentage used was 55%.
DIAGNOSES:
pneumoperitoneum (5/15/2008 - 5/16/2008)
Atelectasis (5/16/2008 - 5/26/2008)

TREATMENTS:
Ventilation (5/15/2008 - 5/21/2008)
Ventilation (7/24/2008 - 7/26/2008) Reintubated for surgical reanastomosis
Oxygen (5/14/2008 - 6/29/2008)
Continuous positive airway pressure (5/14/2008 - 5/15/2008)
High flow nasal cannula oxygen (5/21/2008 - 5/29/2008)
High flow nasal cannula oxygen (6/7/2008 - 6/29/2008)
Chest X-Ray (5/14/2008 - 5/29/2008)
Intubation (5/14/2008 - 5/14/2008)
Surfactant (5/14/2008 - 5/14/2008)
Caffeine (6/23/2008 - 7/4/2008), 10 mg/day Given 20/kg load and 5/kg/day for increased alarms and periodic breathing with desaturations and decelerations

HEMATOLOGY

The initial hematocrit was 31% on 5/15/2008. The most recent hematocrit was 30% on 8/1/2008. She was given 5 transfusions. The blood type is O+. The DAT is negative. The highest bilirubin level was 10.34 mg/dl on 5/20/2008 The last bilirubin level was 2.8 mg/dl on 7/28/2008.
DIAGNOSES:
Anemia of prematurity (5/15/2008 - 7/21/2008)
Jaundice due to prematurity (5/16/2008 - 5/26/2008)

TREATMENTS:
Red blood cell transfusion (5/15/2008 - 6/23/2008), 2 times Transfused also 6/22
Phototherapy (5/16/2008 - 5/26/2008)
Phototherapy (5/28/2008 - 5/31/2008)
Platelet transfusion (5/15/2008 - 5/15/2008)
Transfusion of coagulation factors (5/15/2008 - 5/15/2008)

INFECTIOUS DISEASE

DIAGNOSES:
Sepsis suspected (>5 days therapy) (5/14/2008 - 6/21/2008)

TREATMENTS:
Lumbar puncture (6/24/2008 - 6/24/2008)
Ampicillin and Gentamicin (#1) (5/14/2008 - 5/24/2008)
Antibiotics (1st course) (5/15/2008 - 5/24/2008)
Antibiotics (2nd course) (5/30/2008 - 6/4/2008) vanco / cefotaxime for ileus/bilious emesis
Cefotaxime and Vancomycin (#3) (6/15/2008 - 6/21/2008)

8/2/2008 10:06

NEONATAL DISCHARGE SUMMARY

Ampicillin and Cefotaxime (#4) (6/22/2008 - 6/23/2008) Started on 6/22 for lethargy, increased CRP and left shift. Note: just completed Vanco and Claforan course 6/21-will watch closely and consider changing abx if poor respons
Antibiotics (4th course) (6/23/2008 - 7/4/2008) Vanco and Claforan switched to Meropenem, Tobra, and Ampho due to clinical worsening.
Vancomicin and Cefotaxime (7/6/2008 - 7/14/2008)
Cefotaxime and Vancomycin (#6) (7/24/2008 - 7/29/2008)
Hib Vaccine (8/1/2008 - 8/2/2008)
Pediatrix (DaPT/Hep B/inactive polio) (8/1/2008 - 8/2/2008)
Pneumococcal vaccine (8/1/2008 - 8/2/2008)
Antifungal therapy (6/27/2008 - 7/1/2008)

CARDIAC No issues

NEURO & SCREENING

The most recent neurological tracking showed: Head ultrasound: WNL on 5/18, subacute IVH G1 on 8/1, Eye exam: St 1, Z 2 bilaterally 7/24, Hearing test: due before discharge.

DIAGNOSES:
Germinal matrix bleed (grade 1) (8/1/2008 -)

TREATMENTS:
Head ultrasound (5/15/2008 - 7/31/2008), 2 exams 2nd HUS 5/18
ROP screen immature (7/3/2008 -)

GENITOURINARY No issues

MUSCULOSKELETAL No issues

GENETIC / ENDOCRINE No issues

ADDITIONAL ISSUES

r/o mastoiditis (7/6/2008 - 7/6/2008) CT showed normal mastoid air cells, soft tissue swelling posterior to left ear with no evidence abscess
Morphine sulfate (5/15/2008 - 5/18/2008)
Analgesia / Sedation (5/18/2008 - 5/26/2008) start fentanyl prn
Fentanyl drip (7/26/2008 - 7/27/2008)
Morphine sulfate (7/27/2008 - 7/29/2008)

Blood type: O+. DAT: negative
Social issues: Mom is comfortable to take care of the infant at home, discussed care with the family, family visiting frequently, discharge planning underway, over 30 minutes of discharge activities, mom is getting CPR classes prior discharge.
INTERIM Hx: good output, passed stool, no acute changes over last day, status improved, tolerates full feeds,

EXAM

Weight (g): 2680 (5 lbs, 14 oz) Length (cm): 45 Head circ (cm): 34
VITAL SIGNS: Temperature: 36.8 Heart rate: 135 Respiratory rate: 47 Blood pressure: 84 / 59 Mean BP: 69
Oxygen saturation: 100
GENERAL: alert and active, pink and well perfused
SKIN: no rashes
HEAD: open, flat anterior fontanelle
EYES: no anomalies, equal red relexes
EARS: normally set, no anomalies

8/2/2008 10:06

NEONATAL DISCHARGE SUMMARY

NOSE & MOUTH: nares patient, palate intact
NECK & CLAVICLES: no neck masses, intact clavicles
LUNGS & CHEST: no distress, clear and equal breath sounds
CARDIAC: normal rate and rhythm, no murmurs, good femoral pulses
ABDOMEN & CORD: soft, non-tender, no masses or organomegaly, drying cord
GENITALIA: normal external genitalia
BACK & SPINE: straight spine
LIMBS & HIPS: moves all 4 limbs, stable hips
NEUROLOGIC: normal suck, symmetric Moro, good strength and tone

Special considerations: 1) The infant requires a Sweat Chloride test by 3 months of age due to abnormal CF(IRT) newborn screening test. 2) The infant requires a Head U/S within 1 month after discharge to follow grade 1 subacute IVH.
State newborn screen: abnormal

PLANS

May was discharged to home on 8/2/2008.
The family was instructed to call Dr. Conti for an appointment in 3 days.
Additional appointments: 1) OT and PT follow ups.
2) Follow up with Peds Surgery, 2weeks after discharge.
3) Follow up with early intervention clinic 2weeks after dischrage.
4) Follow up with Peds. Ophthalmologist on 8/13/2008.
Feeding at discharge: MBM ad lib Po Q3-4.
Pending results: The infant requires a Sweat Chloride test by 3 months of age.
The infant requires a follow up Head U/S one months after discharge.
Follow-up tests: 1) Sweat test; 2) Head U/S; 3) CBC, Dif, Retic 1 month after discharge.
Discharge medications: Poly- Vi-Sol with iron 1ml po qd
Special Instructions to family: Peds ER if the infant develops any distress, T> 100.3, Poor appetite, or any unusual symptoms.

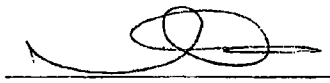

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EXHIBIT "B"

FOOTHILLS PEDIATRIC
WELL VISIT

Front Office DB

NAME Hurst, MayRose Doctor Conti Historian Mom DOB 5/14/08 Date AUG 05 2008 Nurse

CC Well check just discharged

Medications Ø Allergies NKDA

Age 3m HT 19¼, -5 % WT 5%, -5 % HC Birth to 2yrs. 34 / 90 % Temp

Birth WT 2.13

Visual Screen: R / L / HGB: % BP 3 yrs. & older : BMI 2 yrs. & older

SUBJECTIVE:
Feeds: BF
Stools: Well
Voids: Well (-)d,c,v, dys.
Sleeps: Well
Dev: (+)Smiles
Safety: Sepsis cough, temp>101, face rash, Eye d/c
Behavior: (-)colicky
Imm:
Concerns:

Objective:

	N	AB	
GEN	☒	☐	aans
Skin	☒	☐	~~S~~ Rash
Heent	☐	☐	TM's OP Clear
Dental	☐	☐	
Neck	☐	☐	
Chest	☐	☐	Clear
Lungs	☐	☐	
CVS	☐	☐	RRR
Abd	☐	☐	soft
GU	☐	☐	normal ♀
Rectal	☐	☐	
Extrem	☐	☐	
Back	☐	☐	
Neuro	☐	☐	

Assessment: Well Child Plan: RTC @ 4 months old

Tdap Dtap HIB IPV HBV MMR Varivax Menactra

Prev Hep A ROTA HPV PPD Dip-UA Hgb GLU

Flouride FLU

discussed

Safety: ☑
Audiopath / Vision Screen
Anticipatory Guidance/Behavior ☑
Follow up schedule:

Doctor Signature:

Urine Strip

Updated 6/12/08 APP113

EXHIBIT "C"

Summ

FOOTHILLS PEDIATRICS
WELL VISIT

Front Office ✓

Doctor Conti Nurse ✓

NAME MayRose Hurst Historian Parents DOB 5/14/08 Date SEP 09 2008

CC Well Check

Medications Vitamins Iron Allergies NKDA

Age 4mo HT 20 3/4 ↓5 % WT 8.0 ↓5 % HC Birth to 2yrs. 37 ↓5 % Temp ______

Birth WT ______

Visual Screen: R ____/____ L ____/____ HGB: ____% BP 3 yrs. & older ______ BMI 2 yrs. & older ______

SUBJECTIVE:
Feeds: 5oz Enfamil AR Lipil
Stools: Well (−) screams in pain
Voids: Well (−) d,v,c, dys (−) loss of weight.
Sleeps: Well (−) turning blue
Dev: (+) smiles (−) Rolls
Safety: H1 TOG FBO Mem Carseat. No pool
Behavior: (−) Colicky
Imm: UTD - Discussed.
Concerns: ______
Objective:

	N	AB	
GEN	✓	☐	AAS
Skin	✓	☐	S Rash
Heent	✓	☐	TM & OP Clear
Dental	✓	☐	
Neck	✓	☐	
Chest	✓	☐	Clear
Lungs	✓	☐	
CVS	✓	☐	S (M)
Abd	✓	☐	soft
GU	✓	☐	normal ♀
Rectal	✓	☐	
Extrem	✓	☐	
Back	✓	☐	
Neuro	✓	☐	

Assessment: Well Child Plan: RTC @ 6mo
Solids

Static Enceph Refer to PT, OT, ST
Radiologist MRI of Brain

Tdap (Dtap) MR (HIB) MR (IPV) MI HBV MMR Varivax Menactra

(Prev) MI Hep A (ROTA) MD HPV PPD Dip-UA Hgb GLU

Flouride FLU

Safety: ______ ✓
Audiopath / Vision Screen ______
Anticipatory Guidance/Behavior ______ discussed ✓
Follow up schedule: ______ ✓

Doctor Signature: RALPH CONTI MD

Urine Strip

Updated 6/12/08

APP115

FP 00006

Summ.

FOOTHILLS PEDIATRIC
SICK VISIT

SEP 30 2008

NAME HURST, MARYROSE HISTORIAN mom DOB 5/14/08 DATE
AGE 4mo WEIGHT 8.15 TEMP 98.3 NURSE TO FRONT (RPS)
MEDICATIONS Ø ALLERGIES NKDA
CC: Cough - Congestion -

Fever	(N)	Y	
URI	N	(Y)	
Cough	N	(Y)	
Vomiting	(N)	Y	
Diarrhea	(N)	Y	
Constip.	(N)	Y	
Pain	(N)	Y	
Rash	N	(Y)	flare
PO	~~Normal~~		Abn: ↑ ↓
UOP	Normal		Abn: ↑ ↓

Sd Hx Cough & congested

PMHx: Ø PSHx: (+) NEC HOSPITALIZATIONS Ø
FMHx: Ø (allergies) SxHx: daycare (Y (N)) smoke (Y (N)) pets (Y N)

OBJECTIVE

Gen: (AA NAD)
Skin: clear well perfused
HEENT:
- TM's (nl)
- Conjunctiva: (nl)
- Nose: nl
- Oropharynx: MMM
- Tonsils: (nl)

Neck: (supple)
Chest: (symm.)
Lungs: (CTA no W/R/R)
CVS: (RRR no murmur)
Abd: (soft, NT/ND BS+ no mass)
GU: NA (nl)
Rect: (NA) nl
Extrem: (MAE) FROM
Neuro: (no focal findings or change)

Exanthem: EMP Rash on face
abnl:
abnl:
abnl: congested
abnl: erythema
abnl:
abnl:
abnl:
abnl:
abnl:
abnl:
abnl:
abnl:
abnl:
abnl:

ASSESSMENT: Seborrhea
URI Cough pharyngitis

PLAN: RSV (—)
Usual URI treatment
1% HC Cream

RTC: If symptoms get worse or temp > 102°

PROCEDURE:

Pulse Ox: 99/179

Doctor Signature RALPH CONTI MD

Urine Strip

Updated 4/3/08

FOOTHILLS PEDIATRICS
WELL VISIT

Front Office _____

Doctor Conti Nurse _____

NAME Hurst, May Rose Historian mom DOB 5/14/08 Date OCT 01 2008

CC WCC

Medications _____ Allergies ~~0~~

Age 4mo HT 21 / 1 % WT 9-U / 1 % HC Birth to 2yrs. 35½ % Temp 97.8

Birth WT _____

Visual Screen: R _____ / _____ L _____ / _____ HGB: _____ % BP 3 yrs. & older _____ BMI 2 yrs. & older _____

SUBJECTIVE: ~~0~~

Feeds: Formula Stage 1

Stools: Well

Voids: Well (-) d,v,c, dys.

Sleeps: Well

Dev: ~~0~~ Smiles (-) Rolls

Safety: HI Mtg H2o therm carseat.

Behavior: (-) colicky

Imm: Discussed - UTD no- pool.

Concerns:

Objective:

	N	AB	
GEN	☑	☐	AAMS
Skin	☐	☐	Rash
Heent	☐	☐	TM's OP Clear
Dental	☐	☐	
Neck	☐	☐	
Chest	☐	☐	Clear
Lungs	☐	☐	
CVS	☐	☐	RRR (-) M.
Abd	☐	☐	Soft
GU	☐	☐	
Rectal	☐	☐	normal ♀
Extrem	☐	☐	
Back	☐	☐	
Neuro	☐	☐	

Assessment: Well Child Plan: RTC 6 mo

Tdap Dtap HIB IPV HBV MMR Varivax Menactra

Prev Hep A ROTA HPV PPD Dip-UA Hgb GLU

Flouride FLU

discussed

Safety: ☑

Audiopath / Vision Screen _____

Anticipatory Guidance/Behavior ☑

Follow up schedule: _____

Doctor Signature: RALPH CONTI MD

Urine Strip

Updated 6/12/08

APP117

FP 00008

FOOTHILLS PEDIATRIC Summ.

SICK VISIT

NAME Hurst, Mayrose HISTORIAN mom DOB 5.14.08 DATE OCT 18 2008
AGE 5mo WEIGHT 9.4 TEMP 97.3 NURSE Betsy FRONT (CHP)
MEDICATIONS Ø ALLERGIES NKDA
CC: Vomiting

Fever	(N)	Y	
URI	(N)	Y	
Cough	(N)	Y	
Vomiting	N	(Y)	X 8 yesterday
Diarrhea	(N)	Y	
Constip.	(N)	Y	
Pain	(N)	Y	
Rash	(N)	Y	
PO	(Normal)	Abn: ↑	↓
UOP	Normal	Abn: ↑	↓

vomiting x3 yesterday. last one then AM ~ 2 hours ago after nursing.
(+) wet diapers (3 in AM.
passing gas. had BM the day before.
Pertinent hx: ex preemie hx NEC.
older sib vomited 3 days ago.
nanny's children also vomited.

PMHx: _____ PSHx: _____ HOSPITALIZATIONS _____
FMHx: _____ (allergies) SxHx: daycare (Y N) smoke (Y N) pets (Y N)

OBJECTIVE

Gen: AA (NAD) not sick looking, not in distress
Skin: clear (well perfused)
HEENT: TM's (nl)
Conjunctiva: (nl)
Nose: (nl)
Oropharynx: MMM
Tonsils: (nl)
Neck: (supple)
Chest: (symm.)
Lungs: CTA no (W/R/R)
CVS: RRR no (murmur)
Abd: soft, NT/ND BS+ no mass
GU: NA (nl)
Rectal: NA nl
Extrem: MAE, (FROM)
Neuro: no focal findings or change

Exanthem: _____
abnl: _____
abnl: _____
abnl: _____
abnl: oral mucosa moist
abnl: _____
abnl: _____
abnl: _____
abnl: _____
abnl: _____
abnl: healed midline scar.
abnl: soft, flat, non-tender, no guarding.
abnl: BS normoactive
abnl: _____
abnl: _____

ASSESSMENT: _____
Vomiting, no dehydration

PLAN: continue Pedialyte. D want milk. prn

RTC: _____

PROCEDURE: _____

Pulse Ox: _____

Doctor Signature CL CYNTHIA MALEKI MD

Urine Strip

Updated 4/3/08

APP118
FP 00009

EXHIBIT "D"

FOOTHILLS PEDIATRICS

SICK VISIT

NAME: Hurst, May Rose HISTORIAN: Mom DOB: 5/14/08 DATE: OCT 2 4 2008
AGE: 4 MO WEIGHT: 14 TEMP: 97.8 NURSE: [illegible] FRONT: JLT
MEDICATIONS: ALLERGIES: Ø
CC: very constipated !! x 5 days very fussy

Fever	N	Y	
URI	N	Y	
Cough	N	Y	
Vomiting	N	Y	
Diarrhea	N	Y	
Constip.	N	Y	
Pain	N	Y	
Rash	N	Y	
PO	Normal	Abn: ↑ ↓	
UOP	Normal	Abn: ↑ ↓	

very fussy gassy gas [illegible]
crying c̄ ... soft [illegible]/day
occ ... [illegible]
c/w fussiness
[illegible]
3 [illegible] 9 4

PMHx: PSHx: HOSPITALIZATIONS
FMHx: (allergies) SxHx: daycare (Y N) smoke (Y N) pets (Y N)

OBJECTIVE

Gen:	AA NAD		
Skin:	clear well perfused	Exanthem:	alert, fussy [illegible]
HEENT:	TM's nl	abnl:	
	Conjunctiva: nl	abnl:	
	Nose: nl	abnl:	
	Oropharynx: MMM	abnl:	
	Tonsils: nl	abnl:	
Neck:	supple	abnl:	
Chest:	symm	abnl:	
Lungs:	CTA no W/R/R	abnl:	CTA
CVS:	RRR no murmur	abnl:	RRR [illegible]
Abd:	soft, NT/ND BS+ no mass	abnl:	soft NT [illegible] mid scar
GU:	NA nl	abnl:	2 cm
Rectal:	NA nl	abnl:	
Extrem:	MAE, FROM	abnl:	
Neuro:	no focal findings or change	abnl:	

ASSESSMENT: GERD ; vomiting
UT [illegible] (no pain)

PLAN: Gentlease, B.F
Thickened feeds
Zantac 15/5 - 0.2cc po BID daily
#150cc c̄ 2 refills

RTC: 1 wk

PROCEDURE:

Pulse Ox:

Urine Strip

Doctor Signature: [signature]
Kathleen Weber D.O.

Updated 4/3/08

EXHIBIT "E"

SAO
KENNETH M. WEBSTER, ESQ.
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~~JONQUIL L. WHITEHEAD, ESQ.~~
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DISTRICT COURT

CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST, Plaintiffs, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC, MARTIN BLAHNICK, M.D., ALI PIROOZI, M.D., RALPH CONTI, M.D. and FOOTHILL PEDIATRICS LLC, Defendants.	CASE NO. A616728 DEPT NO. XXIV

STIPULATION AND ORDER REGARDING CERTAIN TRIAL EVIDENTIARY/PROCEDURAL RULINGS

Trial Date: February 18, 2014

IT IS HEREBY STIPULATED AND AGREED, by all parties, by and through their respective counsel of record, to entry of the following trial evidentiary/procedural rulings.

1. Alan H. Rosenthal, M.D., Kathleen Sakamoto, M.D., and Mark H. Rothschild, M.D., will not be called to testify at trial; and

2. It is uncontested and agreed by all parties that Plaintiff's Diamond Blackfan Anemia not being diagnosed in the NICU by Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D., was not below the standard of care. All parties agree that it will not be argued before the jury that Plaintiff's Diamond Blackfan Anemia should have been diagnosed in the NICU by Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D.; however, Plaintiff specifically reserves the right to argue, among other things, that the standard of care did require Defendants Martin Blahnick and Ali Piroozi to recognize (1) that MayRose Hurst's anemia was not "due to prematurity"; (2) that there was an undiagnosed pathological cause for the anemia; and (3) that further investigation into the cause of MayRose's anemia was warranted by said Defendants; and

3. It is uncontested and agreed by all parties and their respective experts that MayRose Hurst did not require further hospitalization at the time of her discharge from the NICU. However, Plaintiffs reserve the right to argue that MayRose Hurst's hematocrit and hemoglobin were not stable at the time of discharge and were in fact on a downward decline which indicated MayRose's need for both (1) investigation into the cause of her ongoing anemia on either an inpatient or outpatient basis; as well as (2) instructions to MayRose's parents and pediatrician that she had ongoing anemia that would need to be closely followed to determine if she would continue to require transfusions on a weekly and/or bi-weekly basis as she had done from the date of her birth. All parties agree that Defendants Martin Blahnick, M.D., and Ali Piroozi, M.D., did not fall below the standard of care by discharging Plaintiff from the NICU on August 2, 2008; however, Plaintiffs reserve the right to argue that the method and manner of

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MayRose's discharge, including the discharge plan, instructions, orders, as well as the information given to the parents and/or pediatrician at the time of discharge was below the standard of care; and

4. Settling-Defendant Ralph Conti, M.D., is deceased and is therefore unavailable to testify at trial. All parties agree to the use of his deposition testimony at trial; and

5. All parties agree that lay witnesses will not provide opinion testimony regarding medical care and treatment; and

6. All parties agree to refrain from arguing the "golden rule"; and

7. All parties agree that any evidence or inference regarding the relative wealth and/or "for profit" status of either party is of no consequence to the underlying issues and must be barred; and

8. All parties agree that in order to promote judicial economy, it will be beneficial to all parties concerned if the Court and all counsel know in advance the sequence of witnesses to be called. This will allow all of the parties to adequately prepare their examinations of the witnesses and to have the pertinent file material at court. This procedure is within the discretion of the Court and will serve to enhance the trial judge's control over the orderly flow of evidence; and

9. All parties agree that evidence regarding other lawsuits filed against the defendants and/or other negligence ascribed to the defendants should be barred because such evidence would allow the jury to infer the defendants' propensity for negligence. Such reference is completely irrelevant to a final determination of the merits of this particular case; and

10. All parties agree that all non-party lay witnesses shall be barred from the courtroom prior to their testimony, with the exception of expert witnesses; and

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11. All parties agree that the parties and their counsel shall refrain from any reference to or insinuation about the parties' settlement negotiations; and

12. All parties agree there shall be no mentioning or examining witnesses directly or indirectly, regarding the existence of professional liability insurance covering defendants as said information is irrelevant and prejudicial; and

13. All parties agree that parties and their counsel are barred from eliciting testimony or examining any health care provider with regard to that provider's personal treatment preferences, because that information is irrelevant to the issue of the standard of care and would be prejudicial and misleading to the jury, unless appropriately laid foundation that such treatment is within the generally accepted standard of care; and

14. All parties agree that the parties and their experts shall be restricted to the standard of care applicable in the medical community in May 2008; and

15. All parties agree that parties are barred from presenting evidence or making argument about discovery disputes which took place before trial. Such evidence or argument would be wholly irrelevant to any issue raised in this case, are highly prejudicial, and should be barred; and

16. All parties agree that parties are barred from making any insinuation about or reference to counsel being from Chicago and Utah. Such information is completely irrelevant to a final determination of the merits of this particular case and would be prejudicial and misleading to the jury; and

17. All parties agree that parties and their counsel will not make any insinuation about or reference to the origins of Plaintiffs Tiffani Hurst and Brian Abbington's sexual relationship; and

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18. All parties agree that parties and their counsel will not make any insinuation about or reference to the incident at Toys 'R Us involving Plaintiff Tiffani Hurst and her child in the car; and

19. All parties agree that no evidence exists to support a claim of agency and/or vicarious liability against Defendant Sunrise Hospital and Medical Center for the conduct of Defendant Ralph Conti, M.D.

The parties represent that this Stipulation is a full and accurate representation of certain evidentiary/procedural agreements that they wish for this Court to enter as a binding order for the upcoming trial.

IT IS SO STIPULATED.

Respectfully submitted by:

HALL PRANGLE & SCHOONVELD, LLC

KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
JONQUIL L. WHITEHEAD, ESQ.
Nevada Bar No. 10783
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Approved as to form and content:

PRINCE & KEATING

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PRINCE & KEATING
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Attorney for Plaintiffs
-and-
Jacquelynn D. Carmichael, Esq.
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215 South State Street, Suite 900
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Attorneys for Plaintiffs

. . .

. . .

. . .

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Approved as to form and content:

COTTON, DRIGGS, WALCH, HOLLEY, WOLOSON & THOMPSON

John H. Cotton, Esq.
Christopher Rigler, Esq.
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Attorney for Defendant
Ali Piroozi, M.D.

Approved as to form and content:

MANDELBAUM, ELLERTON & MCBRIDE

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2012 Hamilton Lane
Las Vegas, NV 89106
Attorneys for Defendant
Martin Blahnick, M.D.

Case Name: Hurst vs. Sunrise Hospital, et al.
Case Number: A616728

ORDER

Pursuant to the foregoing stipulation of counsel for all parties, and good cause appearing therefore,

IT IS SO ORDERED.

DATED this _____ day of _____, 2013.

_____
DISTRICT COURT JUDGE

Respectfully submitted by:

HALL PRANGLE & SCHOONVELD, LLC

_____
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EXHIBIT "F"

Marcus C. Hermansen, MD

August 28, 2012

Jacquelynn D. Carmichael, Esq.
Eisenberg and Gilchrist
215 South State Street, #900
Salt Lake City, UT 84111

Re: Hurst

Dear Ms. Carmichael:

I am a board certified Pediatrician and Neonatologist. I am licensed to practice medicine in the State of New Hampshire. I am the Medical Director of the Neonatal Intensive Care Unit at Southern New Hampshire Medical Center in Nashua, New Hampshire and am an Associate Professor of Pediatrics at Dartmouth Medical School. At your request I have reviewed the following materials:

- Medical records of Tiffani Hurst
  - prenatal records
  - Center for Maternal Fetal Medicine
  - Sunrise Hospital and Medical Center
- Medical records of MayRose Hurst
  - Sunrise Hospital and Medical Center
  - Foothills Pediatrics (Dr. Conti)
  - HCA Hospital Corporation of America (Admission of September 23, 2009)
  - Desert Radiologists (Brain MRI of September 30, 2008)
  - Summerlin Hospital (Admission of October 29, 2008)
  - Denver Children's Hospital (Admission of December 1, 2008)
  - Deposition of Martin Joseph Blahnik, MD
  - Deposition of Ralph Conti, MD
  - Deposition of Tiffani Hurst
  - Deposition of Ali Piroozi, MD

MayRose Hurst was born by C-section at 28 6/7 weeks gestation on May 14, 2008 at Sunrise Hospital. Her birth weight was 1280 grams and her Apgar scores were 3 and 6, at one and five minutes, respectively. During her stay in the Sunrise Neonatal Intensive Care Unit she

14 Gregg Road, Nashua, NH 03062 Phone: 603-883-5955 e-mail: DoubleThis@gmail.com

experienced numerous complications of prematurity including respiratory distress syndrome, apnea of prematurity, neonatal sepsis, retinopathy of prematurity, bowel perforation with pneumoperitoneum, and hyperbilirubinemia. Despite her numerous complications of prematurity she had no evidence of brain damage at the time of her discharge. (Footnote 1) MayRose was discharged on August 2, 2008 and "The family was instructed to call Dr. Conti for an appointment in 3 days."

MayRose suffered from anemia during her neonatal hospitalization and required multiple transfusions with packed red blood cells. (Footnote 2) Her hematocrit was 30.0% on August 1, 2008, just one day prior to her discharge. At that time her reticulocyte count was < 0.5%. On August 1 the progress notes indicate that a "Hct = 30%, Retic = 0.5%" with a plan to "monitor clinically, start Poly vi sol with iron." MayRose's diagnosis at discharge was "Anemia of prematurity (5/15/2008 – 7/21/2008)" and the plans included a "CBC, Dif, Retic 1 month after discharge." At the time of discharge she was taking 1 mL of Poly-Vi-Sol with iron daily.

Dr. Conti saw MayRose on August 5, 2008. The office note indicates that MayRose was taking no medications at that time; however, the note of September 9, 2008 indicates that she was taking "vitamins with iron." She was admitted to Summerlin Hospital in October 2008 with anemic shock with an admission hemoglobin of 1.5 mg/dL and a pH of 6.5. A brain CT on November 14 showed "multiple intracranial infarcts and calcifications secondary to hypoxemia" and MayRose was discharged with a diagnosis of hypoxic ischemic encephalopathy. She subsequently was treated at Denver Children's Hospital and diagnosed with "severe anoxic brain injury" and "red cell aplasia thought to be Diamond Blackfan."

Relative to MayRose's anemia, there were two primary departures from the standards of care by the neonatology providers at Sunrise Hospital. These departures were:

<u>Failure to recognize and evaluate the pathological aspect of MayRose's anemia:</u>

- The providers made a diagnosis of the relatively benign condition of "anemia of prematurity" for the period of May 15, 2008 through July 21, 2008. There is no other explanation for MayRose's anemia given and no alternative diagnoses offered. Interestingly, the diagnosis of "anemia of prematurity" is only given though July 21 and there is no explanation for her anemia or her need for blood transfusions after July 21.
- Few newborns born at 28 6/7 weeks gestation with "anemia of prematurity" require one transfusion. Fewer yet require a second transfusion. MayRose required eleven transfusions (I), yet the cause of this requirement was never investigated. While the early transfusions (those given within 72 hours of birth) were probably due to her immediate post-birth medical and surgical problems, as time went by it should have become apparent that another cause was in play. And clearly that cause was not simply "anemia of prematurity" – the diagnosis of "anemia of prematurity" was incorrect and improper.
- A thorough investigation of the problem was indicated and a consultation by a hematologist would have been helpful. Dr. Blahnik still does not acknowledge "any indication to have a hematologist involved" (deposition, page 41). Dr. Piroozi also feels

that "there was no reason for hematology consult at that time." (deposition, page 57) Once the neonatologists chose not to obtain a hematology consultation, then they assume the responsibility to conduct a hematology evaluation of the anemia themselves and they failed to do so.

- In deposition testimony Dr. Blahnik does not attribute all of MayRose's anemia to prematurity. He states there were "other reasons for her anemia" (deposition, page 39) and "we knew the cause of her anemia" (deposition, page 41). Dr. Blahnik attributes the transfusions in the first 72 hours of life to MayRose's initial medical/surgical problems, and her subsequent transfusions to "typical and expected" needs of a premature newborn. (deposition, pages 43-4) The number and volume of subsequent blood transfusions far exceeds those expected for any premature newborn and should not have been attributed simply to "prematurity of anemia."
- Dr. Piroozi feels that MayRose's "anemia wasn't unusual and different based on her condition, based on illnesses and critical condition that she had." (deposition, page 50) He attributes her anemia to more than just prematurity, attributing the problem to the fact that "basically she was a very critical newborn premature baby with multiple problems" (deposition, page 55). Dr. Piroozi felt that the lack of "profound anemia" was justification for a failure to evaluate for the cause of MayRose's anemia. (deposition page 68) However, Dr. Piroozi's logic is faulty – MayRose never had the opportunity to demonstrate "profound anemia" because of the numerous transfusions that were given. Had it not been for the multiple transfusions MayRose would have demonstrated "profound anemia".

<u>Inadequate discharge planning:</u>

- Even though MayRose was anemic and diagnosed with anemia of prematurity and required frequent blood transfusions, she was discharged with a plan to re-check her red blood cell counts (CBC) one month after discharge. This was extremely dangerous knowing that she was requiring transfusions as frequently as every two weeks (she was transfused 4 times in June and 3 times in July) and was discharged anemic with a hematocrit of 30.0% and had virtually no reticulocytes. (Footnote 3) It was predictable that she would be "due" for a transfusion in less than one month after discharge. Dr. Piroozi felt "the baby would be safe to get hematocrit and retic count within one month, considering the baby is going to be under supervision and care of pediatrician with close follow-up." (deposition, page 121-122). But there was no effort to inform the follow-up pediatrician, Dr. Conti, about the need for close follow-up. There was no communication by e-mail, by fax, or by telephone. The communication was left to the family and to a discharge summary, a discharge summary with incomplete and inaccurate information:
    - The discharge summary provided no indication that this infant's anemia needed to be followed closer than that of any other premature infant.
    - The discharge summary provided inaccurate information about the number of transfusions (5 vs. 11).
    - The discharge summary provided no information regarding the lack of reticulocytes on the day prior to discharge.

- The discharge summary implied that the last transfusion given was on June 22 and gave no indication of the three transfusions administered in July.
- The discharge summary provided a diagnosis of "anemia of prematurity" without any expressed concern for other possible causes of anemia.
- The discharge summary indicates that a blood count one month after discharge would constitute adequate follow-up.

The acts of negligence by the neonatologists at Sunrise Hospital caused MayRose to suffer delayed diagnosis and treatment of Blackfan-Diamond anemia.

My opinions are expressed to a reasonable degree of medical probability.

Sincerely,

Marcus C. Hermansen, MD

Footnote 1: A head ultrasound on May 14 was normal. A head ultrasound on May 18 was also normal. A head ultrasound on August 1 showed "new left germinal matrix hemorrhage, grade 1. This may be subacute." Dr. Blahnik acknowledges that a grade 1 hemorrhage "doesn't have significance." (deposition, pages 71-73) Dr. Piroozi was "concerned" about the hemorrhage (deposition, page 108) although he acknowledges that she had "an overall very good prognosis." (deposition, page 109) MayRose's discharge examination on August 2 showed "normal suck, symmetric Moro, good strength and tone." Her physical examination in Dr. Conti's office on August 5 showed a normal neurological examination. A brain MRI on September 30 was normal. Dr. Conti did make a determination of "static enceph" on his September 9 note, but gives no basis for that determination – the child had no subjective findings suggesting brain injury and had a normal neurological examination on September 9. It is unlikely that May Rose had suffered any brain damage at the time of Dr. Conti's assessment on September 9, 2008 and that all of her brain damage occurred at the time of her re-hospitalization for anemic shock.

Footnote 2: The discharge summary indicates "she was given 5 transfusions." Dr. Blahnik and Dr. Piroozi both testified that there were 11 red blood cell transfusions, a number of transfusions consistent with the Blood Bank records in the Laboratory Discharge Summary. Dr. Piroozi explains the discrepancy by blaming "the system and the data entry." (deposition, page 115)

Footnote 3: The progress notes indicated a reticulocyte count = 0.5% on August 1, 2008 although the laboratory print-out actually indicates "< 0.5%" (with a laboratory reference range

of 0.5-1.5%). In deposition testimony Dr. Blahnik acknowledges that low reticulocyte counts are consistent with Blackfan-Diamond anemia (deposition, page 35), but he believes that the value was "within the reference range" (deposition, page 44, lines 14-5) when it was actually less than the reference range. Dr. Piroozi felt the reticulocyte count was low (deposition, page 49 and 56) and started iron therapy in response to the low value (deposition, page 49). Dr. Piroozi is still under the belief that the reticulocyte count was 0.5 (deposition page 53, line 18) when it was actually less than 0.5.

EXHIBIT "G"

JOHNS HOPKINS
MEDICINE

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School of Medicine
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James F. Casella, MD
George J. Dover, MD
Clifford M. Takemoto, M.D.
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John J. Strouse, M.D., Ph.D.
Shirley Reddoch, M.D.
William H. Zinkham, M.D
Emily Barron-Casella, Ph.D.
Patricia Underland, R.N., M.S., C.P.N.P.
Phillip Seaman, PA-C
Kim Winship, LCSW-C
Yolanda M. Fortenberry, Ph.D

August 30, 2012

Jacquelynn D. Carmichael
Eisenberg, Gilchrist & Cutt
215 South State Street, Suite 900
Salt Lake City, Utah 84111

Re: MayRose Hurst
DOB: 5/14/08

Dear Ms. Carmichael

This letter is to provide my expert opinion as to the etiology and interventions that may have prevented MaryRose Hurst's severe brain injury. My opinion is based on my education, training, experience, and knowledge as well as my review of MayRose Hurst's medical records.

My qualifications as an expert witness include my education, training and expertise in the field of pediatric hematology and stroke. I obtained my medical degree from Johns Hopkins University School of Medicine and then completed a combined residency in Internal Medicine and Pediatrics at the University of Rochester. I then completed training in Adult Hematology at the National Institutes of Health and Pediatric Hematology/Oncology in Johns Hopkins University/National Institutes of Health Program. I have active board certification in Pediatrics, Pediatric Hematology/Oncology, and Adult Hematology. I am currently an Assistant Professor of Pediatrics and Medicine at Johns Hopkins University School of Medicine and care for neonates and children with hematologic disorders at Bloomberg Children's Hospital and in the associated outpatient facilities of Johns Hopkins Hospital. I have a clinical and research interest in stroke in children and have published extensively on this topic.

I have reviewed copies of the following medical records of MayRose Hurst:
1. Sunrise Hospital: MayRose's birth and stay in the NICU 5-14-2008 to 8-2-2008-physican notes, laboratory testing, and summaries
2. Foothills Pediatrics: 8-5-2008 to 10-24-2008
3. Summerlin Hospital 10-29-2008 to 11-30-2008-physician notes, laboratory testing, and summaries
4. Denver Children's Hospital 12-1-2008 to 12-15-2008-summaries and physician notes.

You are already familiar with the details of MaryRose's medical history. Additional details relevant to her anemia include nuchal lucency identified on prenatal ultrasound with normal chromosomal analysis, a family history of alpha thalassemia, and anemia at birth with borderline macrocytosis (large red blood cells). MaryRose had multiple transfusions of red blood cells during her initial hospitalization, which was unusual even in light of her complications including her need for surgery, multiple infections and significant inflammation. MayRose's anemia at birth was not "anemia of prematurity." Unfortunately, during MayRose's stay in the NICU her anemia was not evaluated, nor was her family history of thalassemia or the fact of her nuchal lucency taken into consideration.

At the time of her discharge, it was recommended that she have follow-up laboratory testing including a complete blood count and differential and reticulocyte a month after her discharge. This was not done and she was admitted to Summerlin Hospital nearly 3 months after her discharge from the NICU with apnea and poor oxygenation with profound anemia and influenza B infection. It is my expert opinion with a reasonable degree of medical certainty that her profound anemia was a major contributor to her brain injury. This is based on the severity of her anemia and the watershed distribution of her brain injury. The episode of profound anemia could have been prevented if her anemia had been properly evaluated while she was in the NICU. If this had occurred, it would have been discovered that MayRose's anemia was not due to prematurity and required, at a minimum, follow-up with more frequent laboratory testing (complete blood count and reticulocyte count) until such time as a determination as to the cause of her anemia could be made. Similarly, the episode of profound anemia could also have been prevented if the complete blood count that was recommended at 1 month had been obtained, because, with a reasonable degree of medical certainty, she would have been anemic one month after discharge given her hematocrit of 30% on 8/1/12 and a typical rate of decrease in the hematocrit of ~9% per month.

Sincerely,

John Strouse, MD, PhD

John Strouse, MD, PhD
Assistant Professor of Pediatrics and Medicine

EXHIBIT "H"

DEPOSITION OF
RALPH CONTI, M.D.

Hurst, et al. v. Sunrise Hospital and Medical Center, et al.
Case No. A-10-616728-C
June 19, 2012

CONDENSED TRANSCRIPT AND KEY WORD INDEX

TURNER REPORTING & CAPTIONING SERVICES, INC.
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Las Vegas, NV 89128
(702) 242-9263

DISTRICT COURT
CLARK COUNTY, NEVADA

TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST,

Plaintiffs,

vs.

SUNRISE HOSPITAL AND MEDICAL CENTER, LLC; MARTIN BLAHNIK, M.D.; ALI PIROOZI, M.D.; RALPH CONTI, M.D.; and FOOTHILLS PEDIATRICS, LLC,

Defendants.

Case No. A10616728C
Dept.No. XXIV

DEPOSITION OF RALPH CONTI, M.D.
Taken on Tuesday, June 19, 2012
At 2:12 p.m.
At 3441 South Eastern Avenue, Suite 401
Las Vegas, Nevada

Reported By: Karen J. Berry, RMR, CCR 836

APPEARANCES:

For the Plaintiffs: JACQUELYNN D. CARMICHAEL, ESQ.
EISENBERG & GILCHRIST
215 South State Street
Suite 900
Salt Lake City, Utah 84111

For Defendant Sunrise Hospital: JONQUIL L. URDAZ, ESQ.
HALL, PRANGLE & SCHOOLVELD
777 North Rainbow Boulevard
Suite 225
Las Vegas, Nevada 89107

For Defendants Blahnik and Piroozi: CHRISTOPHER G. RIGLER, ESQ.
JOSEPH H. COTTON & ASSOCIATES
2300 West Sahara Avenue
Suite 420
Las Vegas, Nevada 89102

For Defendants Conti and Foothills Pediatrics: PATRICIA EGAN DAEHNKE, ESQ.
BONNE BRIDGES MUELLER O'KEEFE & NICHOLS
3441 South Eastern Avenue
Suite 402
Las Vegas, Nevada 89169

Also present: TIFFANI D. HURST
BRIAN ABBINGTON

Videographer: Patti Lucchesi
Certified Legal Videography

EXAMINATION

EXHIBITS

THE VIDEOGRAPHER: This begins the deposition of Ralph Conti, M.D. Today's date is June 19, 2012. The time is 2:12 p.m. We are at Bonne Bridges Mueller O'Keefe and Nichols, 3414 South Eastern Avenue, Suite 402, Las Vegas, Nevada, 89169.

This case is in the District Court, Clark County, Nevada, entitled Tiffani D. Hurst and Brian Abbington, jointly and on behalf of their minor child, MayRose Lili-Abbington Hurst, versus Sunrise Hospital and Medical Center, Case Number A-10-616728-C.

I'm Patti Lucchesi representing Certified Legal Videography. The court reporter is Karen Berry on behalf of Turner Reporting and Captioning.

Will counsel please identify yourselves for voice identification, then the reporter will administer the oath.

MS. CARMICHAEL: Jackie Carmichael on behalf of the plaintiffs.

MR. RIGLER: Christopher Rigler on behalf of defendants Blahnik and Piroozi.

MS. DAEHNKE: Patricia Daehnke for Doctor Conti.

MS. URDAZ: Jonquil Urdaz for Sunrise Hospital.

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Thereupon--
RALPH CONTI, M.D.
was called as a witness by the Plaintiffs and, having been first duly sworn, testified as follows:
EXAMINATION
BY MS. CARMICHAEL:
Q Will you please state your full name and your address for the record?
A Ralph Conti. Spell it?
Q Sure.
A R-a-l-p-h, C-o-n-t-i. And home address?
Q Yes.
A 1675 Tanglers Drive, T-a-n-g-l-e-r-s, in Henderson, Nevada, 89012.
Q Thank you. Doctor Conti, have you had your deposition taken prior to today?
A Yes.
Q On how many occasions?
A I don't recall.
Q What were the circumstances of those depositions?
A Many, many different circumstances. I've been asked to testify for families. If they're having a legal problem against the police, against various businesses, I've had to testify. I've given my

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deposition for malpractice cases in the past.
Q As an expert or as a treater?
A As a treater.
Q Okay. Have you ever given testimony as an expert witness?
A I believe some of them, yes, have asked me to testify as an expert.
Q So you were a retained expert, an attorney retained you to give expert testimony in a case?
A Yes.
Q Okay, on how many occasions have you testified as an expert?
A I don't recall.
Q It's okay if you don't have a precise number, but can you give me a ballpark?
A Five to ten.
Q Okay. And do you remember what the issues were in any of those cases that you testified as an expert?
A One was a case of Munchausens by proxy. One was a case of a bruise on a child.
This is just the ones that come to mind.
Q Okay. When was the most recent occasion that you testified as an expert witness?
A I don't recall.

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Q Within the last five years?
A Perhaps.
Q And in the five to ten occasions that you testified as an expert witness, were you testifying on behalf of the plaintiff or the defendant?
A I think sometimes on behalf of the plaintiff, sometimes on behalf of the defendant.
Q Okay. Do you recall any of the attorneys that hired you?
A Breen Arntz.
Q Excuse me?
A Breen Arntz, A-r-n-z, is I believe how he spells it.
Q Okay. Any others?
A I don't recall any other attorney names besides Breen.
Q Were there other attorneys, or were you his expert on each occasion?
A I believe there were other attorneys.
Q Have you ever given a deposition as a party to a lawsuit?
A Yes.
Q And tell me about that.
A Three different times.
Q Okay.

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A The first one was a child with encephalitis, with viral encephalitis. The second was a child with a bowel obstruction. And the third was regarding a circumcision.
Q And these were instances where you were, where allegations of malpractice were made against you?
A Correct.
Q Okay. And what was the outcome of the case concerning the child with viral encephalitis?
A I believe it was settled.
Q Okay. And how long ago was that?
A I believe it was 2001.
Q Do you recall the plaintiff's attorney in that case?
A No.
Q Do you recall the name of the party suing you?
A I think it was Howard.
Q Okay. And who represented you in that case?
A I believe Breen Arntz was my lawyer back then.
Q Mr. Arntz?
A Yes.
Q Okay. What about the bowel obstruction

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case, what was the outcome of that case?
A That was also settled.
Q And do you recall the year?
A It was around 2002, I believe.
Q And did Mr. Arntz also represent you in that action?
A I think so.
Q And do you recall the name of the plaintiff in that case?
A No.
Q And then with regard to the last occasion, the circumcision case, what was the resolution of that matter?
A That also settled out.
Q In what year?
A It was about 2002 or three.
Q And who represented you in that case?
A I don't remember.
Q Do you remember the name of the plaintiff?
A I do remember. Wait. It was Bonnie Bulla, I believe was her name.
Q Bonnie Bulla?
A I think that was her name.
Q Do you recall the name of the plaintiff in that case?

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A Baby's first name was Jared. And I don't remember the last name.
Q Jerry?
A Jared, J-a-r-e-d. I don't remember the name.
Q In the viral encephalitis case, was that a failure to diagnose allegation? What was the allegation in that?
A I think so. I don't recall.
Q Do you recall what the allegation was in the bowel obstruction case?
A I think it was the same thing. I think they, you know, I think it was failure to diagnose.
Q What about in the circumcision case?
A The parents didn't like the result.
Q Okay. Why?
A They didn't like the way it looked, I guess.
Q So it was simply a matter of aesthetics?
MS. DAEHNKE: Well, I object to the form of the question. Might lack foundation, call for speculation, and other interesting things.
You can answer if you can.
THE WITNESS: I believe so. Just didn't like the way it looked, so.
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BY MS. CARMICHAEL:
Q Okay. All right. Okay. What did you review in preparation for your deposition today?
A I reviewed the chart.
Q Foothills chart?
A Yes.
Q Did you review anything else?
A Today what did I review?
Q Doesn't have to be confined to today. Just what have you reviewed in preparation for your deposition?
A I can't remember all the papers I've looked through regarding this case.
Q Well, other than the chart, what categories of papers have you reviewed?
A What categories of papers? I'm not sure if I understand.
Q Well, you're telling me you can't remember everything. What can you remember? What have you looked at in preparation for your deposition?
A There's a big notebook, there's a couple of big notebooks that are that thick.
Q Filled with what?
A Papers.
Q Medical records?

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A Some of --
MS. DAEHNKE: You know, counsel, I'll represent that the binders have copies of, photocopies of the chart. And I also made photocopies of the discovery responses. That's what's in the binders.
BY MS. CARMICHAEL:
Q All right. So you've reviewed some discovery responses?
A Yes.
Q Okay. Have you reviewed any depositions, deposition transcripts?
A I believe so.
Q Have you read the depositions given by Tiffani and Brian -- Tiffani Hurst and Brian Abbington?
A I believe I read Tiffani's.
Q Okay. Did you read Doctor Weber's deposition?
A Yes, I believe I read Doctor Weber's.
Q How about the depositions given by Doctor Blahnik or Doctor Piroozi, have you read those?
A I don't recall anything specific about them, but I believe I looked at them, yes.
Q And what have you brought with you today?
A This is my chart.

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Q That's the original chart?
A **Yes.**
Q Maintained at your office?
A **Yes.**
Q For MayRose Hurst?
A **Yes.**
Q Okay. And what dates of treatment does that span?
A **Let's see. Let's see, the first progress note is from July 22 of '09. And the last one is August 5 of '08.**
Wait. I'm sorry. The opposite. August 5 of '08 would be the first note, and then July 22 of '09 would be the last note.
Q Okay. All right. Other than counsel, who have you spoken with regarding the claims in this lawsuit?
A **My counsel. That's pretty much it.**
Q Have you talked with Kathleen Weber about her deposition?
A **Not specifically about her deposition. I just, I remember the day that she did it, but I don't believe that I've talked to her about this deposition specifically.**
Q You didn't ask her how her deposition went,

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or any details about her deposition?
A **No.**
Q Have you discussed the allegations in this lawsuit with Doctor Weber?
A **Early on, we had mentioned it.**
Q What do you -- tell me what you discussed with her.
A **I don't recall exactly what we talked about. I said, "Do you remember MayRose?" And, you know, that we're being sued on her. So that was about it. That's all I recall.**
Q What do you recall Doctor Weber telling you?
A **I don't remember.**
Q You don't remember anything she told you?
A **Not really, no. Not specifically.**
Q Have you spoken with any of the other defendants regarding the claims in this lawsuit?
A **I remember speaking to Doctor Malixi. I don't remember like any of the specifics of what that conversation entailed. I don't recall.**
Q Do you remember anything about the conversation you had with Doctor Malixi?
A **Not much. I remember her being concerned that she had never been sued before. So she was just really broken up about it.**

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Q And what did you tell her?
A **I don't recall. I think I just said, you know, it's -- I don't recall.**
MS. DAEHNKE: You're pounding your...
THE WITNESS: Oh, sorry.
BY MS. CARMICHAEL:
Q Have you ever spoken with Doctor Piroozi about the claims in this case?
A **No.**
Q Have you ever spoken with Doctor Blahnik about the claims in the case?
A No.
Q Do you know Doctor Piroozi or Doctor Blahnik?
A **I believe I've spoken to them on the phone at various times, but I don't, I've never formally met them, no.**
Q Okay. And on those occasions when you spoke to them over the phone, was it ever regarding MayRose Hurst?
A **No.**
(Plaintiffs' Exhibit A marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Conti, I'm handing you what will be

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Exhibit A to your deposition.
A **Yes.**
Q And I'll represent to you that this is a document that was provided to me by your counsel.
A **Uh-huh.**
Q As representing your curriculum vitae, is this document current and up to date?
A **I believe it only goes up to, up to -- yeah, that seems, seems pretty accurate.**
Q Okay.
A **Uh-huh.**
Q Are there any achievements or work experience that would need to be added to this to bring it current, or does this represent a current...
A **It's pretty current.**
Q Okay. All right. Let me ask you then, on your board certification, it indicates that you recertified in 1998. Is that correct?
A **That's correct.**
Q And are you due for another recertification?
A **Yes. Yes.**
Q When did that become due?
A **It's due this year.**
Q This year?
A **Uh-huh.**

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Q And do you plan to do that?
A **Yes.**
Q Okay. On your work experience, it indicates that you were working at Green Valley Pediatrics before Foothills Pediatrics?
A **Correct.**
Q Do you see that?
A **Yes.**
Q And you were the managing partner at that practice. Is that correct?
A **Yes, that's correct.**
Q Can you tell me why you changed practices, or how that came to be that you moved from Green Valley Pediatrics to Foothill?
A **We just became a very big group, and I wanted to do something smaller at the time. It was a long time ago.**
Q So you just left, you left Green Valley?
A **Yes.**
Q And you formed Foothill Pediatrics?
A **Yes.**
Q Okay. Do you have any publications? Have you ever published?
A **Yes, I was published on a vaccine study.**
Q When was that?

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A **About 2003, maybe, 2004. Somewhere around there.**
Q And what was the study about?
A **Rotavirus vaccine.**
Q Any other publications?
A **Another one on what they call ProQuad, which is a combination of chicken pox and MMR.**
Q Another vaccine study?
A **Yeah.**
Q Okay, and when was that published?
A **Around the same time.**
Q Anything else?
A **I think that's mostly it.**
Q Okay. So Foothill Pediatrics, LLC, does that organization continue today?
A **I don't think so. I think it's been changed.**
Q It's been changed?
A **Yeah, I don't think the LLC exists anymore. I think it's an LLLC, or something like that. I don't understand all that.**
Q When was that change made?
A **Let's see, early this year, I believe, in January.**
Q Okay, what is the new entity's name?

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A **I believe it's still called Foothill Pediatrics, LLLC, I think is what it's called.**
Q Why was the name changed?
A **Because we wanted to make Doctor Garcia head of the group.**
Q Doctor Garcia?
A **Yes, correct.**
Q So is Doctor Garcia now the managing partner?
A **Yes.**
Q What's Doctor Garcia's first name?
A **Claudia.**
Q So you have essentially stepped down then as managing partner?
A **Correct.**
Q And that was effective the first of this year?
A **Around there.**
Q And the old entity, what has become of it?
A **I don't know.**
Q We were informed at some point that there was a bankruptcy proceeding. Is it in bankruptcy?
A **No. No longer.**
Q Was it discharged?
A **Yes.**

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Q Who are the -- are there any other managing members of the new entity other than Doctor Garcia?
A **I don't believe so. Just myself.**
Q You're also a managing partner?
A **I don't know exactly what my title is. Am I managing partner? I don't know.**
Q Okay, well, what was the purpose of the reorganization?
A **So that Doctor Garcia could be the main purpose -- could be the main person doing the contracting.**
Q Okay. And how many physicians are currently employed by Foothill, by the new entity?
A **One, two, three, four -- six, I believe. Six.**
Q Does that include yourself?
A **Yes.**
Q And Doctor Garcia as well?
A **Yes.**
Q Is Doctor Weber still there?
A **Yes.**
Q And Doctor Malixi?
A **Doctor Malixi is in retirement.**
Q Here in Las Vegas?
A **She lives here part of the time, and she's**

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in the Philippines a lot.
Q Okay. So who then are the other physicians besides Doctor Weber, Doctor Garcia, and yourself?
A Doctor Mendoza, Doctor Faro, and Doctor Hyla.
Q What was the last one?
A Hyla, H-y-l-a.
Q Okay. So I've got paperwork from the Secretary of State for Nevada that indicates the business license of the old entity expired February 29. I assume that that license was not renewed to that entity? Is that true?
A I don't believe so.
Q Okay. And you're now doing business under a business license for the new entity?
A I believe so, yes.
Q Where do you currently hold hospital privileges?
A St. Rose Siena, and St. Rose -- and San Martin.
Q San Martin?
A Yeah.
Q Any other hospitals?
A I have my privileges on hold at several other hospitals.

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Q Let's talk about Sunrise. Has Sunrise placed your privileges on hold?
A Yes.
Q And why was that?
A Because of my indictment in the --
MS. DAEHNKE: To the extent that answer calls for him to assert his Fifth Amendment, I have to object.
MS. CARMICHAEL: Well, I think he can say why the hospital placed his privileges on hold. I mean we're not going to get into any details of your criminal indictment.
MS. DAEHNKE: I think he said as much as, based upon the advice of his criminal counsel and me, he said as much as he can about that.
BY MS. CARMICHAEL:
Q You have been criminally indicted. Is that correct?
A Yes.
Q Are your hospital privileges also on hold at Summerlin?
A Yes.
Q Are there any other hospitals in the area where you held privileges and in which they have been placed on hold?

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A Yes.
Q What other hospitals?
A Centennial Hospital, Southern Hills Hospital, Valley Hospital.
Q But none of those hospitals have -- well, have any of those hospitals terminated your privileges?
A None of the ones that I listed, no.
Q Huh?
A No.
Q Have you ever, during your medical career, had your hospital privileges terminated by a hospital?
A Once at Spring Valley Hospital. Just this year.
Q And why were your hospital privileges terminated at Spring Valley Hospital?
MS. DAEHNKE: I would object to the extent that it calls for anything regarding implication of his Fifth Amendment right, which he's asserting and which counsel and I discussed prior to the start of this deposition.
BY MS. CARMICHAEL:
Q And if you want to assert that Fifth Amendment right, it's, you're well within your right to do so, but you'll need to assert it.

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A Okay. Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Okay. Prior to -- well, let's see. Back in 2008.
A Yes.
Q Did you have a contractual relationship with Sunrise Hospital?
A Contractual relationship?
Q A business relationship with them. Did you have some kind of a business relationship with Sunrise?
A No.
Q Okay.
A I don't think so.
Q Have you ever signed a contract with Sunrise Hospital?
A I don't think so. Just, just privileges.
Q Okay. Back in 2008, you did provide pediatric care to newborn babies born at Sunrise Hospital?
A Yes.
Q Is it true?
A Yes, I did.
Q Okay. And why don't you explain to me a

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little bit about how that would work?
I assume that anybody that had a doctor/patient relationship with you and for whom you provided pediatric services, when that party would go into the hospital to deliver, you would be notified and you would provide pediatric care to that child? Would you do that?
A Yeah, we would call the hospital in the morning. And if we have any, do we have any new babies there to see. And if they say yes, we go over to the hospital and see the new babies.
Q Okay. And would some of those babies be, belong to families with whom you had not yet established --
A Yes.
Q -- a pediatric relationship with?
A Yes.
Q Okay. And I assume that the hope then would be that they would want to continue with your practice --
A Sure.
Q -- once the child was released from the hospital?
A Yes.
Q Okay. And in attending to those babies, I

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assume you had occasion to work with babies born prematurely?
A Yes. But in general, babies born prematurely would go to the NICU, and you wouldn't work with them.
Q You would not work with premature babies?
A No. I mean not until they got out of the hospital.
Q All right. With regard to the babies you would work with, however --
A Yes.
Q -- whether that baby was going to follow with you or follow with another pediatrician, would you make sure that there was a pediatrician on board to follow that child after they were released?
MS. DAEHNKE: Object to the form of the question.
MR. RIGLER: Join.
THE WITNESS: I don't understand the question.
BY MS. CARMICHAEL:
Q In caring for babies at the hospital, while they're still at the hospital.
A Right.
Q Right. Would one of the things that you would do be to make sure that they were set up to follow with a pediatrician after they were released?
A Yes, I mean you would write follow up with Foothills Pediatrics by this particular date.
Q Okay. All right. When I took the deposition of Doctor Weber, one of the things she said on page 20 of her deposition is that when she was attending to babies at the hospital, she would also send the discharge notes and the admission notes to the attending pediatrician that the parents chose for the baby. Is that something that you would do?
A Send the discharge notes and the -- not ordinarily, no.
Q You would not do that?
A I don't -- I mean if it's something that needed to be signed out to another doctor, I would call the other doctor and let them know if there was some specific issue that needed to be raised with, with the child.
Q So we've talked about the three occasions you've been sued for medical malpractice. Is that right?
A Yes.
Q Have there been any other occasions other than this action?

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A I believe that's it.
Q Okay. And other than the criminal indictment that's been mentioned, have you ever been charged with a crime?
MS. DAEHNKE: I do not know what the doctor is thinking. Can we take a break? Because I need to, if it's something that's protected.
MS. CARMICHAEL: Sure.
THE VIDEOGRAPHER: Off the record at 2:44 p.m.
(A short break was taken.)
THE VIDEOGRAPHER: We're back on the record. This marks the beginning of tape number two. It's 2:54 p.m.
BY MS. CARMICHAEL:
Q Doctor Conti, there was a question pending when you asked for a recess.
MS. CARMICHAEL: (To the reporter:) Would you please repeat the question?
(The last question was read back.)
MS. DAEHNKE: And I'm going to object to that question and instruct the doctor not to answer on the grounds of relevance, privacy, and privilege.
MS. CARMICHAEL: Okay, criminal crimes are relevant because it goes to credibility. They're

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discoverable, and they're admissible. Criminal convictions are admissible.
MS. DAEHNKE: That wasn't your question. You could -- well, that wasn't your question. I have the same objection.
BY MS. CARMICHAEL:
Q Other than the criminal indictment that we're aware of, Doctor Conti, have you been convicted of any crimes in your past?
MS. DAEHNKE: And I would object on privilege, privacy, and relevance. If you want to ask him if he's been convicted of any felonies, you're entitled to that.
BY MS. CARMICHAEL:
Q Have you been convicted of any felonies?
A No.
MS. CARMICHAEL: And, you know, I am entitled to know if he's been convicted of misdemeanors as well.
MS. DAEHNKE: You, if you would like --
MS. CARMICHAEL: It may not be admissible at court, but it is discoverable.
MS. DAEHNKE: I disagree with you, and I'm instructing him not to answer on the grounds of privilege, privacy, and relevance.

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MS. CARMICHAEL: Okay. All right.
BY MS. CARMICHAEL:
Q Do you still have an ownership interest in the Foothill practice?
A Yes.
Q And what is your ownership interest?
A I don't know. What is my ownership interest?
Q Yes.
A I, I'm a part owner of the practice.
Q Excuse me?
A I'm a part owner in the practice.
Q I understand that. How much? What part do you own? What is your interest?
A I, I don't know.
Q You don't know --
A No.
Q -- what the terms of your ownership interest are with your partner?
A No.
Q Are there any other owners besides you and Doctor --
A Garcia.
Q -- Garcia?
A No.

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Q But you're telling me today that you don't know what the split is between you and Doctor Garcia?
A No, we haven't worked out any details on that yet, at all.
Q Okay. Have you been convicted of any crimes involving moral turpitude or dishonesty?
A No. What's -- I don't know what moral turpitude is.
Q Well, maybe you should discuss it with your attorney and she can tell you --
MS. DAEHNKE: The answer was no. He said no.
MS. CARMICHAEL: And then he said he doesn't know what moral turpitude is.
MS. DAEHNKE: Well, do you want to define moral turpitude for him?
MS. CARMICHAEL: I thought I would leave that to his lawyer to do. I'm not going to define --
MS. DAEHNKE: Well, his lawyer already object -- well, you asked the question, counsel. You and your client asked the question. So he's a doctor. We got a lot of lawyers in here.
MS. CARMICHAEL: Okay. I'm entitled to know if he's been convicted of any crimes involving moral turpitude. And so if you're comfortable with his

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answer, then that can stand.
MS. DAEHNKE: Well, I, counsel, you asked the question. I instructed him. We could spend all day here, if you like, on this question. He said no. And I've instructed him. And I do not think that you're entitled to anything other than conviction of a felony.
BY MS. CARMICHAEL:
Q With regard to your current criminal indictment, what are, what have you been charged with? What are the charges?
MS. DAEHNKE: And I'm going to object. And the doctor has already asserted his Fifth Amendment privilege.
THE WITNESS: Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
BY MS. CARMICHAEL:
Q So you're declining to even tell me what the charges are?
A Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Okay. At what stage are the criminal proceedings at this point?

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A Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Do you know whether your case is going to go to trial?
A Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Have you thus far been offered any plea negotiations?
A Based upon the advice of counsel, I assert my rights under the Fifth Amendment of the Constitution.
Q Going back to the care that you provide to babies while they're in the hospital, have you ever cared for a premature baby that's not in the NICU? They were just born prematurely but they're not in the NICU?
A Yes.
Q And I want to read you some of Doctor Weber's testimony and just ask you if you agree or disagree.
A Okay.
Q I asked her on page 19 of her deposition, "And what, if anything, did you learn regarding

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concerns that would be specific to caring for premature babies following their discharge from the hospital?"
She answered, "That's a very broad question, but I'll answer it the best I can. All of them need follow-up. That's the first thing."
Do you agree with that?
A Yes.
Q She goes on to say, "So we would contact or make sure the parents have a pediatrician that they're ready to see. And if they don't, you get them connected to one."
Do you agree with that?
A Yes, we try and follow them ourselves.
Q Okay. And she goes on to say, "And that the pediatrician is aware and can accept the patient."
Do you agree with that? Is that something you would do?
MS. DAEHNKE: Object to form.
But if you can answer, go ahead.
THE WITNESS: Can you rephrase that?
BY MS. CARMICHAEL:
Q So what she's getting at here, I believe, is that in the instance when they're not going to go with your practice, that they're going to go with a

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different pediatrician, do you make sure that pediatrician is aware of the child and can accept the patient?
A If there's a specific concern regarding the patient. But if there was, they probably wouldn't be being followed by a general pediatrician. Probably would be a neo baby, a NICU baby.
Q Okay. I'm just repeating what she said --
A Okay.
Q -- she would do, or did.
Okay, she goes on to say, "If they can accept the patient, then we usually send the discharge notes or any admission notes to the attending pediatrician the parents choose for the baby."
Do you agree or disagree with that? Is that something you would do?
MS. DAEHNKE: I would object to the form. It's argumentative. It's compound. Possibly takes it out of context.
But if you can answer, go ahead.
THE WITNESS: So you're asking if, if they're not going to follow with somebody in our group, that they're going to go to somebody else, would I Xerox the discharge summary and send it to the other doctor? Typically, no.

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BY MS. CARMICHAEL:
Q Okay. Thank you.
Moving now to your office practice, your clinical practice --
A Yes.
Q -- how many premature babies have become your patients over the years?
A I have no idea. Over the course of 22 years, I don't know, maybe -- you want like a number?
Q A ballpark. Obviously, you don't know precisely.
A Say 300, 400.
Q Okay. In providing pediatric care to a premature infant, a baby that was born prematurely.
A Yes.
Q Do you believe it's important to know what occurred during the neonatal course?
A Yes.
Q Is it important to know what problems or medical conditions the infant experienced while in the NICU?
A Neos get about, there's about seven or eight problems, and they almost all have all of them.
Q Okay. Now if you could answer my question. Do you believe it's important to know what problems or

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medical conditions the infant experienced while in the NICU?
A Of course.
Q Okay. How do you go about finding out what problems or medical conditions the infant experienced while in the NICU?
A Usually, I just ask the parent. I mean it's fairly obvious.
Q You believe that the parents have the medical sophistication and knowledge to be able to explain to you completely and fully what medical problems and issues their child had in the NICU?
A Most parents, yes. I mean after their babies graduated from NICU, usually the parents take the crash course in neonatal medicine. And they're aware of what's going on. And they're usually very good historians.
Q Do you believe it is important to know and understand what medical issues continue to require follow-up after the baby's release from the hospital?
A Yes.
Q And how do you find out what those issues are?
A Again, typically, if there's a, sometimes the parents come in with a summary. Sometimes the

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NICU has called me and let me know there are certain specific issues. A lot of times, you don't have either one of those. And so, you know, the parent is a pretty accurate historian and, and that's how you do it.
Q So if the NICU doesn't call you regarding a premature infant that becomes your patient, and if the parents don't bring you a discharge summary, is it your testimony today that you would then just solely rely upon the parents' report regarding the problems that the infant had in the NICU and the problems that need following up?
A Yes, I could get enough information from the parent.
Q Do you think it is important to know about abnormal test results that the child had during the neonatal course?
A Yes.
Q And how do you find out about those abnormal test results?
A Either the NICU tells me, or it comes from a summary, or the parent lets me know.
Q So if the NICU doesn't call you, and the parents don't come with a discharge summary, you would expect parents to be able to recall and tell you

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accurately about abnormal test results their child had while in the NICU?
A Yes.
Q What do you do to educate yourself regarding your patient's neonatal course?
A What do I do -- can you rephrase that question?
Q Yeah, what do you do? What affirmative steps do you take to educate yourself regarding your patient's neonatal course?
A I, again, if there's specific concerns that were raised by the NICU doctor, if there's a summary, or if, you know, I can ask the parent questions.
Q Okay.
A Was the baby on parenteral fluid? Were they intubated? Were they on a ventilator? How long were they on the ventilator for? What's the most oxygen the baby required? Do they want us to follow up with ophthalmology? What was the state of the eyes? What's the state of the GS? What are the feeds right now? Is the baby pooping? Is the baby peeing? Was there a brain bleed?
Q These are questions though that you are asking the parents?
A Yes.

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Q Is that right?
A Yes.
Q Do you call the NICU doctor and ask him those questions?
A If there's a question, sometimes, yes.
Q Sometimes yes?
A If there's a question, if I can't understand it, or if there's something that went on that was very unusual, I would ask the NICU doctor. But that would be very rare.
Q Well, and the only way you would know whether or not something unusual went on without speaking to the NICU doctor is if the parents accurately convey that information to you. Right?
A Correct.
Q Okay. How in the world do you know if you're getting all of the facts and all of the information from the parents regarding the neonatal course?
MS. DAEHNKE: Object to the form and the tone.
But you can certainly answer.
THE WITNESS: How I do know? Because most parents are very accurate. They are. They, they learn a great deal about neonatal medicine while the

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baby is in the hospital. And they come out knowing a lot. And I have faith in my parents. I believe them.
BY MS. CARMICHAEL:
Q Is it your experience, Doctor Conti, that oftentimes, if not all of the time, the hospitals that care for premature babies in the NICU will send -- that then become your patient -- will send the discharge notes to your office? They'll copy you on those?
A Repeat that question. I'm sorry.
MS. CARMICHAEL: (To the reporter:) Will you read it back, please?
MS. DAEHNKE: Then I'll object to form and argumentative and vague and ambiguous.
(The last question was read back.)
THE WITNESS: Yes, oftentimes.
BY MS. CARMICHAEL:
Q That's pretty standard practice, isn't it?
A Yeah, oftentimes they will, they will send a discharge summary.
Q Okay. And what is your office protocol when that summary is received? What happens with that summary?
A It gets copied and put on the baby's chart.
Q By whom?

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A By Medical Records.
Q Okay. Do they notify you that the discharge summary arrived?
A No.
Q Okay. So then how do you learn, how do you come to know when a discharge summary has arrived in your office?
A You look in the chart. And if it's there, it's there. If it's not, it's not.
Q Okay. So when you review the chart and find these discharge summaries copied and placed into them, do you read them?
A Yes.
Q And in your experience, do parents -- well, I think you already testified that in your experience, parents will oftentimes bring you a copy of the discharge summary --
A Yes.
Q -- as well?
A Sometimes they do. Correct.
Q And when they do, do you read them?
A Yes, usually we, we copy them. And usually I leave the original to, to the parent, and use that copy and put it in the chart. And we read it right then.

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Q What about the prenatal course? Do you think it is important to know what occurred during that timeframe as well?
A Sure. If it's relevant.
Q Would it likewise be important to know about abnormal test results during the prenatal period?
A It depends on the test result. I mean, you know, there's lots of abnormal results that can come out that would be completely irrelevant to taking care of the baby.
Q Okay. If the birth mother was consulting with a perinatologist during the prenatal course, would it be important for you to know what condition the perinatologist who was treating them was concerned about?
A Sometimes, yes.
Q Did you receive any education or training regarding the clinical significance of an abnormal nuchal translucency or nuchal fold on ultrasound during the prenatal period?
A That's usually a sign for Down's Syndrome.
Q And other than MayRose, are you aware of ever caring for any other infant who had an abnormal nuchal translucency or nuchal fold on ultrasound prior to delivery?

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A I believe it was mentioned from time to time.
Q During your medical training and education, did you receive any training regarding the diagnosis and treatment of rare blood disorders?
A Yes.
Q What did that training consist of?
A I believe when I was a resident, we did rotations in hematology oncology.
Q Okay. And did you receive education or training with respect to how to differentiate between anemia due to prematurity and anemia caused by a specific blood disorder or genetic defect?
A Yes.
Q And what did that training consist of?
A Again, as, you know, part of your residency, you do a, you know, rotation or two in hematology oncology, and sometimes it comes up during that.
Q So how do, what do you do to differentiate between anemia during to prematurity and anemia caused by a specific blood disorder?
A You know, the diagnosis of anemia, you first look at the size of the red cells. They're either small, normal, or large.
If they're too small, you think about iron

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deficiency, you think about sideroblastic, you think about lead poisoning, you think about anemia of chronic disease.

If they're large, you think about B12 and folate deficiency.

If they're normal, you, you look at a retic count and you see if they're hemolyzing or if they're not.

I mean the diagnose -- you know, there's a thousand things that cause anemia. So.

Q And when you say small, normal, or large, you're talking about microcytic, normocytic, and macrocytic.

A Correct.

Q Correct?

A That's correct.

Q Okay. And I believe you said that -- well, we'll come back to that in a minute.

Okay. So I assume you've also then received education and training and understand how to differentiate between amenia that's the result of an iron deficiency and amenia that has nothing to do with an iron deficiency?

MS. DAEHNKE: Object to form.

You can answer if you can.

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THE WITNESS: I, I know how to diagnose anemia of iron deficiency. Is that the question?

BY MS. CARMICHAEL:

Q You would be able to determine, you know how to tell whether anemia is being caused by an iron deficiency?

A Yes.

Q Okay. All right. Other than MayRose, have you ever cared for an infant, to your knowledge, who had anemia as a result of a genetic defect or a specific blood disorder?

A I have a couple kids who have hereditary spherocytosis.

Q Did you diagnose that?

A No.

Q They came to you with that diagnosis?

A Correct.

Q Prior to MayRose, were you aware of a condition known as Diamond-Blackfan anemia?

A Yes, I've heard of it before.

Q What, what did you know about that disease?

A It's called pure red cell aplasia. It's usually -- what do I know about Diamond-Blackfan anemia is your question?

Q Yes.

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A Okay. It's called pure red blood cell aplasia. It's associated with absent radii, absent thumbs, limb defects. It's very rare. It goes under the category of normocytic anemias with a low retic count. What they call the production anemias.

Q Okay. Okay. Switching gears. Do you recall when you first met Tiffani Hurst?

A Yes, when she had her first baby Tristin.

Q And you remember caring for Tristin?

A Yes.

Q Do you have an independent memory of MayRose?

A Yes.

Q Did you or anyone from your office ever show up to see MayRose while in the NICU?

A No.

Q Why not?

A Because that typically wouldn't be the practice. That wouldn't be standard practice. Usually they're being taken care of by the NICU until, until the time they're discharged from the NICU, and then I would see the baby.

Q Okay. Do you recall any phone calls from Ms. Hurst while MayRose was in the NICU asking you to become involved in her care?

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A I have no memory of that, no.

Q Did you ever speak with Doctor Blahnik or Doctor Piroozi or any physician at Sunrise Hospital regarding MayRose Hurst prior to her discharge?

A I don't recall speaking to one of the doctors regarding MayRose, MayRose prior to discharge, no.

Q How about following her discharge?

A Following her discharge, yes, I met her in the office.

Q No, how about following her discharge, did you speak with Doctor Blahnik or Piroozi or any physician at Sunrise Hospital who had cared for her in the NICU?

A No, I do not believe so. I have no recollection of that.

Q Why would you -- why not? Why didn't you contact them?

A Because she seemed like a typical preemie.

Q So there -- okay. What do you mean by a typical preemie? What is a typical preemie to you?

A She had one of the, she had a couple of the conditions that preemies usually have a lot of times.

Q Such as?

A NEC, N-E-C. And that's what I remember

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primarily about her history, that she had NEC.
Q What is your understanding of MayRose's neonatal course?
A I've learned a lot, of course, since, since this case began, and before that, you know, after she got sick, you know. At the time, I learned what was important about it.
Q Okay, and realizing it may be difficult for you, but I want you to try to distinguish between what you know now and what you knew then. And I'm asking you specifically when MayRose started treating with you as her pediatrician, what was your understanding at that point of her neonatal course?
A Again, the thing that stands out the most to me is that she had developed necrotizing enterocolitis. And that was the most significant thing about her medical history.
Q And what was your understanding of her condition upon discharge from Sunrise?
A She was still of a low birth weight -- she was still of a low weight. So we were going to have to grow her.
And I remember, you know, I remember the thing about the NEC.
And I remember there was some question about

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her, her brain. And so at a later visit, we got an MRI of her brain.
That was the main things I remembered about her.
Q Okay.
A At the time.
Q And were you aware of, besides the MRI and the NEC, were you aware of any other medical issues that needed specific follow-up care on?
A I remember them asking me about cystic fibrosis. There was some question of cystic fibrosis based on her course, which I thought was unusual, because it's very rare in African Americans. So.
Q Anything else?
A Well, now I know about the anemia.
Q But you did not know about the anemia at the time?
A I have no specific, I don't remember whether I, whether or not I dealt with the anemia specifically. No, I mean it's very, almost all preemies, when they come out of the NICU, have the diagnosis of anemia. Most of them have received transfusions. It's just a typical part of the history.
Q And do you know as you sit here today

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whether or not you were aware that MayRose had received transfusions during her stay in the NICU?
A I believe the mom had mentioned it, yes.
Q So this information that you obtained about the NEC, the question about her brain, the cystic fibrosis, the anemia, the transfusions, how did you learn that information?
A I, I believe that the, that Tiffani, her mom, told me those things right at the time of when I met the baby.
Q Okay. Given this information that Tiffani provided to you, did you feel that it would be beneficial to review the discharge summary for MayRose, to find out specifically what the NICU physicians were recommending as far as follow-up?
A I've dealt with babies like that many, many, many times before. And I didn't feel any specific need at that point in time that, that a summary needed to be reviewed. I mean, you know, I've seen, you know, 500 kids like MayRose before and had no trouble dealing with them.
Q You've seen 500 kids with an undiagnosis -- undiagnosed case of Diamond-Blackfan anemia?
A No. Preemies.
Q Do you have any knowledge regarding Tiffani

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Hurst's hospital course before MayRose was delivered?
A Regarding the mother's hospital course?
Q Right.
A No. I, I don't recall. I know it was a difficult pregnancy.
Q Did you have any knowledge of what treatments or medications she and the baby received prior to delivery?
A I have no specific memory.
Q Did you know if MayRose was a vaginal birth or a C-section delivery?
A I believe she was a C-section, but I do not remember.
Q Were you, did you know of any medications that were administered to try to stop the labor?
A No, that would be, typically, when they try and stop labor they would use terbutaline. But that's really not very relevant.
Q Did you have an understanding as to why MayRose was delivered prematurely?
A Happens all the time. I mean like, you know, typically, there is no reason. I mean.
Q Okay. Anecdotal responses aside, in this specific instance, did you have an understanding as to why MayRose was delivered prematurely?

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A I don't think I, did I specifically know why MayRose was -- I mean almost never do you find out why the baby was delivered prematurely. I mean premature births happen all the time. I mean usually there is not a specific reason.

Q So the answer is no, you did not know why MayRose was delivered prematurely?

MS. DAEHNKE: The answer is what he said.

Doctor, if you want to look at your chart, or if you need to clarify the answer for counsel, given that you're not an OB.

THE WITNESS: I mean this is typically not something that we would deal with. As a general pediatrician, you wouldn't.

BY MS. CARMICHAEL:

Q What, if you know, what would be the clinical significance of delivery at 28 and a half weeks for the child? What are the biggest concerns at that point?

A The biggest concerns would be lung maturity. You know. The need for surfactin. Brain bleed, by far more that would be way up there. Did the baby have a PDA? Was there an infection that was treated? That's where the NEC comes in.

Almost all of them during the course of

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anemia hospitalization, particularly a 28-weeker, is going to develop anemia at some point. And almost always it's from the frequent blood draws.

So, you know, anemia is like pretty much the diagnosis of I would say virtually every 28-weeker who's ever been born. Usually requiring frequent transfusions. Or multiple transfusions, I should say.

Q Okay. What do Apgar scores tell you?

A Very little. An Apgar score is kind of an outdated, you know, it stands for appearance, respiration, grimace, activity, and reflex. So I mean it's sort of a gross approximation of what a baby's brain is doing at the time. Like their condition when they're born at one minute, and then at five minutes, and then again at ten minutes. But they have very little import on care anymore.

Q Okay. All right. Did you ever know what MayRose's Apgars were?

A I don't recall specifically, no.

Q Okay. With regard to hematocrit, do you know what the normal range for a premature infant is?

A It depends on the age at gestation.

Q Okay. So what would the normal hematocrit be, what would be the normal range be for a 28-and-a-half-week-old?

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A I do not know specifically.

Q And I think you've indicated that there are lots of different reasons for anemia. Is that true?

A Yes. But a preemie, there's primarily one.

Q And what is that?

A That would be blood loss anemia from the frequent blood draws.

Q Frequent blood draws to, to do CBC's?

A To monitor CBC, electrolytes, blood gases.

Q Okay. Did you ever review any of MayRose's neonatal lab results during the time she was your patient?

A I don't recall. I don't believe so, no.

Q Now, what is your understanding -- or what was your understanding when MayRose became your patient as to the status of her anemia at the time of her discharge from Sunrise?

A I don't recall. I believe -- I remember Tiffani mentioning that the baby had, had had anemia and required some transfusions.

Q Okay. Did you do anything to follow up on that to see if the baby was still anemic?

A You do what you need to do. You know. You give every baby the tests that they need, and you do nothing more.

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Q Did you do anything to follow up on MayRose's anemia to see if she was still anemic?

A You examine the baby. And I would examine MayRose, and on every patient you kind of do this to the eyes and you can see if they're anemic or not.

Q You can tell --

A Every baby.

Q You can tell --

A Absolutely.

Q -- on a baby by looking in their eyes if they are anemic?

A By looking at the conjunctiva of the eyes, yes, you can.

Q And was MayRose anemic?

A No.

Q What is your understanding, or what was your understanding, when MayRose became your patient, with regard to her reticulocyte count at the time of her discharge from Sunrise?

A I don't remember what her reticulocyte count was at the time of discharge.

Q You didn't know. You had no idea what the reticulocyte count was at the time of discharge, did you?

MS. DAEHNKE: Object to form. Are you

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asking what he knows now, what he knew then?
MS. CARMICHAEL: I'm talking about what he knew then, when she became his patient.
MS. DAEHNKE: That wasn't your question.
THE WITNESS: The reticulocyte count is not something you're typically going to look at on preemies who come out of the NICU. I mean.
BY MS. CARMICHAEL:
Q Unless, of course, they had an issue with their reticulocyte count. Right?
A Perhaps.
Q And if they had a very low reticulocyte count that basically demonstrated they weren't making any reticulocytes, that would be something that you would probably want to follow. Do you agree with that?
MR. RIGLER: Objection to form and foundation.
MS. DAEHNKE: Join. I'm joining the objection.
THE WITNESS: Again, a reticulocyte count is not, I mean it can be high or low on a preemie. And it's almost never relevant. I mean if a baby has iron deficiency anemia, the reticulocyte count is going to be low. So, you know, when you put them on iron,

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sometimes it goes up, and sometimes it doesn't.
BY MS. CARMICHAEL:
Q Isn't just the reverse the case, Doctor, that if it's an iron deficiency, the reticulocyte count will typically be high?
A Not if, as a matter of fact, you use the, you put them on iron. If the reticulocyte count goes up after that, then you think, gee, it could be iron deficiency anemia.
But then after you've had then on iron for awhile, the reticulocyte count is going to be normal or low anyway. So no, the reticulocyte count is typically not that important.
Q Okay. Do you know whether, or did you know, when MayRose became your patient, whether a different natural diagnosis regarding the cause of her anemia was ever undertaken during the neonatal course?
A Can you repeat that question? Did I know whether?
MS. CARMICHAEL: (To the reporter:) Will you repeat the question, please?
(The last question was read back.)
MS. DAEHNKE: Do you have that question clear? Is the question did you or did you?
MS. CARMICHAEL: Did, when she became his

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patient.
THE WITNESS: Yes.
I'm sorry, the question, can you repeat it?
MS. CARMICHAEL: (To the reporter:) Would you read it again?
MS. DAEHNKE: Well, the question as you phrased it, which she's going to read back, says do you or did you. And so did you want her to read it just saying did you?
MS. CARMICHAEL: I'll clarify.
BY MS. CARMICHAEL:
Q When MayRose became your patient.
A Yes.
Q Did you at that time have an understanding as to whether or not a differential diagnosis regarding the cause of her anemia was ever undertaken during her neonatal course?
A I don't recall that being a question, no.
Q Did you know that her father had thalassemia?
A No.
Q You don't recall --
A I don't recall that. I don't recall that being a question or an issue.
Q Do you remember Mr. Abbington telling you

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that he had thalassemia?
A I have no specific memory of him telling me that, no.
Q Did you --
A It's possible he might have. I don't recall that.
Q Okay. Did you ever do anything to determine whether she had, MayRose had inherited her father's thalassemia?
A To work up thalassemia, you wouldn't work that up until a little bit later date. You would look for an elevated hemoglobin A2 fraction. You get a hemoglobin electrophoresis. But that wouldn't kick in until months later. Weeks to months later.
Q Let me ask you this: When MayRose became your patient, did you have an understanding of whether her anemia was microcytic, normocytic, or macrocytic?
A You know, again, typically, you know, if you look at preemies, if you look at babies in general, the cells are a little bit larger than when you look at it for an older child of four and adult. So those numbers about macrocytic, microcytic on a preemie, on a newborn baby, they're kind of skewed. They're kind of skewed to the high side. So again, what looks to be a normocytic anemia can actually be a macrocytic

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anemia in an older kid, or a microcytic.
Q And my question was, did you have any understanding, when you assumed MayRose's care, as to what her anemia had been in the NICU? Normocytic, microcytic, or macrocytic?
A It wouldn't be something you would typically look at. I mean, you know, almost all the anemias that come from the nursery, there are the regular normocytic iron deficiency blood loss anemias that you see just from frequent blood draws.
Q Okay.
A It's true on almost all preemies.
Q And did you check to see if in fact MayRose's had been normocytic?
A I do not recall checking to see whether it was normocytic or not.
Q Okay. Diamond-Blackfan anemia is macrocytic, characterized by reticulocytopenia. Is that correct?
A Typically, Diamond-Blackfan is going to fall under the normocytic anemias.
Q Do you agree that Diamond-Blackfan anemia is characterized by reticulocytopenia?
A Yes.
Q Were you aware that within the ten days

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prior to MayRose's discharge she was transfused three times? Were you aware of that when you assumed her care?
A I have no specific memory of that. And again, that wouldn't be unusual in a preemie.
Q Were you aware that her hematocrit was also falling at the time of her discharge?
A Again, that wouldn't be unusual for a premature baby, that sometimes hematocrits are falling at the time of discharge. They're approaching their nadir, you know, their low point with the red cells.
Q So if it's --
A -- which occurs at around three months anyway, so.
Q If it's not uncommon then, if it's normal for a baby's hematocrit to be falling at the time that they're discharged from the NICU, is that an issue then that the pediatrician should follow up on or not?
MS. DAEHNKE: If you can answer -- object to form. If you can answer the question, just answer the question.
THE WITNESS: Okay, I'm sorry, repeat. Should I notice that the hematocrit is falling?
BY MS. CARMICHAEL:
Q No, my question is, I believe your testimony

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is that it's not uncommon for the hematocrit to be falling --
A Correct.
Q -- in a premature infant that's getting discharged from the NICU?
A At about three --
Q That's not uncommon?
A -- to four months. Correct.
Q Okay. So my question to you is, then should the pediatrician assuming the care of that infant, is that an issue that the pediatrician should follow up on?
A You should look at every child for anemia. I mean everyone who comes in gets looked at for anemia. It's just part of my routine exam. I look at the conjunctiva of the eyes, and you can see what the hemoglobin is pretty accurately.
Q Okay. So then why, Doctor, would the NICU doctors find it necessary to draw blood to check her hematocrit if they could just simply look at her eyes and, "Oh, she's fine"?
MR. RIGLER: Objection, form, foundation.
MS. DAEHNKE: Join.
MS. URDAZ: Calls for an expert opinion, speculation.

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MR. RIGLER: Join.
THE WITNESS: NICU doctors do a lot of blood tests. You know. That is the reason that the babies become anemic is because they do a lot of blood tests. And they know that, and we expect that. And, you know, they have to get some electrolytes. I mean they're looking at not only just what the hemoglobin is, there's looking at the platelet count. I mean there's a lot of reasons, you know, to get a blood test. And it's nice to, you know, if you're going to draw it for something else, you might as well look at what the hemoglobin is also.
So I don't see what your point is.
BY MS. CARMICHAEL:
Q Okay. But as you sit here today, it's your testimony that you can tell whether a child's hematocrit is normal simply by --
A Yes.
Q -- looking at their eyes?
A Yes, it is.
Q Were you aware that MayRose had not made it three weeks without needing a blood transfusion since the day she was born? Did you know that when you assumed her care?
A I have no specific memory of that. But

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again, that is very, very typical for preemies in the, in the NICU.
Q Okay. If a preemie is needing transfusions every three weeks at the time of their discharge, is that something that the pediatrician would need to follow-up on when they assume care of that baby?
MS. DAEHNKE: Object to form.
You can answer if you can.
THE WITNESS: You do test on the baby -- I mean you are following up on that. By looking at the baby, you are following up on it. I mean you are following up on that problem as it exists. I mean you don't want to draw a lot of blood when you don't have to.
BY MS. CARMICHAEL:
Q And for those babies that have serious genetic blood disorders, how does your eye test work for them?
A You should still be able to tell whether they have anemia or not. I can tell whether they have anemia or not. Whether it's, I mean by these rare, you know, like you're saying, these rare genetic blood disorders.
Q Were you aware that within the ten days prior to MayRose's discharge she had a low and falling

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retic count? Did you know what when you assumed her care?
A Didn't we just answer that question before?
Q I don't, I don't remember you answering that one.
A Repeat the question then.
Q Did you know when you assumed her care that she had a low and falling retic count at the time she came out of the hospital?
A I know you asked me that question earlier.
MS. DAEHNKE: Well, just for purposes -- asked and answered. You can answer again so we can just move on.
THE WITNESS: No, I do not believe I was specifically aware that her retic count was falling at the time.
BY MS. CARMICHAEL:
Q What is the clinical significance of a low and falling reticulocyte count?
A Didn't I answer that one also? Okay. A clinical significance of a falling retic count could be that the baby was just put on iron. You know. Like when you first put them on iron, the retic count initially rises, and then it falls, it goes back down to normal.

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So the fact that the retic count was falling, you know, usually it's not going to be very relevant.
Q And if they haven't just been put on iron, what would the clinical significance be, if you know, of a low and falling reticulocyte count?
A That it's probably iron deficiency anemia.
Q Are you aware that a low reticulocyte count can indicate bone marrow disorders or aplastic crisis?
A Yes. It goes under the production anemias, yes.
Q And in fact, it points to suppression of the bone marrow and aplastic anemia. Right?
A Or a viral infection which also suppresses the bone marrow.
MS. CARMICHAEL: (To the reporter:) Would you mark that?
(Plaintiffs' Exhibit B marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Conti, I've handed you what will be Exhibit B to your deposition.
A Yes.
Q And I'll represent that I pulled these from your chart.

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A Yes.
Q And I believe they represent the six office visits that MayRose had with your clinic.
Could you just look those over and tell me if that is correct?
A Yeah, these were the six from August -- before she got very sick. Before she got sick.
Q Okay, yes.
A Yes.
Q Thank you for that correction. Yes.
Okay, so August 5 being the first one, October --
A Yes.
Q -- 24th being the last?
A Correct.
Q Okay. All right, let's just look at the first visit. This visit, she actually saw you. Is that correct?
A Yes, that's correct.
Q And this was a well check?
A Yes, that's correct.
Q She had just been discharged from the hospital a couple of days earlier?
A Correct.
Q Is that right?

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A **Uh-huh.**
Q Okay. And who's writing is on this?
A **It's probably Tiffani Rainstanos, probably like my nurse who writes my notes for me.**
Q Okay. And here you note, she, I guess, Tiffany noted under "Development," she has a plus with "smiles." So the baby was smiling at this time?
A **Correct. Correct.**
Q All right. Did you, in addition to this chart note here, did you make any independent notes of your own?
A **I don't believe so, no.**
Q Is that not your practice, you don't do your own notes?
A **Typically, no.**
Q Okay. What do you recall the parents telling you on this visit?
A **I remember hearing about the NEC. I remember hearing about -- I mean necrotizing enterocolitis. I remember hearing about the cystic fibrosis question. I remember, you know, we were concerned about the brain at that time. And, you know, but the fact that she was smiling was encouraging. We talked about how she was feeding, how she was pooping, peeing, sleeping. We talked about**

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scheduling. We mentioned about development. How do you tell when the baby is going to get sick, feeding, lethargy, irritability.
Q And what did you tell the parents with regard to how to tell when the baby gets sick?
A **Typically, a baby is going to be not eating well, lethargic, or irritable. Lethargic means not sucking on the feeder well. Irritable means weak, whining, crying, doesn't stop.**
Q How did MayRose appear on this visit, do you recall?
A **She appeared well. I mean she, you know, for a preemie who had just been through what she had been through, she appeared to be doing quite well.**
Q Okay. If you'll turn to the next visit.
Well, and let me just ask you back on the first one. So have you told me everything you recall the parents telling you?
MS. DAEHNKE: Mr. Abbington, do you need to take a break? Because we could just take a quick break and you could get some water or something?
MR. ABBINGTON: I'm okay.
THE WITNESS: Okay. I'm sorry?
BY MS. CARMICHAEL:
Q Have you told me everything you recall the

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parents --
MR. ABBINGTON: What did I do?
MS. DAEHNKE: Nothing. I thought you needed a break. I'm sorry.
MR. ABBINGTON: I'm okay.
MS. DAEHNKE: Okay.
MR. ABBINGTON: Thank you though.
MS. DAEHNKE: Okay. Okay.
Okay, sorry, Doctor.
THE WITNESS: That's okay.
MS. CARMICHAEL: If anyone, including you, ever needs a break, just say so.
THE WITNESS: Okay, thanks.
BY MS. CARMICHAEL:
Q Back on the first visit. Do you, have you told me everything that you remember mom and/or dad discussing with you about MayRose on that visit?
THE VIDEOGRAPHER: Excuse me, you're covering the mic.
THE WITNESS: Oh, I'm sorry. Thank you.
Everything that they said to me? I mean that was four years ago. So I don't know if I can recall exactly everything that was being said to me at that time.
//

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BY MS. CARMICHAEL:
Q Well, sure. I'm asking you if you told me everything you remember about your conversations with mom and dad on that date?
A **I'm sure if you asked me later, I could probably tell you a couple more things. But I believe to the best of my ability I'm telling you, the best of my memory I'm telling you what I remember.**
Q Okay. And what do you remember about MayRose yourself on that occasion?
A **She was little. You know, she had the typical preemie, like, it's not like exactly muscle wasting, but I mean, you know, real, real skinny.**
But she was breathing well. She looked pretty good. I mean, you know, considering, you know, that she had been through the NEC.
And she had been through, you know, there was a question of cystic fibrosis. I thought that was unusual. But we went ahead and like, I remember the mom mentioning like, you know, she wanted, you know, I remember Tiffani mentioned she wanted that ordered. And I said, "Okay, if that's what, you know, if that's what we're doing, I mean, yeah." You know, if that's what, you know, mom wanted and, you know, the neos wanted, she mentioned the neos wanted it. And so.

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THE VIDEOGRAPHER: We need to change tapes.
MS. CARMICHAEL: Okay.
THE VIDEOGRAPHER: This marks the end of tape number two. It's 3:53 p.m. We're off the record.
(A short break was taken.)
THE VIDEOGRAPHER: We're back on the record. This marks the beginning of tape number three. It's 4:05 p.m.
BY MS. CARMICHAEL:
Q Doctor Conti, taking you then back to this first visit that you had with MayRose.
A Yes.
Q Do you have a memory of both of her parents being with her on that visit?
A Yes.
Q Okay. And we were going over sort of the, the information that you were discussing with the parents on that visit.
Do you remember whether or not the topic of the brain bleed came up on that visit?
A You know, the brain's always a concern and it tends to be kind of like where I tend to focus. I, I believe that did come up. I have no specific memory talking about a bleed in the brain. But I know that,

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you know, it's just such a common thing in preemies that I always ask about it.
Q Okay.
A And, and the degree of the bleed and, you know, how we're going to follow it up, and what it means for the development, and so on.
Q Do you remember what the parents told you with regard to the brain bleed?
A I do not specifically remember, no. I'm sure they would have mentioned it, but I don't remember specifically what they said, no.
Q Do you believe you had an understanding on this, as of this first visit as to the, to the degree of the bleed, or the seriousness of the bleed?
A I, I would have understood it at the time. But I, I, yes, I believe I would have had an understanding of the degree -- you rank them one to four. So depending on what the rank was.
Q And as we sit here today, what is your understanding as to the level of MayRose's brain bleed?
A I don't recall.
Q Do you know whether or not you ever knew the degree, what the degree of her bleed was?
A I'm sure I would have known at the time,

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yeah. If there was a brain bleed, I would have asked like what grade it was, and I can tell you based on that. Do I remember what they told me it was then or, you know, what it is now? Or, I mean I don't even, to be quite honest, I'm not even recalling that there was actually a brain bleed. But.
Q Okay. Do you, but any information that you would have obtained regarding the brain bleed would have come from MayRose's parents. Is that correct?
A Probably. Probably. I mean almost always the parent knows, you know, the degree of the bleed. I mean, you know, they know that that's a real important number, and they know it, you know, it really impacts the baby's future.
Q Okay. In MayRose's case, did you, do you know whether or not you did any independent research to determine what, whether she had a brain bleed and what degree of bleed it was?
A I do not recall specifically. I know I would have asked about it. I ask on every preemie: Do we have a bleed in the brain? Do we have a ventricular hemorrhage, is what it's called. And what was the grade of it.
I don't recall specifically whether she had one or not, or if she did, what grade it was.

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Q Okay. As of this first visit, what, if any, concerns did you have for MayRose?
A Mainly development.
Q In what regard?
A Any preemie, even one who has had an uncomplicated course, can show signs late of developmental problems.
Q What kinds of developmental problems?
A Stiffness, spasticity, anything ranging from ADHD's to severe mental retardation. I mean that's, you know, that's the range of things you can see. But I mean, you know, you're always hopeful, you know, based on what, you know, the -- typically, the thing that impacts that most is the history of, of a brain bleed. And if there's not one, if there's a low grade one, you say okay, we should be okay here. Let's, you know, let's remain cautiously optimistic.
Q Okay. And do you remember seeing anything in your examination of MayRose on this date that caused you to have concern for her?
A No. She was just a, a preemie. She had the unusual-shaped preemie head. I think the fancy medical word is plagiocephaly. But we affectionately call it "toaster head." You know, I mean it's typically what you see in a preemie who's been through

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a NICU course.
Q Did you express any concerns, share any concerns with mom or dad about MayRose on that date that you recall?
A I don't, I don't recall expressing any specific concerns. Again, you're always going to watch out for the brain. I mean that's one thing we really focus on, so.
Q Okay. All right, and in fact, at some point at, at Ms. Hurst's request, you helped her to obtain a follow-up MRI of MayRose's brain. Do you recall that?
A Correct. I believe it was the second visit. And I remember her mentioning about an ultrasound of the head. And I said let's get the real one, you know, because MRI's are much better tests, I think. I think it really shows even subtle defects.
Because they can have this condition called PVL, periventricular leukomalacia, that sometimes doesn't appear until late. And it can even appear like late, late. But I mean but that can, you know, the best sign of that, or the best test for that would be an MRI rather than a head ultrasound. Head ultrasounds sometimes does not show if it's there.
Q Okay. And you, and so you helped her order a follow-up MRI?

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A Correct.
Q Okay. And do you recall the test results of that MRI?
A I thought it was normal. To my recollection, it was a normal MRI.
Q Okay. All right. And that -- let's see if I have that.
MS. CARMICHAEL: (To the reporter:) Will you mark that, please?
(Plaintiffs' Exhibit C marked for identification.)
BY MS. CARMICHAEL:
Q And I'm handing you, or you've been handed what will be Exhibit C to your deposition. And are those in fact the MRI results that you received back on MayRose Hurst?
A Looks like it, yeah. I believe that's true.
Q And it appears from that document --
MS. CARMICHAEL: There you go, Patricia.
MS. DAEHNKE: Thank you.
BY MS. CARMICHAEL:
Q -- that that test was done on September 30. Is that right?
A Yes, correct.
Q Okay. So that was almost two months after

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her discharge from the NICU. Is that correct?
A That's about right.
Q Okay. And those results are indeed normal. Is that right?
A Yes, they are.
Q Okay. And do you remember that Mrs. Hurst also asked you to help her schedule some follow-up testing? I believe it's called a chloride sweat test?
A Yeah, that was the cystic fibrosis -- I thought we, I thought they were, it was more like a blood test we were looking for to -- I'm trying to remember now. It was, it was either there was like kind of a like a soft marker that she might have the gene for CF, cystic fibrosis, and so order the sweat chloride, or that we had to do the sweat chloride later. I thought they wanted genetic testing done for CF. I thought it was more like a blood test that we had ordered. But I don't recall specifically. I remember there was a test for CF that was ordered. Whether the sweat test or, or the actual genetic test, which is more accurate.
Q Okay.
A Sometimes a sweat test won't be abnormal until later.
(Plaintiffs' Exhibit D marked for

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identification.)
BY MS. CARMICHAEL:
Q I'm handing you what will be Exhibit D to your deposition, Doctor. And it's a two-page exhibit. Do you see that?
A Okay.
Q And does that refresh your memory --
A Yes.
Q -- regarding --
A Oh, yes.
Q -- what test was ordered by your office?
A Uh-huh.
Q And what test was ordered?
A They ordered a sweat test. And it was a Grade I intraventricular hemorrhage. So we ordered a, looks like they were going to order a head ultrasound, CT scan. But I know it was an MRI that we eventually ordered.
Q Okay. But you did order the sweat chloride test.
A Correct.
Q Is that right?
A Correct.
Q And do you remember the result from the sweat chloride test?

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A **I believe it was normal.**
Q Okay. All right. And then just taking you back to that first page of Exhibit D, where you've got Grade I IVH?
A **Yes.**
Q Her medical records reflect a Grade I germinal matrix bleed. Is there any distinction between a germinal matrix and an IVH?
A **Grade I is also known as a germinal matrix hemorrhage.**
Q Okay. And with Grade I, the prognosis is generally very good. Is that true?
A **Pretty good. Yes. Absolutely.**
Q Okay. All right. And as we discussed, the MRI came back normal. Correct?
A **Correct.**
Q Okay. And it is your memory that the sweat chloride test also came back normal?
A **Correct.**
Q All right. And then on that page one of Exhibit D, it indicates that you're also ordering I believe Synagis to start in September?
A **Yes.**
Q And is that a treatment that's preventive to avoid RSV?

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A **That's correct.**
Q Okay. All right. Do you remember also ordering a swallowing study? She was referred to speech therapy, I believe, for a swallowing test?
A **That's possible. I don't recall specifically doing that. But that's a lot of preemies will have difficulty eating, swallowing. So you order what they call a modified barium swallow test.**
Q Okay. And do you recall what the results of MayRose's swallow study was?
A **I do not recall.**
Q All right.
A **I imagine it was normal, otherwise we would have...**
Q Taking you back then to Exhibit B to your deposition, the chart notes, the visit notes?
A **Yes.**
Q If we could go to the next visit?
A **Okay.**
Q You saw her on this occasion. Is that correct?
A **Yes.**
Q And again, the writing on this chart note is not yours other than your signature. Is that true?
A **Correct.**

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Q Okay. So would you have filled out any other paperwork or notes --
A **No.**
Q -- in connection with this visit? Okay.
Do you have an independent memory of this visit?
A **An independent memory, no.**
Q Do you remember whether both parents were present, or just one?
A **I thought just mom was there.**
Q Okay. And do you remember how MayRose looked on that occasion?
A **I thought, again, I thought she was looking okay. She was gaining weight, which I thought was good. She -- what else? There was some questioning about that she was refluxing. But she wasn't -- I'm just taking that from the chart. Independent memory -- I believe that's when the conversation occurred regarding the MRI versus the head ultrasound.**
Q Okay. All right. And you can refer to your note for these next questions.
A **Uh-huh.**
Q So what, what was going on with her, according to your note, on this visit?
A **Let's see. She was breast feeding. Was**

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also being supplemented and Enfamil AR at the time. She was pooping and peeing good. We looked for signs of reflux. She wasn't screaming in pain. She wasn't losing weight. She wasn't turning blue. There was no diarrhea, vomiting, constipation. She was smiling. She was not rolling yet.
Let's see, we talked about head injury, ingestions, water injuries, thermal injuries, car seat. We asked about a pool. The baby was not colicky.
Immunizations were up to date at that point. And that's when we did the first set. It probably was actually the second set. The first set we give them in the hospital. Typically, that's what would be done.
Her exam was normal. Her neck supple without rash. Eardrums and throat were clear. The chest was clear. Heart without murmur. Abdomen was soft. Normal female.
Well child with a question, you know, with a question of static encephalopathy, which is like a kind of a code word for CP. So that's why we were getting the MRI.
Q Okay, and that's because she had the Grade I bleed?

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A Correct.
Q During her neonatal --
A You have to sort of. Right.
Q Okay. Did you see any other, I mean other than knowing that she had had the Grade I bleed that needed follow-up --
A No.
Q -- were there any other indications?
A No memory of any problems at that point in time.
Q Okay.
A I remember, and I think the mom had said we needed to get a referral for PT, OT, and ST. I mean that's why we would typically do that. I believe the mom had requested that that referral be done, and so we did that as well.
Q Okay. Do you remember Mrs. Hurst telling you that she, the baby was receiving those services through Summerlin -- or excuse me, through Sunrise, I believe, Hospital, and she wanted to have those services provided elsewhere, and asked you for the referrals?
A That's a possibility. I have no specific memory of that. But...
Q And those services --

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A It's highly possible.
Q -- are typical for a preemie?
A I mean most of them don't require that. But some do. Some do.
Q Okay. All right. Anything about MayRose on the second visit that caused you any concern?
A No.
(Plaintiffs' Exhibit E marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Conti, if you'll look at Exhibit E to your deposition. This document came from your chart. Is this something that you have parents fill out when you assume the care of their children?
A Yes.
Q Okay. And do you read these documents?
A Almost never.
Q So you're admitting that you don't typically read these?
A No.
MS. DAEHNKE: Object to form.
BY MS. CARMICHAEL:
Q Okay. How did you know -- you mentioned that you did give the baby some immunizations. How did you know what immunizations the baby had received

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and where to pick up with those?
A I didn't. I mean typically if the baby is in the hospital in the NICU for two months or more, they'll usually do the first set of immunizations.
Q So you would just make that assumption and then go from there as far as which immunizations to give next?
A Well, you wouldn't just make the assumption. You would ask the mom, has the baby received any immunizations yet.
Q And if the mom wasn't sure what had been given, what would you do in that case?
A Then we would have to call the hospital. Because that would be, you know, very significant.
But typically, you know, 99.9 percent of your moms are intelligent women, like Mrs. Hurst, like Tiffani. And so I would take her at her word. If she said immunizations had been given, and usually they will say, yeah, the first set has been given. I mean parents know that. They're, they're mostly a pretty intelligent crowd.
Q All right. If you will turn to page two of this document?
A Uh-huh.
Q Do you see down there in section G, where it

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says, "Has your child had," and it goes through a list of various immunizations. Do you see where Ms. Hurst has drawn a bracket and said, "Unsure, check the discharge statement"?
A Yeah, I see that's written there.
Q Now, your testimony is you wouldn't, you probably wouldn't have read this. Right?
A Correct.
Q So I'm just wondering, how do you, do you have any knowledge about how you would have determine what MayRose had had and where those immunizations should pick up at that point?
MS. DAEHNKE: Other than what he's already testified to?
MS. CARMICHAEL: That the mother told him?
MS. DAEHNKE: He testified what his custom and practice was if they weren't certain.
But go ahead, answer.
BY MS. CARMICHAEL:
Q I'm asking in this specific case of MayRose Hurst?
A I don't recall. I mean I don't, again, this, I don't recall seeing this. So, okay, what is my typical practice?
Q No, I'm asking you, do you have a memory of

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what you did in MayRose's case?
A No specific memory. I mean typically, again, the mom will mention it to me.
Q Okay. Where she's referring you specifically here to the discharge statement, do you have a memory of going then and reviewing the discharge statement at that time?
A The discharge statement? Oh, the discharge summary?
Q Right.
A I do not recall whether or not I saw the discharge summary at this point in time.
Q Okay. Okay, if we could go to the next office visit.
A Uh-huh.
Q Now, this does not -- this is a sick visit. Right?
A Correct.
MR. RIGLER: What is the date of that?
MS. CARMICHAEL: The date is September 30, 2008, Foothills Pediatrics 0122.
BY MS. CARMICHAEL:
Q Did you see the baby on this date?
A Yes.
Q Okay. And do you have an independent memory

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of this visit?
A No.
Q Okay. Based on your chart note then, or what we have here -- and again, none of this is in your writing. Correct?
A Correct.
Q Okay. What were the, what were the concerns or what was the purpose of the visit on this date?
A The baby was having some cough and congestion, as the chief complaint. There was no fever. Baby had some sniffles. Baby had some cough. There was no vomiting or diarrhea, no constipation. The baby didn't seem to be in pain. The baby had a little rash on the face. Was eating all right and peeing all right.
Baby had a history of NEC. Nobody smoked in the house. Baby didn't go to day care.
Exam was pretty normal except for a little rash on the face. Baby had a little congestion in the nose, a little redness in the throat. The lungs were clear.
So the baby ways diagnosed with seborrhea, upper respiratory infection, cough, pharyngitis, which is a sore throat. Come back if symptoms gets worse or temp is greater than 102.

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The RSV test was negative, so no RSV. Also we said usual URI treatment, which means suck out the sniffles with saline drops. Keep her sitting up. And one percent hydrocortisone cream for the face if necessary.
Q Okay. Do you remember anything about this visit, any conversation you may have had with Mrs. Hurst about MayRose?
A Specific conversation, no.
Q Okay. Was there anything about this visit that alarmed you or concerned you?
A No.
Q Okay. All right. And will you turn to the next page, please? Foothill Pediatrics Bates 0121. The date is October 1, 2008. So the very next day.
A Uh-huh.
Q And this is the regularly scheduled well visit. Is that right?
A Correct.
Q Okay. And do you have an -- did you see the baby on this date?
A Yes, I did.
Q Okay. And do you have an independent memory of this visit?
A No, I don't.

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Q Okay. Then based again on the chart note, what can you tell me about this visit?
A Baby was on formula. Had begun some stage one foods. Was pooping and peeing good. There was no diarrhea, vomiting, constipation, or pain with pee. The baby was smiling. The baby was not rolling yet.
We talked about head injury, ingestional injuries, water injuries, thermal injuries, and car seats. Baby was not a colicky baby. Shots were discussed and were apparently up to date. And mom didn't have a pool. Everything else was okay.
The exam was normal. Her neck supple. With without rash. Eardrums and throat were clear. Chest was clear. Lungs without murmur. Abdomen was soft. Was a normal female. Well child.
Come back at six months. Second hepatitis B shot was done.
Q Okay. And on the ENT portion of the exam?
A Uh-huh.
Q What does that say, TM and OP?
A Oh, tympanic membranes and oropharynx.
Q Clear?
A Yeah, ears and throat.
Q Is there any indication on this chart that the eyes were examined?

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A You wouldn't ordinarily note that.
Q You would not note that?
A No. I mean you always, I always examine the eyes. It's just one thing, you know, you look, you just go like that with the conjunctiva. You can look at the baby.
Q And that is something you do on every visit with every child?
A Pretty much.
Q But you never note it?
A No.
Q All right. So on this visit, this is just the day after she was there with the cough?
A Uh-huh.
Q She's assessed as a well child?
A Yes.
Q So she's better from whatever she, issues she was having? Yes?
A I would imagine, yes.
Q Okay. Any concerns at this point for the baby?
A Doesn't look like it, no.
Q Okay. All right. Okay, if you'll just turn to the next visit?
A Uh-huh.

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Q Dated October 18, 2008.
A Yes.
Q Foothill Pediatrics 0120.
A Uh-huh.
Q Now, on this occasion, you did not see the patient. Is that correct?
A No. Correct. It was Doctor Malixi.
Q Okay. Did you have any conversations with Doctor Malixi about this visit?
A No.
Q Did you ever discuss this visit with Doctor Malixi?
A I don't believe so.
Q All right. Did you ever review this chart note?
A I believe I've looked at this chart note since, yes.
Q Okay. In conjunction with this litigation?
A Yes.
Q All right. Did you look at it prior to this litigation being filed?
A No.
Q Okay. And just from your review of this chart note, what were the baby's, what was concerning about the baby on this occasion?

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A Baby had vomited three times the day before. Then she writes in her note, "Vomited three times yesterday. Last one was this morning, was about two hours before the office visit." Let's see. Something diaper. She was passing gas. She had a bowel movement the day before. Oh, she had had a wet diaper in the morning. She was passing gas. She had a bowel movement the day before.
Past history: Ex-preemie. History of NEC. Older sibling was throwing up five days ago. Nanny's children had also vomited. So looks like there was a virus going on in the house.
She writes, "No acute distress." I'm trying to see what she writes here. Not in distress -- oh, not sick looking, not in distress.
She looked at the mouth. She says the oral mucosa was moist. So the baby is not too dehydrated. Abdomen is soft. There's the healing midline scar, which would have been from the NEC, the N-E-C. The, let's see, abdomen was soft, flat, nontender, no guarding. Bowel sounds were nonreactive. That's good. Assessment then was vomiting with no dehydration.
She said continue the Pedialyte. Something as needed. I'll figure that out in a little bit. I'm

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not sure exactly what she says what the plan. Oh, no, no milk, it looks like. Or she can do milk. BRAT -- okay, there we go. I thought that means BRAT diet and milk as needed.
Q Okay. Do you have any criticisms of the care that was rendered by Doctor Malixi on this date?
A No.
Q Okay. All right. Then taking you to the next chart note.
A Uh-huh.
Q This is the visit on October 24, 2008, with Doctor Weber. Is that right?
A Uh-huh.
Q Foothill Pediatrics Bates 0119.
A Uh-huh.
Q Okay. Now, Doctor Weber had just recently started with your office as of the date of this visit. Is that true? Within a few months of that?
A I don't remember when exactly when she started. I suppose it's possible. Probably somewhere around there.
Q All right. And you had a policy, since she was a new doctor, of reviewing her chart notes?
A Correct.
Q At that time. Is that correct?

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A **Correct.**
Q All right. And why is it that you felt the need to do that?
A **You pretty much do it on all the, everybody when they first start.**
Q Okay. Just to make sure they're following your office protocols and that their treatment is in line with the kind of treatment you would want them to provide?
A **Uh-huh.**
Q As your employee?
A **(Nods.)**
Q Yes?
A **Yes.**
Q Okay. So you signed this note. Is that true?
A **Yes, correct.**
Q Okay. Did you, does that indicate that you read the note?
A **Yes -- no. Not necessarily. You know, there were like a thousand charts that would stack up. And so I would, you know, sign them and, you know, you, you -- I mean, you know, you glance through the note and you make sure it's decently written, and that the care is adequate and.**

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Q Are you acknowledging that you may not have read this chart note?
A **It's possible.**
Q At the time, in October of '08, how often would you, like what was your policy with regard to reviewing Doctor Weber's notes? Would you do it on a daily basis? Would you get to it a week later, a month later?
A **Weekly.**
Q Weekly?
A **Yeah.**
Q So her notes were accumulate over a week's period of time?
A **Correct.**
Q And then you would go through them?
A **Correct.**
Q And sign them?
A **Correct.**
Q Okay. So do you have any idea of the precise date you would have signed this note?
A **No.**
Q But it would likely have been at least a week later?
A **Probably less than a week. You know, they would accumulate up over a week. And so once a week I**

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would go there and I would sign the notes.
Q Was it a particular day of the week that you would dedicate to signing these notes?
A **Yes, but at the time I don't know what day of the week it would have been. Someone has to go to, I was going on Tuesdays sometimes, sometimes on Wednesdays, and sometimes on Thursdays at various times. And I don't know what, what day of the week I would have been there in this particular week in October of '08.**
Q Okay. Take a look at this note. And what does it, and what can you tell me about MayRose's presentation on this day and what Doctor Weber has noted as the assessment and plan?
A **Oh, okay, assessment and plan. She has GERD, gastroesophageal reflux disease. She's vomiting. And she's got some weight loss.**
MS. DAEHNKE: Doctor, hands away.
THE WITNESS: Oh.
MS. DAEHNKE: Thank you.
THE WITNESS: I'm sorry.
MS. DAEHNKE: That's okay.
THE WITNESS: She's got some gastroesophageal reflux disease, vomiting, and some weight loss. She wanted her back in a week. She

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planned to put her on Gentlease and Zantac.
BY MS. CARMICHAEL:
Q Okay. Is there any indication anywhere in this note that you can see that would lead you to believe that Doctor Weber suspected the baby may have the flu or a viral illness?
A **Not based on this note, no.**
Q Do you know as we sit here today whether or not you read -- do you recall reading this note?
A **I have no specific memory of reading this specific note. You mean before, before the legal thing began?**
Q Correct. Correct.
A **I have no specific memory of reading this note before. I've read it since.**
Q Okay. At some point in time, did you become aware that Doctor Weber had ordered some labs --
A **Yes.**
Q -- in connection with this visit?
A **Yes.**
Q And when did you first become aware of that?
A **I believe after I read through the case.**
Q Oh, so after the litigation was filed you became aware of that?
A **Correct.**

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Q And not before?
A **I don't recall. I mean it, it may, like once I knew she was sick, I could have read through it back then. I don't recall specifically.**
Q Okay. Do you remember having any conversations with Doctor Weber about this visit in close proximity to the time it occurred?
A **I don't recall any specific conversations. I believe we had talked about it, and I said, "How did she look then?" She said, "Well, she looked like she was refluxing." And I don't really – I don't recall any specific conversations with Doctor Weber regarding this particular note.**
Q Shortly after this October 24, 2008 visit, did you learn that MayRose had been hospitalized at Summerlin Hospital?
A **Yes.**
Q Okay. And how did you come to learn that?
A **Tiffani called me and told me.**
Q Tell me what you recall about that conversation. What did she tell you?
A **I remember she had said the baby was in the hospital. And she said she had a hemoglobin of one. And I thought, you know, are we sure that that's right? I remember, I remember that part of the**

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conversation.
Q Because that would be quite highly incompatible with human life, wouldn't it?
MS. DAEHNKE: Object to form.
MR. RIGLER: Join.
THE WITNESS: It will be low. I thought it was a lab error.
BY MS. CARMICHAEL:
Q What else do you remember about that conversation?
A **I remember we talked about what, what might be causing it. You know. We talked about perhaps a B12 deficiency. We needed to look at, you know, and then I called the, the PICU shortly after that and spoke to the other doctors there about her daughter.**
Q You did? And tell me about that conversation. Who did you speak with?
A **I don't remember. I don't remember the doctors' name.**
Q One or more doctors?
A **I think I spoke with, oh, over the course of the hospitalization, I spoke with, I think at least two doctors.**
Q Okay, and what did they tell you?
A **At the time we were looking at -- I remember**

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they said she coded for awhile in the ER. And that they had brought her up. And that they were looking at could this be histio -- erythrophagocytic histiocytosis. So it's just a really unusual, you know, disease where the white cells get converted by a virus into like these red cell-eating cells. So.
Q Did you come to know, in discussing this with the PICU doctors, that she, when she presented to Summerlin she was in severe anemic shock?
A **She was in hypovolemic. And -- she was in hypovolemic shock. Her blood fluids were really low. Her blood pressure was very low. And yes, incidentally, it was found that her hemoglobin was very low.**
Q So someone did tell you that she had severe anemic shock?
A **Yes. Tiffani was the first one to tell me though.**
Q Okay. Did, did Tiffani ask you to come to Summerlin and participate in the care of her child?
A **You know, we were talking on the phone quite often then. I don't recall her specifically asking me to go to Summerlin Hospital and look at the child. I mean, you know, once they're in the PICU, I mean the doctors who are looking at her there are quite good.**

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And I have confidence in them, so.
Q Did you ever visit MayRose while she was at Summerlin?
A **In the hospital, no.**
Q How many conversations did you have with Tiffani while MayRose was in Summerlin?
A **Several.**
Q And can you recall the substance of any of the other conversations?
A **How was she doing. You know. I remember us trying to get her to Denver. I remember talking about Denver. That's where she wanted her to go upon discharge.**
Q And why Denver? Do you recall what --
A **There's where.**
Q -- MayRose's diagnosis was --
A **Yeah, at the time, it was several days into the hospitalization they diagnosed she had watershed influx in her brain. We were expecting then, you know, her to have some neurologic deficit. So Tiffani had researched it and wanted her to go to Denver. And so we just made it happen.**
Q Do you have any understanding, did anybody convey any information to you as to the cause of the watershed brain injury that MayRose sustained?

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A It can happen from hypotension. I mean, you know, she was a full code. So it could have happened anytime during that course. It could have even been directly from the virus itself. I mean we, we considered all those things. All that was talked about. It could have been from the, you know -- I mean I'm not an ICU doc, so.

Q I'm just asking you if anybody told you or gave you a diagnosis or a cause for that watershed brain injury? I'm not asking you for your theories.

A It's called hypoxic ischemic encephalopathy. So it can be from lack of oxygen, lack of blood flow. That's what this is called. Yeah.

Q Okay. All right. After learning about MayRose ending up at Summerlin Hospital, did you go back to Doctor Weber and discuss with her this clinic visit?

A I have no specific memory of talking with Doctor Weber right after this. I probably asked her, but I don't recall specifically about a conversation with Doctor Weber four years ago.

Q Do you recall going back and reading this chart note, taking a close look at it to see what was going on with the baby on this date?

A Yes, at the time, I believe I looked at the

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note. But again, I have no specific memory of right, right when, when I did that.

Q Okay. Did you look at lab values that came into your office from the labs that Doctor Weber had ordered?

A No, I do not believe seeing any lab values from the labs that Doctor Weber ordered. I mean not at the time.

Q Did you know from talking to Doctor Weber that she had ordered labs on that visit?

A I remember her mentioning something about labs being ordered.

Q But you didn't ever inquire as to the results of those labs?

A I may have. I don't recall.

Q Did you ever see the lab values that were taken in the ER room of Summerlin Hospital when MayRose presented there?

A I have no -- I may well have checked on them, but I do not recall specifically.

(Plaintiffs' Exhibit F marked for identification.)

BY MS. CARMICHAEL:

Q Doctor Conti, referring you to Exhibit F of your deposition -- let me just find my copy here. It

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is Foothill Pediatrics Bates 0159, 0160 and 0161.

I want you to look at those three documents together. They appear to be the same lab results, but each document's slightly different.

A Yes.

Q Do you see that? On the one Foothill Pediatric 0161.

A Uh-huh.

Q Do you see where it's listed the physician name Weber, K?

A Yup, uh-huh.

Q Okay. So I believe these are the labs that Doctor Weber ordered. And can you tell me, can you read for me the tests ordered there?

A Let's see. CMP14 -- Comprehensive Metabolic Panel 14.

Q What was that?

A Comprehensive Metabolic Panel is what you see listed underneath. Plus a GFR, glomerular filtration rate. Venipuncture. Non-LCA request. Okay, it was probably, that probably means it was a, it was requested from another lab, probably. And there was a request problem.

That's what it says under "Tests Ordered" that I'm reading.

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Q Okay. And if you look down under, do you see at the bottom of that page where it says "Request Problem"?

A Yes.

Q Okay. And there it identifies a test, a CBC with a differential platelet. Do you see that?

A Yes, I do.

Q And they're apparently indicating that they had an insufficient specimen to be able to do that test?

A Right.

Q Okay. Let me just ask you this: See the initials on that page KW?

A Uh-huh. KW.

Q Do you recognize those?

A Yes.

Q Are these Doctor Weber's --

A Yes.

Q -- initials?

A Yeah, looks like Doctor Weber's.

Q All right. And do you see the writing, "Was admitted Wednesday, October 29, 2008, due to severe anemia"?

A Yes.

Q Do you recognize that writing?

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A I don't know it, although -- I do not recognize that writing specifically, no.
Q Do you recognize the signature or the initials below that writing?
A No, I do not. I'm sorry.
Q Okay. Looking at this, these lab results, those that they were able to obtain?
A Uh-huh.
Q Is there anything of concern in those results?
A In retrospect, or right at the time? I mean the CO2 is low. So, you know, it shows like the baby's fluids are going to be low. So, yeah, there's a little cause for concern right there, the CO2.
Q So looking at that in the context of it coming back in October of '08, would that low carbon dioxide value indicate to you the baby was dehydrated?
A Yes.
Q Would it have any meaning beyond that to you?
A That would be the main thing I would be concerned about.
Q Okay. All right. Okay, looking at Foothill Pediatric 0160.
A Uh-huh.

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Q The middle sheet in that three-page document.
A Uh-huh.
Q Do you recognize the writing in the margin of the upper left-hand corner?
A No, I do not. EM.
Q Okay. Then we also have Doctor Weber's initials on this?
A Yes, correct.
Q This document as well. Correct?
A Yes.
Q Okay. If you compare the two documents, you've got a date the sample's collected. And those match as October 28?
A Uh-huh.
Q A date entered of October 29. And that matches on both documents. Correct?
A We're talking about the previous form?
Q Right.
A Yes.
Q The middle one and the last one.
A What they collected. Yes.
Q Do you see the date reported? Do you see where those differ? We've got one that says 10/31, and one that says 10/30?

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A Yes.
Q Do you have any explanation for why those dates would differ?
A Probably this was the first report that came out, and this was the second one, I would imagine. This sheet was printed up on the 31st, and this was printed up on the 30th.
Q Okay. And then if you'll look at the first page of that exhibit, Foothill Pediatric 0159?
A Yes.
Q Do you recognize the handwriting in the, at the bottom of the page, where it says, "Did not have enough for CBC and was in ER at the time, called for redraw and per mother did not need to be done at that time"?
A Yes.
Q Whose writing is that?
A I do not know.
Q Oh, you do not recognize?
A I do not recognize the handwriting, yeah.
Q Okay. Was any of this reported to you during this October 31st timeframe?
A I don't remember specifically it being reported. I have seen, there is this note on the front page of my chart where I've written on a

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prescription pad "MayRose Hurst," and I've written "October 27, hemoglobin hematocrit."
So was I aware -- I don't know what the significance of this is either. That may have just been something I wrote down. I don't know.
Q Is that your handwriting on that?
A Yes, this one is.
Q Okay. I have that. We'll talk about that next.
Before we go on to that though, do you see how the date the specimens collected is October 28; and then the date reported, depending on the document, is either the 30th or the 31st?
A Yes.
Q And this is, the lab we're talking about here is LabCorp. Right?
A Yes.
Q Does your office have experience dealing with LabCorp on a regular basis?
A Yes.
Q And is that two- to three-day lag in the date that the specimen is collected and the date it's called in and reported to your office, is that typical for LabCorp?
MS. DAEHNKE: Object to the form of the

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question.
THE WITNESS: At the time, I don't remember what would have been, you know, par for the course for them. You know, I haven't had any major problems with LabCorp in the past.
BY MS. CARMICHAEL:
Q How often do you typically get lab results back from LabCorp?
A Couple times a week, I would suppose.
Q No, no, no. How often, from the time you send the patient in for the blood draw to the time the result comes back, what is typically the length of time?
A Twenty-four to 48 hours.
Q Okay. So a day to two days is typical?
A Yeah.
Q And sometimes as many as three days?
A Depending on the result, but possible.
Q Okay. Do you ever expect to get those results as soon as four hours?
A Yeah, if they're markedly abnormal, then yes.
Q If they're markedly abnormal?
A Correct.
Q Okay. All right. If you sent a patient in

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with an order for labs and you mark the order stat, how soon would you expect to get those results back?
A For a CBC, if I drew it in the morning, I would expect to get it by that evening.
Q So a whole day, a whole business day? That is, not 24 hours, but eight hours?
A It could be as much as eight hours, yeah.
Q And that's for a stat order?
A Yeah.
Q Okay. And an order that's not stat, the 24 to 48 hours, is typical?
A Would be typical.
Q Okay.
(Plaintiff's Exhibit G marked for identification.)
MS. CARMICHAEL: Actually, that goes with that.
THE WITNESS: Yeah, it's on the back.
BY MS. CARMICHAEL:
Q Okay, Doctor, referring you then to what will be Exhibit G to your deposition?
A Uh-huh.
Q It's a two-page document. And I believe that you've just fairly testified that that is in your writing. Is that correct?

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A Yes, correct.
Q Is both page one and two of that document in your writing?
A Not the whole thing is in my writing. The word, on the first page, the word "Quest" is not in my writing. And on the second page, "Quest LabCorp, no labs reviewed" -- no labs reviewed. That's not my writing either.
Q Okay. All right. So this is, it looks like a prescription from your prescription pad. Right?
A Correct.
Q It has MayRose Hurst's name on it?
A That's correct.
Q And it appears that you're ordering a hemoglobin hematocrit test. Is that right?
A Not necessarily. It's probably just I was writing a note that on October 27, this was done, ordered, and -- but I don't know. I have a date written down, and I have hemoglobin hematocrit, and I have MayRose's name. So I mean as to what it means now, or what was being told to me, or when it was written, I really have no idea.
Q Okay. Well, in looking at your chart, MayRose saw Doctor Weber on October 24. Is that right?

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A Yes.
Q Okay. And there is no visit with your office on October 27. Is that right?
A Yes.
Q Okay. So do you have any memory of how you would have come to be writing this on October 27?
A It could have been a thousand ways. I mean that doesn't necessarily mean I was writing this on October 27. It may have been that someone showed up on October 27 to get a hemoglobin hematocrit drawn and they couldn't do it. It may have been -- I mean to ask me what it means now, I would have no idea.
Q Okay. But you're not suggesting that you, on October 27, ordered a hemoglobin and hematocrit lab to be done on MayRose, are you?
A I don't believe so. I, I don't know.
Q All right.
A It's possible I was.
THE VIDEOGRAPHER: We need to change the videotape.
MS. CARMICHAEL: Okay.
THE VIDEOGRAPHER: This marks the end of tape number three. We're off the record at 5:02 p.m.
(A short break was taken.)
THE VIDEOGRAPHER: We're back on the record

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at 5:06 p.m. This marks the beginning of tape number four.
BY MS. CARMICHAEL:
Q Doctor, you've submitted some written answers to discovery requests in this case. Do you recall doing that?
A No.
Q Okay.
(Plaintiffs' Exhibits H and I marked for identification.)
BY MS. CARMICHAEL:
Q Would you review what will be Exhibit H and I to your deposition?
A Sure.
Q Take a look at those. Does that refresh your memory about providing discovery responses in this case?
A Okay.
Q Did you review those answers, those responses?
A I'm looking at them now.
Q Well, I appreciate you're looking at them now.
A Yes.
Q Did you sign these verifying that you had

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reviewed them, you knew the contents to be true, and that you're declaring under penalty of perjury that they are true?
A Yes, I did.
Q Okay. Okay, so they are your responses?
A Yes.
Q And you stand by them?
A Yes.
Q Okay. All right. Okay, have you ever reviewed the, MayRose's discharge summary?
A Yes.
Q You have. Okay.
(Plaintiffs' Exhibit J marked for identification.)
BY MS. CARMICHAEL:
Q Okay. When do you recall reviewing that discharge summary for the first time? When is the first time you reviewed it?
A My first very specific recollection of reading it is in 2010, in August of 2010, was the first time I specifically remember going through it.
Q Okay.
A But I may have seen it before that. I do not recall.
Q All right. And in response to request for

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admission number two, you acknowledge that your office was provided with the discharge orders, that you did receive those?
A Yes.
Q Okay. You just don't know when or how that occurred because you didn't ever read them until August of 2010. Is that correct?
A My first specific memory –
MS. DAEHNKE: I object. That misstates his prior testimony.
But go ahead.
THE WITNESS: My specific memory of reading it was in August of 2010. But I may have read it before. I do not have any specific memory of whether I did or whether I did not read it before.
BY MS. CARMICHAEL:
Q Well, if you had read it when you assumed the care of MayRose Hurst, you would have seen that you were being asked by the NICU doctors to follow up with her with a CBC and differential test within 30 days?
A Yes.
Q Is that correct?
A Yes, that would be correct.
Q Okay. And had you taken the time to read

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the discharge instruction and actually seen that order, I assume you would have executed on that. Is that true?
MS. DAEHNKE: Object to form.
THE WITNESS: Can I answer it?
MS. DAEHNKE: Yeah. Yeah.
THE WITNESS: Not necessarily. You know, you do what tests, you do what you do on the baby based on what the baby needs. Not necessarily what they're requesting here.
I mean if you didn't, you know, if you believe at the time the cause of the anemia is chronic blood loss anemia from blood draws and you get a kid that doesn't look very anemic, why are you going to bother drawing the blood at that point in time?
BY MS. CARMICHAEL:
Q Okay. So your testimony today is that even if a group of NICU doctors felt that part of her discharge orders required her to get a follow-up CBC in 30 days, you may disagree with that and may not actually do as they recommended. Is that your testimony today?
A That's, um -- okay, rephrase that question before I answer it. Can you, can you repeat the question before I answer it?

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Q I can. Do you need me to word it differently, or do you just --
A No, that's okay. You can just word it.
MS. CARMICHAEL: (To the reporter:) Go ahead and read it back then.
(The last question read back.)
THE WITNESS: Those discharge orders are a suggestion. And they're not requiring, I believe the word "require" is incorrect. I mean they're suggesting that that's what you get when you look at that.
But, you know, if you decide that it's not necessary, I, you know, I believe that you shouldn't do it. I mean you could give every kid what they need and no more and no less.
BY MS. CARMICHAEL:
Q Okay. And do you take into account the difference in knowledge that you would have seeing the baby as she comes into your care versus the knowledge that the NICU physicians would have of the entire course of their care while she was in the NICU?
MS. DAEHNKE: Object to form, foundation. It's ambiguous. Argumentative.
But go ahead. Answer if you can.
THE WITNESS: So am I totally discounting

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what they -- am I --
MS. DAEHNKE: Let's just try and answer her question. If you can't answer it, then ask her to rephrase it.
THE WITNESS: Okay, can you repeat it again?
(The last question was read back.)
MS. DAEHNKE: Same objections.
You can answer if you can.
THE WITNESS: Do I discount their opinion? No, of course not. Like I respect their, their opinion. But I'm going to have an opinion of my own. And it, you know, it's going to agree with them most of the time, and there may be some instances when I do not agree with them.
BY MS. CARMICHAEL:
Q Okay. So to be clear, in this case, is it your testimony that even if you had read this discharge order on the first day that MayRose came to you, on August 5, 2008, based on your assessment of her as time goes on that she was not anemic, you would have chosen not to do this test, the CBC with differential?
MS. DAEHNKE: Object to the form of the question. It's argumentative. It misstates -- mischaracterizes his testimony.

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But if you can answer.
THE WITNESS: I don't recall whether I read the discharge summary or not.
If I had read it, and I'm looking at the kid, and I'm looking at this, I'm looking at MayRose, and I think she absolutely didn't need this, I probably wouldn't do it.
Unless sometimes, for instance, patient comes in and mom wants an allergy referral. I've seen this kid for allergies. He's been well treated in the past. But he really doesn't need an allergy referral. But if mom wants and requests it, I would definitely do it.
Sometimes a patient comes in and they're being recommended, they're here to be cleared for ear, nose and throat surgery to put tubes in the ears. And you look at the ears and they look perfectly fine. And I would say, well, maybe we should, you know, maybe we should wait. Maybe just, you know, give th ears a week or so, and let's see how they look in a week.
So I might not agree with the specialist who recommended a certain thing. That's a possibility. If it was in the best interest of the child to avoid a procedure, avoid a test, you know, if it's not

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indicated, and then it's contraindicated and then it shouldn't be done.
So I, you know, I'm the one looking at the child right then. You know. I would expect a three-month-old preemie, like three months old after the date they were born, to be, you know, to be at kind of like at their low point for anemia. Like they would be hitting their nadir right around then.
So unless the kid was, you know, markedly anemic, I mean you could actually cause anemia by continuing to draw blood on the child, if they didn't, you know -- if they weren't that anemic -- if they were the anemic and you continue to draw blood on them, you could actually make them anemic.
So considering the cause of the anemia -- I'm sorry, go ahead.
BY MS. CARMICHAEL:
Q Are you done?
A Yeah.
Q Okay. All right. So without speaking to the neonatologist that cared for this child, you would only be guessing as to why they wanted a CBC diff and retic one month after her discharge. Is that true?
A No. Again, almost always -- I'm basing it on, you know, at this point in time, 18 years of

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experience, having taken care of preemies and, you know, knowing the neonatologists, you know, like, you know, they draw so much blood there, and so many of these kids come out of the NICU have anemia of chronic blood loss. I would, you know, I'm not trying to discount any of their opinions or say that my opinion is more valuable than theirs.

But I'm not just guessing, I'm basing it on past experience, and I'm looking at the child and trying to decide what is best for this child right now.

Q Okay. But I think we've discussed, and I really don't want to replow ground we've been over, but you've admitted that you didn't know that her hematocrit was still falling at the time of her discharge, you didn't know that her reticulocyte was low and still falling at the time of her discharge. There were things you did not know. Isn't that true, Doctor Conti?

MS. DAEHNKE: Objection. That misstates his testimony. If you want to replow that, go right ahead.

THE WITNESS: I don't agree that I didn't know. I...

BY MS. CARMICHAEL:

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Q You knew her lab results at the time of her discharge?

MS. DAEHNKE: Which lab results would you like him --

THE WITNESS: I don't recall like which, you know, I mean do I recall specifically knowing, do I have a specific memory of knowing exactly what the lab results were at the time? No, I don't.

But at the same time, I mean, you get a good feeling for what's going on with the kid just by looking at him and reviewing. I mean there was some lab result that stared out at me, you know, how common it is for a kid to have a falling hematocrit and a low, a borderline low, borderline low hematocrit and a low reticulocyte count at the time of discharge from the nursery? It's common.

BY MS. CARMICHAEL:

Q Well, you didn't review her labs though, any of her labs from her NICU stay. Correct?

A I don't know if I said I had been reviewing any of the labs from the NICU stay. I mean I'm sure we reviewed pertinent information from the NICU stay.

Q Did you review labs from the NICU stay?

MS. DAEHNKE: I object to the form, the tone. You're badgering the witness. If you would like him to re-answer questions you've asked before, show him a lab and ask him if he recalls if he reviewed it or not.

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MS. CARMICHAEL: Thank you for your advice. This is my deposition --

MS. DAEHNKE: Excuse me. This is my client and I'm entitled to assert objections on his behalf. Yes?

MS. CARMICHAEL: I understand that.

MS. DAEHNKE: And you've asked him certain questions. You're mischaracterizing his testimony. Just because it's late in the day and you have to get a flight doesn't mean that he needs to change or admit that he's testified differently than he already has.

MS. CARMICHAEL: Thank you.

MS. DAEHNKE: Uh-huh.

BY MS. CARMICHAEL:

Q Doctor Conti.

A Yes, ma'am.

Q Are you testifying now that you reviewed MayRose Hurst's labs from her stay in the NICU?

A I do not have any memory specifically of reviewing her labs, no.

Q Thank you. I did believe that we established that earlier. Okay.

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MS. DAEHNKE: It's a different question, Jackie.

BY MS. CARMICHAEL:

Q You -- knew, the things you did know though, you did know she had been in the NICU for almost three months. Right?

A Yes.

Q You did know that. And you do know that neonatologists issue discharge instructions. Right? You know that?

A Yes.

Q Okay. And you knew from her parents that she had had a complicated course. Correct?

A No more complicated than most other 28-week preemies.

Q Okay. But complicated nonetheless. She had had NEC. Right?

A Fairly typical course for a NICU grad.

Q You knew she had NEC. Correct?

A Yes.

Q You knew she had anemia. Correct?

A Yes.

Q You knew she had blood transfusions?

A Yes.

Q Okay. You knew that she had a brain bleed?

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A Yes.
Q Okay. All right. And you knew from your experience that hospitals typically send copies of the discharge orders to the pediatricians. You knew that as well. Right?
A Yes.
Q Okay.
A I mean they often do.
Q All right.
A I can't say usually. But they often do. And they often call me also. But...
Q But in this case, you did not find it important enough to go to the file, or go to the NICU doctors, or go to whatever source you needed to do to find out what the NICU doctors were recommending for her follow-up care. Is that true?
A No, it's not true that I didn't find it important enough. I found MayRose very important, as I find all my patients. And I wanted to give her the best care possible. So it's not like I didn't find her important enough to check it out.
I had done it the way I've always done it, which is to rely on, you know, what the mother can tell me. Knowing what I know about neonatology, which is, you know, quite a bit; and knowing the cause of

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the anemia in 99.9 percent of the cases of NICU grads; and knowing that a Grade I bleed is not usually a big serious thing; and knowing that, you know, NEC, once it resolves, the kid is usually fine; I mean do I think she wasn't important enough? Absolutely not. And I think that that's...
Q Well, not her necessarily. But whatever the NICU physicians were recommending was not --
A No --
Q -- that important to you?
A No, of course it's important to me. Okay.
Q Can you tell me then why you didn't read the discharge instructions in this case?
MS. DAEHNKE: Object. And that mischaracterizes once again his testimony.
THE WITNESS: I don't recall whether or not I read the discharge summary or not.
BY MS. CARMICHAEL:
Q Okay. In any event, whether you read it or whether you didn't, you did not comply with the NICU doctors' request that you draw a CBC and diff with retic count 30 days after discharge. Correct?
MS. DAEHNKE: Object to form with regard to comply.
But answer the question if you can.

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THE WITNESS: I did not order a CBC with retic count at the time. We order what the child needs and nothing more.
BY MS. CARMICHAEL:
Q And it was your opinion, based on your examination of MayRose, that she did not require a follow-up CBC with differential and retic count. Correct?
A Yes.
MS. DAEHNKE: Well, object as to what time.
MS. CARMICHAEL: Thank you. That will be all.
THE WITNESS: Thanks.
MS. URDAZ: No questions.
MR. RIGLER: No questions.
THE VIDEOGRAPHER: This concludes the deposition of Ralph Conti, M.D. It's 5:25 p.m. We're off the record. Digital tape number four.
(The deposition concluded at 5:25 p.m.)

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CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE

I, RALPH CONTI, M.D., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my testimony in said action, that I have read, corrected, and do hereby affix my signature to said transcript.

RALPH CONTI, M.D.
Deponent

REPORTER'S CERTIFICATE

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Karen Berry, a duly commissioned Notary Public, Clark County, State of Nevada, do hereby certify:

That I reported the taking of the deposition of the witness, RALPH CONTI, M.D., commencing on June 19, 2012, at 2:12 p.m.

That prior to being examined, the witness was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of shorthand notes taken down at said time.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in my office in the County of Clark, State of Nevada, this____day of_____ 2012.

_____

EXHIBIT "I"

DISTRICT COURT
CLARK COUNTY, NEVADA

TIFFANI HURST AND BRIAN *
ABBINGTON, JOINTLY AND ON*
BEHALF OF THEIR MINOR *
CHILD, MAYROSE LILI *
ABBINGTON HURST * CASE NO. A616728
Plaintiffs * DEPT. NO. XXIV
v. *
SUNRISE HOSPITAL AND *
MEDICAL CENTER, ET AL. *
Defendants * Pages 1 - 83

Deposition of John J. Strouse, M.D.
Baltimore, Maryland
Friday, December 14, 2012

Reported by: Kathleen R. Turk, RPR-RMR

December 14, 2012
12:35 p.m.

Deposition of John J. Strouse, M.D., held at the offices of:

John J. Strouse, M.D.
The Johns Hopkins Hospital
Division of Pediatric Hematology
Rubenstein Child Health Building
200 North Wolfe Street, Suite 3006
Baltimore, MD 21287

Pursuant to notice, before Kathleen R. Turk, RPR-RMR, a Notary Public of the State of Maryland.

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Also Present:
Martin Blahnik, M.D., via Skype

CONTENTS

Thereupon,

JOHN J. STROUSE, M.D.

A Witness, called for oral examination by counsel for the Defendant, having been first duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE DEFENDANT

BY MR. COTTON:

Q Doctor, please state your name.

A My name is John Strouse.

Q And, Doctor Strouse, what's the nature of your medical practice?

A I'm a pediatric and adult hematologist at Johns Hopkins University.

Q Do you have any kind of residency or fellowship in neonatology?

A I do not.

Q Have you ever had any employment as a neonatologist in the United States?

A I have not.

Q And at any point in time have you held yourself out in the medical community as being an expert in neonatology practice?

A No, I had the same neonatology training as everyone else gets in pediatrics.

Q Basically a rotation through?

A A total of four months and some moonlighting experience in the, in the NICU.

Q And my question was do you hold yourself out in the medical community as an expert in neonatology practice.

A Only in neonatal hematology.

Q In your curriculum vitae, Doctor, there were a number of journal articles and projects that you worked on.

Are any of those -- do they deal with the diagnosis and treatment of Diamond-Blackfan anemia?

A No.

Q Have you ever done any extended research, other than for this lawsuit, on the diagnosis and treatment of Diamond-Blackfan anemia?

A I care for two patients with Diamond-Blackfan anemia that I diagnosed, so I've had fairly extensive reading around those patients in my general practice.

Q Are those the only two patients that you've personally diagnosed with Diamond-Blackfan anemia?

A Yes.

Did you -- yes was my response.

Q No, we didn't hear the response. Thank you.

Doctor, how many occasions have you received patients with Diamond-Blackfan anemia that had been diagnosed in the Neonatology Intensive Care Unit?

A None.

One patient of mine was initially -- was initially anemic at birth and received their diagnosis when they saw me as they were born at a facility without a pediatric hematologist.

Q How many weeks after birth was it when the child saw you?

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A Sometime in the first month. I'm not exactly sure when.
Q Doctor, just generally, what's the initial treatment for Diamond-Blackfan anemia?
A Transfusions, typically, for the first year would be the standard of care in most centers in the United States.
Q And what sort of treatment is rendered to a child that's diagnosed with Diamond-Blackfan anemia?
A Typically, after the, after the first year or so of transfusions, a trial is made of high-dose corticosteroids to see if that will result in resolution of the anemia.
Q What impact does the giving of those corticosteroids have on the immune system of the child?
A It suppresses the ability of the child to fend off certain infections. They typically get treated with an antibiotic to reduce the risk of infection during that time.

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Q Doctor, outside of this lawsuit that we're involved with here, how many times have you acted as an expert witness in a medical malpractice case?
A This is the, I believe, the fifth case that I've been involved in and the first that has gone to deposition.
Q And how many times have you acted as an expert in a medical malpractice case for the claimant or plaintiff?
A It's about half and half.
Q Do you have any idea where the Plaintiffs got your name as a potential witness in this case?
A They used a headhunter.
Q Do you have a name for that headhunter?
A I do have his name. I would need to look it up to remember it.
He was from -- he lives in Pennsylvania, and he was a physician assistant.
Q But that would be something, I take it, that after the deposition you could get to

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Ms. Carmichael for our purposes.
A I could.
Q How many times have you acted as an expert witness in a medical malpractice case in the Maryland or Virginia vicinity?
A Twice.
Q Both of those times, were they for the claimant or for the defendant?
A One is -- one was for the claimant, and one was for the defendant.
Q And where was the one for the plaintiff?
A The one for the plaintiff was in -- was a case which was in Virginia, Northern Virginia.
Q And what about for the defendant? Where was that one?
A That's a case from University of Maryland, so Baltimore.
Q Ms. Carmichael has provided us with your report, Doctor.
Have you reviewed any documents in addition to those set forth in your report to

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prepare for your deposition today?
A I've reviewed some additional depositions from expert witnesses.
Q When you say depositions, do you mean reports?
A Yes, I'm sorry, so the reports from the, from the -- from the pediatric intensivist from Harvard, a report from two neonatologists, and a report from a neuroradiologist, Doctor Zimmerman.
Q Correct me if I'm wrong, Doctor, but you have not been retained to render opinions regarding the standard of care for a Board-certified neonatologist.
A I have not.
Q Did you conduct any form of a literature search in support of your opinions here?
A I did.
I looked up nuchal lucency as -- I did a literature search on that -- and I did a limited search on transfusions in, in very low birth weight infants and extremely low birth weight

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infants.
Q Do you have a list of the literature that you relied upon in coming up with your opinions or conclusions?
A I do not have a complete list.
Q Can you give us the names of any of the articles that you feel are supportive of your position?
A I can certainly give you the name of the article on nuchal lucency.
Q Okay.
A And I can give you -- there were, there were actually two references -- there were actually two references that were in one of the neonatology reports which I looked up.
Q And what were those two references?
A They were -- the reference was from this PINTS study and another study -- this was actually an expert witness for the defense -- the other study was a study from Iowa, which I could find the references again. One of them I have on my

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laptop.
Q The first -- how do you spell the first study that you mentioned?
A I think it was P-I-N-T-S was the, was the name of the study.
It was a multi-center study of transfusion in infants.
Q Was there any particular publication in which you found that study?
A It was -- I'm pretty sure that that was in Pediatrics in 2006 was the journal.
2005 or 2006.
Q What about in terms of the transfusions in very low birth weight infants, do you know what that article was?
A I would need to -- I would need to check. I would need to look it up on my laptop to remember what the author was.
I think that -- one was in Pediatrics, I think, in 2005, and the other was in 2006.
Q And, again, could you provide that to

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Ms. Carmichael when we get done with the deposition, the names of those articles?
A I can, yes.
Q Okay. Doctor, are you familiar with a concept of clinical observations in the practice of medicine?
A Can you be a little more explicit?
Q Well, a lot of doctors have told me that they were taught from Day One in medical school that clinical observations of a patient are very important in reaching a diagnosis and a plan of care.
Would you agree with that?
A I would agree with that.
Q And how do you define those clinical observations?
A So clinical observations include the information that you can collect directly from the patient without laboratory studies, so that would be history and physical exam, and then other, other observations that are recorded in the

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medical record. So I would include other observations by the nursing staff, respiratory therapy, other people on the care team.
Q In terms of an infant, how do you develop those clinical observations?
A So you, you -- it's generally from interactions with the parents of the infant. It might be from talking to the doctors that cared for the mother of the infant during the pregnancy and getting their clinical observations related to the pregnancy. And then direct observation and examination of the infant.
Q And as a practical matter in your profession, why is it important for a doctor to have clinical observations in the decision-making process?
A Well, I would say that history is at the core of, of diagnosis and treatment as well as physical exam.
As a rule of thumb, people say the history is the most important and after that

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physical exam and then laboratory observations --
Q In your personal --
A -- and tests.
Q -- practice at Johns Hopkins, do you develop a plan of care and initiate a plan of care without having had clinical observations of a patient and their records?
A For the -- for the most part, no.
I have done some medical second opinion which is from a distance, so where you review the records, sometimes collect some additional information, and then make recommendations.
But in, in general, we like to have direct observation and replication of the history.
Q So if someone's going to be your patient, you don't develop a plan of care for them without first having seen them, examined them, touched and held them, if you will?
A Right, for two reasons.
We think that is, in general, the best medical practice when possible and, also, because

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that's when we develop our, our relationship with the patient is usually with that first contact, not by telephone contact.
Q Would you consider it to be below the standard of care for you to initiate a long-term plan of care for a patient without first having ever seen them?
A So we -- like I said before, we do do medical second opinion where we provide that advice having looked at medical records as part of our International Medicine Program, so we do do it.
It is not the -- it is not the first choice, but --
Q For a patient that you could have hands-on experience with, would it be below the standard of care to develop a plan of care where you're the primary treating doctor without first having seen the child?
A It would be, yes.
Q Doctor, in looking at your report -- and

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I don't claim to be a doctor, so bear with me -- it appears that your opinion is that -- one of your opinions is that profound anemia was a major contributor to the brain injury in this little child, correct?
A That is true, yes.
Q And when you -- when you say profound, what do you mean by profound?
A When -- when Mayrose presented to the, to the hospital, she had a hemoglobin of 1.5.
In general, a hemoglobin of less than 7 would be considered severe, and that's really the -- that really is the -- among classification, that really is as low as the classification system for anemia goes.
But she had, she had a degree of anemia that is probably not compatible with life in many children and certainly is enough that you would expect to see significant complications from it -- have a high probability of significant complications.

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That's what I meant by profound. It's not a technical term in the classification of anemia.
Q Okay, that's what I thought.
When you say it was profound, are you talking about being profound within one month after discharge from Sunrise or within one month of the events here that caused her some problems?
A I was talking about at the time that she presented to the hospital with her, with her episode of, of severe illness.
I don't know what her hemoglobin was a month after she left the hospital. I can speculate on what it was and probably give an educated guess of what the range would be, but I can't say what her hemoglobin was a month after she was discharged from the hospital because it wasn't tested.
Q Are you able to state in relationship to the October 29th, 2008, hospitalization when her anemia became profound?

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A I cannot say exactly when her anemia became particularly severe.
Q You indicate that you thought the profound anemia was a major contributor to her brain injury.
Do you remember that statement?
A I do.
Q And what other contributory factors were involved in her brain injury?
A So her brain injury could have had some contribution from her having a respiratory illness and decreased oxygen saturation. That may have contributed to her brain injury as well.
There was the possibility that she had preexisting brain injury prior to this event, but that is unlikely given that she had imaging studies prior to this event which did not show significant brain injury.
Q Any others?
A I think those are the things that are, that are most likely.

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Q Doctor, in your report, you indicate that -- have you got a copy of your report right there?
A I can pull it up on my laptop.
I have it.
Q On the second page of your report, the paragraph starts you're already familiar.
Do you have that?
A Yes, I do.
Q Okay. The second sentence says additional details relevant to her anemia include nuchal lucency identified on prenatal ultrasound with normal chromosomal analysis.
What's the relevancy of the nuchal lucency?
A So a nuchal lucency has an association with a number of abnormalities, and one of those abnormalities would be anemia, anemia in utero.
So chromosomal abnormalities are the most common, and you can see thickening of the, the -- this nuchal region in children that have

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chromosomal abnormalities, including Trisomy 21, which is, I think, what is most well-known for it, but if you look this up in PubMed, this is one of the searches that I, that I did, it's associated with other genetic illnesses other than chromosomal abnormalities and anemia in utero as well.
Q And is that one of the articles that you were talking about, those studies?
A Yes.
Q The PINTS study and the Iowa study?
A No, those, those were -- those were actually studies of transfusion in neonates. This is -- this is another study.
There's some case -- there was a case report with Diamond-Blackfan anemia, but it's something that's well -- that was a single case report, but it's something that's well-described in, in the medical literature.
Q The article on nuchal lucency, that's the one you're going to get us the name of?

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A Sure.
Q Or do you actually have it right there on your computer?
A I do not think I have it on my computer that I can find very quickly.
Q Is there a difference between nuchal lucency and nuchal translucency, or is it the same thing?
A I think that it's referring to the same thing.
I am not a perinatologist, so this is not my area of expertise, but I believe that it refers to the same thing.
Q In the records that you reviewed, Doctor, from Sunrise Hospital, did you see any evidence in the records that the perinatologist had communicated any finding of nuchal lucency to the neonatologist at Sunrise?
A I did not see -- I did not see that in their communication from the perinatologist documented.

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Q Doctor, I think you said you're not an expert, but do you know whether or not you can have false positives on nuchal lucency or translucency?

A I -- I can speak from my personal experience as someone that's had the testing done on their children. With all tests, you can see false positives and false negatives -- these are screening tests -- but, in general, the more extreme the value, the less likely it is to be incorrect in all, in all testing.

And there, obviously, there are things related to the ultrasonographer where they can have inadequate training or do the test incorrectly.

I know that the quality control is pretty strict at the institution that we went to to have our kids because you push pretty hard on it when people decide to have chromosomal testing based on those with some risk of losing their pregnancy.

Q Doctor, what is hydrops fetalis?

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A Hydrops fetalis is a condition where you basically have swelling of the, of the fetus because of severe anemia, congestive heart failure, and it can result in -- it can result in death of a fetus from severe anemia.

Q Did you see anything in any of the ultrasound or echos on this child that indicated that there was a presence of hydrops fetalis?

A I did not -- I did not have the -- are you talking about the prenatal, the prenatal evaluation of this child?

Q Yes, sir.

A I don't believe that I saw prenatal reports on, on Mayrose.

Q If this child was, in fact, anemic in utero, would you have expected to see the presence of hydrops fetalis on any ultrasound or echos?

A It depends on the severity of the anemia.

If the anemia is very severe, it's expected to occur. For a more mild to moderate anemia, it often does not occur.

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Q And how do you define mild to moderate anemia in a premature baby?

A It really depends -- it, it really depends on where they are in their development, so the, the normal levels of hemoglobin and hematocrit vary with gestational age.

So for any given gestational age, I would, I would -- if it's something that I'm very familiar with, I would just do it from memory. Otherwise, I would look it up in a reference table in a textbook.

Q If you had an ultrasound or an echo on this child a month before the actual delivery in May of 2008, what would you expect to see in terms of values on hematocrit or hemoglobin?

A So this would have been at like twenty-four weeks gestation?

Q Yes.

A Are you asking me what -- for normal values or for this child?

Q This child.

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A I would expect -- it's, it's really hard to say.

I would expect that they probably would have been a little bit lower than they were at birth because your hemoglobin increases as you get a bit older, but it's hard, it's really hard for me to know what it would be.

Q Would you expect to find enough anemia to show the presence of a hydrops fetalis?

A Hydrops fetalis doesn't usually get better in utero, so I would be surprised if the child would be so anemic that they would have hydrops.

In general, children that are thought to be at high risk for anemia in utero have testing done to evaluate for that. The non-invasive test is looking at the velocity of blood flow to the brain, middle cerebral artery velocities, and that's done by ultrasound.

If suspicion is high, they'll do -- they'll do umbilical cord blood sampling. So they

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go in and take a sample of blood from the baby from the umbilical cord, and if the child's particularly anemic, they will sometimes transfuse the blood at the same time that they're sampling.

Q If you have a child with the diagnosis of anemia of prematurity, would you expect to see the hydrops fetalis on the echos or on the ultrasounds?

A Only -- not, not usually because anemia of prematurity is really a physiologic anemia. It's not a pathologic anemia that you would expect to cause hydrops.

Q Doctor, what's the half-life of the red blood cells in a premature baby?

A Is this their, their own red blood cells or the red blood cells that are transfused into them?

Q Both.

A So it, it varies.

Red cell survival is decreased in a newborn baby, and that probably depends some on

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gestational age, but I think of something on the order of fifty to sixty days as opposed to about a hundred and twenty days for an older child or an adult.

For transfused blood, it depends on a number of factors. Most important probably is the, the compatibility of the blood. Most of the time the blood will be completely compatible, but if there's incompatibility, the half-life can be quite short.

And then the half-life of transfused blood can be shortened depending on the age of the blood. So older blood that's been sitting around in the blood bank for a longer time doesn't last as long as blood that has been freshly collected. And then when you give blood, some of the blood is right collected from people, some of the blood is old in their bodies, so you expect it wouldn't last quite as long, and then some's new.

So some centers try to collect the young portion of the blood and just transfuse that.

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That's pretty uncommon, though.

Q Is there roughly a day range on the half-life of those transfused bloods?

A I would say that, you know, something on the order of sixty days, but there's quite a bit of variation.

Q Is it normal in a premature baby to find macrocytic red blood cells?

A So, again, it comes down to the gestational age of the infant.

So all infants have large red blood cells, but it can be -- they can be abnormally large for the age of the infant.

Q Did you find abnormally large red blood cells in this child?

A So at birth, her red cells were right at the, right at the limit of normal versus abnormally large for her gestational age.

Q Did you see any persistent macrocytosis in this baby here?

A No, she actually became microcytic for

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gestational age, which is what you would expect when you're transfusing in adult red blood cells.

Q Is there any point in time when you saw any persistent macrocytosis?

A No, she was, she was actually in the -- rapidly went into the normal range, which is what you would expect because we were really seeing mostly transfused blood at that time.

Q You, also, then talk about the family history of alpha-thalassemia.

Do you see that?

A I -- I do.

Q Okay. And what is alpha-thalassemia?

Which I have a hard time pronouncing.

A Sure.

Thalassemia means by the sea, and that's because it's common of people of Mediterranean ancestry; also, people of African ancestry and from large sections of Asia.

It is a hemoglobinopathy. That just means a defect in the development of hemoglobin.

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Hemoglobin is made up of four little pieces. Two of those are called beta chains, and two of those are called alpha chains.

Alpha-thalassemia is when you have a relative shortage of the alpha chains so you can't make hemoglobin as well, and that actually causes some injury to the developing red blood cells so you get what's called ineffective erythropoiesis that you have less ability to make red blood cells.

It's a production problem as opposed to a destruction problem.

Q Are you able to state to any reasonable degree of medical probability that the father here passed that on to this child?

A So I did not see testing of the father, so I can't tell you whether he had alpha-thalassemia or not.

If he did have alpha-thalassemia, you can have -- there are different types. He would have -- if he had alpha-thalassemia, he probably

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would have passed along at least one abnormal alpha gene to Mayrose.

There are four alpha genes that you carry, and typically you do not show any recognizable clinical or laboratory signs unless you have at least two of them that are changed, and that's a very mild condition called alpha-thalassemia trait or minor.

Q Okay. Is that something that could be determined by genetic testing on this little child today?

A It's something that could be determined by genetic testing, yes.

Q Doctor, does Maryland have a newborn screening program for hemoglobinopathies?

A It does, yes.

Q And, again, thalassemia is one of those, correct?

A Thalassemia is a hemoglobinopathy.

Q And are you aware of the fact that this child was screened for that?

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A Yes.

Actually, all children in the United States are screened for hemoglobinopathy unless they opt out.

The screening for thalassemia is somewhat effective at picking up severe versions of thalassemia but does not identify most cases of thalassemia minor or trait, the more mild forms of it.

Q When you --

A At least in --

Q I'm sorry, go ahead.

A At least in Maryland.

I -- I do not know the details of the newborn screening program for hemoglobinopathy in Nevada, but because of the technical aspects of it, it is fairly difficult to pick up the mild forms of thalassemia on newborn screening without doing genetic testing, which is fairly expensive and not something that is routinely done by most newborn screening programs.

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Q If someone has a mild or very mild thalassemic condition, is that something that, in any event, could be passed on to a child such as this child here and affect her production of red blood cells?

A It could.

It would cause a more mild decrease in production, but it could contribute to the degree of anemia in the neonatal period, especially in a child that had other reasons to be anemic.

Q Would you agree with me, Doctor, that you would be speculating as to whether or not the father's condition of alpha-thalassemia here would have any effect on this child's production of red blood cells?

A I would say it's a little bit more than speculation.

If -- if this child had two abnormal alpha-thalassemia genes, which she could have gotten from her father if her father had alpha-thalassemia which he reported, which is

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usually fairly reliable but not completely reliable, and the prevalence of alpha-thalassemia having at least a carrier mutation is about one -- is about ten percent. So -- in African-Americans.

So the mother of the child was African-American as well, I believe, so there's a reasonable chance that this child could have had alpha-thalassemia trait.

Q And are you able to state to a reasonable degree of medical probability as opposed to a possibility that this child, in fact, has alpha-thalassemia and that it's impacting her production of red blood cells?

A No, I cannot.

Q Doctor, is there any evidence at all that the father here was transfusion-dependent because of any alpha-thalassemia?

A So there was no mention made of that in the medical record, and I would be surprised if he was transfusion-dependent with alpha-thalassemia because it's relatively uncommon in people of

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African ancestry.

Q Macrocytic red blood cells, is that something consistent with a thalassemia condition?

A It is not.

Typically, children with alpha-thalassemia are microcytic compared to their gestational age normal range at birth.

Q Doctor, are you aware of the fact that this child had, I think it was four transfusions, at the time of surgery in mid-May of 2008?

A Was this the -- was this -- are you referring to the initial surgery, or is this the --

Q I'm talking about the initial surgery.

A Yes, I was aware of that.

Q I take it that that's appropriate to transfuse a premature baby for that condition.

A So that's -- I would say that is generally the standard of care.

Could I -- but wasn't this child transfused -- this child was anemic at birth prior

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to surgery?

Q I believe so.

Do you know what the other transfusions were for?

A So the, the trans -- are you talking about the remaining transfusions for this child?

Q Yes, sir.

A My understanding was that the transfusions were predominantly given as preoperative transfusions.

Q Did you see any transfusion that was specifically noted as being given for anemia of prematurity?

A I did not.

Q Are you able as a hematologist to rule out that any of those transfusions were not necessary based on the clinical judgment of the doctors treating the child at the time?

A So I believe that transfusion is a clinical decision that is challenging to make if the patient is not in front of you.

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So I would not -- I would not want to judge whether they were clinically indicated or not.

Q Doctor, is there a normal average, if you will, age of diagnosis of Diamond-Blackfan anemia?

A So I think that there's a -- yes, there's a -- that most -- some cases are diagnosed at birth -- that's the minority -- fifteen percent, maybe. And then most of the remaining cases are diagnosed in the first year of life, but there are patients that even get diagnosed as -- later in childhood and rarely in adulthood.

Q Is there a relatively large percentage of the children that do have Diamond-Blackfan anemia who present with other congenital anomalies?

A Yes.

Q Do you know what that percentage is that present with other congenital anomalies?

A So if you have a geneticist that's very good at dysmorphology, it's over half, probably approaching two-thirds, maybe three-quarters.

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I would say that in a clinical exam by someone that's not trained as a dysmorphologist, someone like myself, it would probably be less than that.

Q While this child was present at Sunrise Hospital, in the records you note there, did you see any reference to any congenital anomalies that would be consistent with Diamond-Blackfan anemia?

A I did not.

Q In fact, in looking at the records of Foothills Pediatrics or Summerlin Hospital or Denver Children's Hospital, did you see any notation that would indicate that this child was presenting with congenital anomalies consistent with Diamond-Blackfan?

A Actually, can I -- can I take a step back?

On the discharge paperwork, was there a mention of an ASD, or am I --

Q I don't -- I don't know.

THE WITNESS: Do you have the

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discharge paper?

MS. CARMICHAEL: Uh-hmm.

A I'm sorry, no, so no anomalies noted.

Q (By Mr. Cotton) Doctor, is it usual to have a high or low platelet count in an infant with Diamond-Blackfan anemia?

A So some patients with Diamond-Blackfan anemia have elevations of their platelet count and white count.

Q And I mispronounced this yesterday, but I'll try to pronounce it correctly today.

I want to talk about a retic count.

A Okay.

Q Are you familiar with that, sir?

A Sure, reticulocyte count?

Q Yes, sir.

Do you know what the reference rate was for the retic count at Sunrise Hospital in May of 2008 -- May, June, July, and August of 2008?

A So I believe it was 0.5 to 1.5 percent, and then there was also a normal range for the

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absolute reticulocyte count as well.

Q Is it your opinion, if I heard you correctly, that that retic count was likely low due to blood transfusions even if the child wasn't anemic?

A I -- I think that there are a number of reasons why the reticulocyte count was likely low at -- there were two separate occasions.

On the second occasion, I think that it was probably low because the child had been transfused up to a relatively physiologic or a hema -- a hematocrit which was in the normal range for an infant of, of that post-gestational age, maybe, post-birth age.

So in that, in that way, you decrease your signal to make more red blood cells, so you expect the reticulocyte count would be normal or, you know, low normal, could easily go into the, into the lower than normal range when you're approaching that, that -- when you get above the threshold to make red blood cells.

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Q What about the first retic count?

A The first retic count, I think, was also around the time that the child was ill which can also suppress the reticulocyte count.

So I think that there are -- there are many reasons why a reticulocyte count can be low, and there certainly are reasons other than not being able to make red blood cells when you're ill for, for both of those occasions.

Q Can you have a low retic count due to a lack of vitamins or iron in the child?

A You can.

It's -- it's unusual to be deficient in iron when you've been transfused because transfused blood is a very good source of iron, but there certainly are other nutrients that can cause a low reticulocyte count.

Q Okay. Beyond being ill on admission, could the lack of vitamins or iron at that point in time also result in a low retic count?

A Yes.

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Q Can you have a low retic count due to multiple antibiotic treatments?
A There are some antibiotics that can suppress the production of red blood cells.
Q Do you see any of those that were given here that can suppress the production of red blood cells?
A None that are -- that it's a particularly common occurrence with.
Q Any at all?
A Can you remind me what the antibiotics were?
Q No, I was just asking if you can recall any.
A None that, none that commonly -- none that commonly cause red cell suppression.
The ones that probably are most commonly used in children and not much in neonates, Bactrim can cause decreased red cell production, linezolid, chloramphenicol, which doesn't get used much anymore, are the ones that it could just

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decrease in production.
There are other antibiotics that cause anemia by other mechanisms.
Q Now, my statement, assuming that you can have a combination of transfusions, lack of vitamins or iron, multiple antibiotic treatments, that that could also result in a low retic count.
A That's true.
Q Doctor, how often do you -- are you called in to see an infant in the NICU when there's been only one low retic count?
A I -- I can't say because I know the NICU doesn't call me -- I don't know who they don't call me about.
Does that make sense?
Q I'm asking how many times you know that you were called when there was only one.
A Oh, being called because the retic count is low?
Q Right.
A That would be a very rare occurrence;

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that being the only reason that we were called to see a child would be for a low retic.
Q Can you have low retic counts in, in children -- infants, if you will -- who have anemia of prematurity?
A So anemia, yes, if you -- it depends when you check the retic count.
If you check the retic count when they have another reason that they shouldn't be able to make red blood cells, of course, you could have a low retic count, but then it's not necessarily anemia of prematurity. If it's because you have an infection, that's called anemia of inflammation, a little different than anemia of prematurity.
I think of anemia of prematurity as having a, a more pronounced physiologic nadir. Physiologic nadir's when everyone comes down normally until they start making their own red blood cells and it reflects that you get a lot, much higher levels of oxygen when you're outside

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your mother if your lungs are healthy than when you're inside because you're kind of getting second-hand oxygen off of mom's red blood cells. So you, you have less drive to make red blood cells once you come out into the world, so you drop-drop-drop until you, you kind of turn back on the gas to make red blood cells.
So anemia of prematurity is really a more pronounced version of that where you come out and you aren't as high because you were born early and you didn't have a chance to make enough blood, and then you fall faster and earlier before you kind of get caught back up, and that's compounded a little bit by the things that we do to premature infants, like taking a lot of blood.
Q Based on what you said, then, Doctor, if a patient has been transfused and it was shortly after a surgery or to address a sepsis situation, any kind of a procedure at all, I take it the retic count's going to be affected by those transfusions.

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A Certainly.
Q Doctor, are you aware of the fact that Doctor Piroozi recommended a complete blood count, a differential, and a reticulocyte count on this child within one month after discharge?
A I am aware of that.
Q And were you made aware of the fact that that recommendation in writing was in the pediatrician's file and that the mother had actually given a copy to the doctor?
A Yes.
Q Would you agree with me, Doctor, that pediatricians, Board-certified pediatricians, are knowledgeable and capable enough to diagnose and follow infants after a NICU discharge?
A It is within the scope of -- it is within the scope of training. I would say that for particularly complicated children, they might need the right pediatrician.
Q Generally, if the patient's gone out of the NICU but has to stay in the hospital in your

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institution, are they generally followed by pediatricians?
A They're often followed by general pediatricians and a collection of subspecialists.
Q But you agree if the pediatrician in this case had ordered the recommended tests for Mayrose within one month of her discharge that that likely would have shown some anemia?
A I think it would have almost certainly shown significant anemia.
Q And would you agree with me if that pediatrician had ordered those tests and looked at the results that the episode of profound anemia here could have been prevented?
A I do.
Q Is there any evidence in the records to show any operations or clinical sepsis or multiple transfusions while the pediatrician was caring for this child that would mask any underlying anemia?
A No.
Q Okay. Would you expect -- at least,

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based on the recommendations here -- would you expect a competent pediatrician to actually order and assess the complete blood count and retics recommended by Doctor Piroozi within one month post-discharge?
A Yes.
Q Doctor, outside of the opinions that you shared with us in your report of August 30th, 2012, and those opinions you've shared with me now, do you intend to offer any other opinions at the time of trial that you're aware of?
A I think that I may be offering an opinion about the, about the appropriate evaluation of anemia in the neonatal period.
Q Why don't you tell me what that opinion is?
A Sure.
So I think it's -- it's two things.
It's whether additional evaluation was appropriate for this infant in the, in the NICU and what that evaluation would be.

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Q Okay.
A So it is my -- it is my professional opinion that this child had enough concerning signs that additional evaluation of the anemia was appropriate in the NICU and closer follow-up upon discharge in the NICU.
Neonatology includes a great deal of hematology in practice, and some of the -- much of the work in neonatal hematology was done by neonatologists. So the appropriate provider for that could have been a neonatologist or a pediatric hematologist because I think it is within the scope of practice of, of some neonatologists and some would, would consult.
And if I had been consulted on this infant during that period, I think that the, the things that we discussed before -- the nuchal lucency, the family history of alpha-thalassemia, and the, the number of transfusions -- were all unusual and really would have led to additional evaluation in the -- during the hospitalization.

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I think that initial evaluation during the hospitalization would have been fairly limited because of the multiple transfusions, but it would have consisted of testing of the parents for thalassemia typically, given that the child had been transfused early on in life, and typically would have included probably some testing for nutritional deficiencies given the macrocytosis of the, of the infant if, if an early blood specimen was available, and then closer follow-up of the child after they had been discharged from the hospital.

It may have also included additional reticulocyte counts during the period of -- during the period that the child was in the NICU, but as I mentioned before, I'm not sure that they would have been, that they would have been illustrative.

Low reticulocyte counts are something that have many reasons, as we talked about, and Diamond-Blackfan anemia is not something that I think would have been diagnosed in the initial

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NICU stay, no matter what the evaluation would have been.

Q You say you would have recommended closer follow-up.

When you say closer follow-up, are you talking about post-discharge?

A Right, of the, of the complete blood count and reticulocyte count.

Q Would following up with a CBC and a reticulocyte count within one month after discharge have been a close-enough follow-up?

A If I had seen this child, I would probably typically either see them back if they were local, or if they were from farther away and had been transferred in here for their neonatal care, I probably would have gotten a CBC within two weeks.

Q Whether they were two weeks or one month in this case here, Doctor, wouldn't have made any difference in the outcome here, would it?

A It wouldn't have made a difference in

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the, in the end outcome, but if you really think of this as a -- I mean, there were multiple errors that -- there, there were multiple errors in my mind that led to this child having the brain injury, and if they had been diagnosed with significant anemia earlier or if it had been emphasized -- if they had been diagnosed earlier with the anemia or if they were being followed by someone that specialized in neonatal anemia, it would have been diagnosed before the pediatrician failed to get this lab test.

Q The practical matter is, if once the child's in the pediatrician's hands, whether he had diagnosed it in two weeks or thirty days, still would have had the same outcome here if he doesn't do the test, correct?

A That is true.

Q And would you agree with me, Doctor, that if a neonatologist does have skills and expertise in anemia and blood conditions, it is within their clinical judgment whether or not they need to call

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in a pediatric hematologist?

A Certainly, but -- I mean, I've reviewed many, many notes on this child, and the mention of the anemia was quite limited.

Anemia of prematurity is not what this child had when they were -- during this initial hospitalization.

Q During the initial hospitalization, there were sufficient transfusions, though, Doctor -- correct me if I'm wrong -- that it would have required some time frame for the baby to be removed from the time of those transfusions to get an accurate read on the complete blood count.

A That is true.

Q When you say there were enough concerning signs that additional evaluation of anemia should take place, what are the concerning signs you talked about?

A Sure.

Nuchal lucency, a family history of alpha-thalassemia which causes a

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hyperproliferative anemia, low reticulocyte count anemia, and a number of transfusions which is unusual for a child of this gestational age and birth weight in the modern era.

Q Recognizing that it's unusual for a child of this age and birth weight in this era, if a child has septic problems, bleeding in the stomach, operations, those -- that's not a normal child premature, is it?

A I would say that those are, those are common -- those are common complications of neonatal care -- and, again, I am not a neonatologist -- but NEC is a quite common complication in very low birth weight infants, especially ones that the mother had tocolysis that this child did, and NEC -- NEC requiring surgery is a little less common.

This child did have a -- more than -- more surgical procedures than your average child that weighs twelve hundred grams.

Q As you sit here today, though, Doctor --

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correct me if I'm wrong -- you're not in a position to criticize the number of transfusions given this child because you weren't treating the child?

A I'm not criticizing the number of transfusions. I'm saying that the number of transfusions is on -- is more than you would typically expect an infant of this gestational age and birth weight to get.

Q The mere fact that they're more than the number you would expect doesn't mean that the child has a Diamond-Blackfan anemia condition, does it?

A Certainly -- certainly not.

There are many causes -- there are many causes of anemia, and this child turned out to have a very rare one that is unrealistic to expect someone to diagnose in the NICU in a twenty-eight-week-old. I mean, it's very -- a very challenging diagnosis.

But this child was anemic, was anemic at

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birth, had borderline macrocytosis, nuchal lucency, and more transfusions than your typical infant like this, I believe, would get in the, in the NICU.

Q Doctor, if a child is being released or discharged from the NICU such as this child here, was there any reason to order up CBCs or retic counts if you didn't have some lingering concern that there might be anemia present?

A So that's -- that's an interesting question.

I do not know what the routine follow-up is of an infant of this gestational age and with these complications. I think it would be reasonable even in someone without a suspicion of a potential hyperproliferative anemia to follow up with a CBC and a retic just because of issues like iron deficiency that can be seen, but I, I -- I'm not a -- I don't know what the usual practice is in the, the NICU from Summerlin, and I don't know what even the usual practice is from our own NICU

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here.

Q Doctor, do you have any physical evidence, any documents you've seen, that indicates that the husband here actually had alpha-thalassemia?

A I do not.

Q And, in fact, I think you told us you have not had an opportunity to look at the perinatologist records.

A I do not believe I have.

I do have -- I have seen the testing done on the mother for hemoglobinopathy, and it did not appear that she had alpha-thalassemia or was a carrier for the seven most common alpha-thalassemia mutations, which picks up not all but many of the ones that are seen in people of African ancestry.

Q And my statement, assuming that the test results you saw, would have been the same test results had that test been done while this child was in the NICU?

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A Yes.
For the -- you mean for, for the mother?
Q Yes, sir.
A Yes.
Q Now, I'll ask the question again.
Any other opinions you intend to offer at trial other than those you've completely shared with us now and also your report?
A I don't think so.
Q Thanks.
MR. COTTON: That's all I've got, but other counsel may have other questions.
Thank you.
THE WITNESS: You're welcome.
EXAMINATION BY COUNSEL FOR THE DEFENDANT
BY MR. McBRIDE:
Q Doctor, good morning. My name is Robert McBride. I just have a few questions for you.
I take it, since you have not seen any records of the perinatologist, you have not seen any ultrasounds that might demonstrate any nuchal

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translucency; is that right?
A That's right. That's correct.
Q And have you asked Plaintiffs' counsel if there are any such documents or records that you could review in order to firm up your opinions?
A I have not.
Q Are there any documents that you specifically asked for that you have not been provided?
A No, there are not.
Q And do you feel that you've reviewed all the materials you need to review in order to render your complete opinions here today?
A There's certainly information that would be valuable for me to review, but I don't believe it's available.
I would have loved to have known what the father's CBC was, his blood smear, and some testing on, on him related to, related to his diagnosis of thalassemia.
Diamond-Blackfan anemia is often

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inherited as well, so if the parents had had testing done, even testing such as a CBC, sometimes you can see signs of an asymptomatic -- I would say a, a carrier state -- which can sometimes be asymptomatic and not diagnosed and that people can have the same Diamond-Blackfan mutation but be less affected.
So we see family members that have mild anemia and macrocytosis as a, as a clue that their child has Diamond-Blackfan anemia.
Q But you have not requested any of that information from Plaintiffs' counsel as of today, true?
A My -- no, I have not.
And my understanding is that there was not laboratory testing available on the father.
MR. McBRIDE: Doctor, would you mind if we take maybe just a five-minute break very quickly so I can look over my notes and see what follow-up questions I might have?
THE WITNESS: Certainly.

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MR. McBRIDE: Okay, thank you.
(Thereupon, a recess was taken.)
Q (By Mr. McBride) Doctor, just a few more questions.
Going back to the nuchal lucency, where did you obtain the information that this child had nuchal lucency identified on prenatal ultrasound?
A I -- I think that the information was in the, the mother's deposition, and I'm not sure if there was another -- maybe it was in some of the physician notes -- maybe it was in some of the physician notes as well from the -- I would need to go back and check. I think it -- I think it might have been in physician notes as well. It might have been when she had her hematology opinion or at an earlier date.
Q Are you aware of any mention of nuchal lucency in the records from Sunrise Hospital while the child was in the NICU?
A I would need to go back and check my notes.

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I did not see it in -- I certainly did not see it in the admission note or the progress notes from the neonatologist in the early portion of the child's admission.

Q Okay. How about in the discharge summary? Do you recall seeing that mentioned there?

A I do not believe it was in the discharge summary.

Q Okay. And the same question for the family history of alpha-thalassemia, where did you obtain that information?

A The family history of alpha-thalassemia, I believe, was in some of the physician notes as well as being in the, the deposition from Mayrose's mother.

Q All right. And are you aware of it being specifically mentioned in the physician notes while the child was in the NICU?

A I'm, I'm not -- I don't remember.

It certainly wasn't in the admission note

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family history, which is the typical place that the family history is obtained.

Q And would you expect if that information had been conveyed, either the nuchal lucency or the alpha-thalassemia, had been conveyed to any of the neonatologists taking care of this child that that would have been noted by those physicians in the records?

A I have to say that the admission note was very brief, so I think that there wasn't, there wasn't a lot of detail in the history in the admission note.

Q But would you expect that at some point that if that information had been conveyed by the parents to the physicians that that would have been contained in the, in the physician notes or somewhere in the Sunrise Hospital chart?

A That would have been the, the standard of care.

Q So as you sit here, you're not able to point specifically if it, in fact, appears

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anywhere in those records, right?

A I would need to go back -- I would need to go back and, and review it to tell you the specific -- to find the specific location.

Q Okay. Doctor, at the time that you were asked to review this case by Plaintiffs' counsel, were you aware that this was a case involving a patient who had Diamond-Blackfan?

A I did know the diagnosis of the patient at the, at the time that I agreed to review it.

Q And at the time you provided, or when you were first contacted regarding reviewing this case, did you offer any opinions at that time in your initial consultation with Plaintiffs' counsel?

A I did not -- I did not offer an opinion until I offered my formal opinion, I believe.

Q And are there any other opinions which you haven't already told us about which you intend to offer at the time of trial?

A There are not.

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Q Okay.

MR. McBRIDE: Thank you.

That's all I have.

MS. WHITEHEAD: Okay, I have just a few questions. I'll try to speak up nice and loud for you.

EXAMINATION BY COUNSEL FOR THE DEFENDANT

BY MS. WHITEHEAD:

Q Doctor, I noticed in your CV that you've given several lectures on anemia of prematurity. I believe it was in February of '07, Pediatric Grand Rounds at St. Agnes Hospital.

Does that sound familiar?

A Not anemia of prematurity specifically.

Q Common causes of anemia in children?

A Right.

Q That's correct.

Do you have any of the slides or presentation notes that you gave?

A I do have my slides from that lecture, yes.

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Q Okay. The same with -- I believe there was another one that you gave -- I'm assuming -- it says it was a CME, I'm assuming that you gave that lecture on anemia in children.
A Uh-hmm.
Q And do you have the slides or the notes on that as well?
A I certainly do, uh-hmm.
Q Could you provide those to counsel for us?
A I can.
I'll warn you that they don't talk about neonatal anemia. It's usually -- they don't focus on neonatal anemia because it's different, so it's really more older children, but I'm happy to provide it to you.
Q Okay. Is there any discussion in there about any anemia of prematurity?
A I don't believe there is.
Q Okay. Well, if we can have a look at it just to make sure.

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Okay. And other than the opinions that you've expressed today and that are in your report, do you plan on offering any other opinions in this case at time of trial?
A I do not.
Q Okay.
MS. WHITEHEAD: I have no more questions.
MS. CARMICHAEL: Just a couple follow-up. More clarification.
EXAMINATION BY COUNSEL FOR THE PLAINTIFFS
BY MS. CARMICHAEL:
Q Doctor, in that initial neonatology admission note, is there any evidence that the neonatologist admitting this child made any effort to take any kind of a history of the -- of what occurred during the child's neonatal period or, excuse me, prenatal period?
A Sure.
There was -- there was no, there was no mention of a, of a perinatal history other than, I

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think, all normal or something like, like that.
If I can look at the note, I can give you the exact words.
But there was -- I don't think there was a remarkable, anything that was noted to be remarkable, until the time that they had really presented to the hospital.
Q Okay. And you've read the deposition of Tiffani Hurst and Brian Abbington, the parents of the children --
A Yes.
Q -- the child?
A Yes.
Q And you've -- you've read the testimony that both parents indicated that the alpha-thalassemia and the nuchal lucency was reported to the physicians.
Do you recall that?
A Yes.
Q Okay. Is there any evidence anywhere in the neonatal records of Sunrise Hospital that any

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neonatologist ever requested any blood work on the father or the mother?
A I don't -- I don't believe so.
It's routine that there's some blood work done on the mother with delivery, so there's -- there is information -- there is information that would have been available on the mother from the time of delivery, including usually a CBC, but I did not see a mention of that in the notes.
Q Okay. And it is your opinion, given the abnormal things that you pointed out -- the nuchal lucency, the alpha-thalassemia, the higher number of transfusions, and the macrocytosis -- that this child should have had a more thorough workup in the NICU for her anemia?
A Yes.
MR. COTTON: Form and foundation and competency objections.
MR. McBRIDE: Join.
Q And in reading the discharge instructions, is it pretty clear to you -- is it

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clear whether or not there was any concern about anemia in the discharge instructions?

MR. COTTON: Same objections.

MR. McBRIDE: Join.

A So the discharge instructions had kind of two classes of recommendations. There were two recommendations that were prioritized, and that was the follow-up for cystic fibrosis testing at three months and the recommendation to repeat the head ultrasound, and then there were a series of other recommendations that were not emphasized to the same degree that were a list of six or seven recommendations that included the CBC and reticulocyte count.

Q Okay. Is there anything in the discharge instructions that show a concern, an ongoing concern, on the part of the neonatologist that this child has significant anemia that needs close follow-up?

MR. COTTON: Same objections.

MS. WHITEHEAD: Objection;

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speculation.

A There was -- there was no mention made of the evaluation or a specific concern about the anemia other than the diagnosis of anemia of prematurity.

Q Okay. And in the discharge summary, at least, the diagnosis of anemia of prematurity has a closure date on it of July 21.

Is that your memory?

A That is -- that is correct, that there was a start and closure date for the diagnosis of anemia of prematurity.

Q Okay. Based on the child's issues during the NICU period, is it your opinion that the child should have been followed after discharge by a hematologist?

MR. COTTON: Same objections.

MR. McBRIDE: Join.

A So I can, I can say that this -- if I had seen this patient in consultation, I would have followed them after discharge as a hematologist.

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If a neonatologist had evaluated them for their anemia and had been concerned about their anemia, they probably would have arranged for a follow-up with the hematologist.

We see the, the children in the NICU that have significant anemias diagnosed by the neonatologist that we usually see them prior to discharge.

Q Okay. And, Doctor, what was this child's rate of decline in her red blood cells during her period of time in the NICU?

MR. COTTON: Form and foundation objections.

A If you look at the amount of blood that she received in the, in the NICU, she was typically dropping her hematocrit eight or nine percent a week based on the amount of blood that she was getting and the expected rise in hematocrit from that blood.

Q And at a decline rate of eight or nine percent per week, what would be the standard of

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care for follow-up on that child?

MR. COTTON: Form and foundation objections regarding a neonatologist standard of care.

Q From a hematologic point of view.

MR. COTTON: Form and foundation objections.

MR. McBRIDE: Join.

A Typically, we would need to transfuse a child that was dropping that fast every one to two weeks.

MS. CARMICHAEL: Thank you, Doctor.

Those are all the questions that I have.

MR. McBRIDE: I just have a couple of follow-up questions.

EXAMINATION BY COUNSEL FOR THE DEFENDANT

BY MR. McBRIDE:

Q Doctor, are you aware if you have reviewed portions of the medical records from Sunrise Hospital, or have you been provided with

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all of the medical records from that hospitalization?
A I believe that I was provided with all of the medical records for the hospitalization.
Certain portions of the record, including the respiratory therapy and some of the nursing record, I skimmed, so I did not review in detail.
Q And, Doctor, are you aware of when Doctor Blahnik, when his last involvement with this child was?
A I was reminded, reminded by counsel that his last involvement with this child was shortly before he went on vacation, which I believe was in mid-July.
Q And if I were to tell you July 13, 2008, does that sound about right?
A It does.
Q Okay. And are you aware that Doctor Blahnik was not involved at all with the discharge instructions for this patient?
A I, I was told that that was how the

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practice worked; that the, that the responsibility was shifted to the next physician.
Q And at the time of discharge, or I think you already somewhat answered this, are you aware if there's any evidence that this child had suffered an anoxic brain injury at the time of discharge from Sunrise Hospital?
A I think that there's pretty solid evidence that this child had not suffered anoxic brain injury at the time of discharge.
MR. McBRIDE: Thank you.
That's all I have.
MR. COTTON: Jackie, do you want to read the Doctor his rights about reading and signing?
MS. CARMICHAEL: Yeah, sure.
Doctor, you do have the right to receive a copy of the transcript of your deposition to review it for accuracy and make sure that your answers were correctly transcribed.
Would you like to exercise that

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right?
THE WITNESS: I would.
MS. CARMICHAEL: Okay. Madam Court Reporter, would you please send the transcript directly to Doctor Strouse.
MR. COTTON: Okay, thanks.
(Thereupon, at 1:48 p.m., the examination of the witness was concluded.)

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CERTIFICATE OF NOTARY PUBLIC

I, Kathleen R. Turk, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

_____
Kathleen R. Turk
Notary Public in and for the
State of Maryland
My Commission Expires:
March 17, 2015.

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DEPOSITION ERRATA SHEET

Our Assignment No. 393029
Case Caption: Tiffani Hurst, et al., vs. Sunrise Hospital and Medical Center, et al.

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me, and the same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

Signed on the _____ day of _____, 20___.

_____

John J. Strouse, M.D.

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DEPOSITION ERRATA SHEET

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John J. Strouse, M.D.

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John J. Strouse, M.D.

EXHIBIT "J"

Page 1

DISTRICT COURT
CLARK COUNTY, NEVADA

* * * * * * * * * * * * * *

TIFFANI HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST,

Plaintiffs,

V.

Case No.: A616728

SUNRISE HOSPITAL AND MEDICAL CENTER; MARTIN BLAHNIK, M.D.; ALI PIROOZI, M.D.; RALPH CONTI, M.D.; and FDOTHILLS PEDIATRICS, L.L.C.,

Dept. No.: 24

Defendants.

* * * * * * * * * * * * * *

DEPOSITION OF MARCUS HERMANSEN, M.D.

Deposition taken at Regus, 1 Tara Boulevard, Suite 200, Nashua, New Hampshire, on Thursday, December 13, 2012, commencing at 1:46 p.m.

Court Reporter: Michele M. Allison, LCR, RPR, CRR
NH LCR No. 93 (RSA 310-A)

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Also Present: Martin Blahnik, M.D.

* * *

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WITNESS: Marcus Hermansen, M.D.

(Exhibits copied and appended to transcript.)

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MARCUS HERMANSEN, M.D.,
having been duly sworn by Ms. Allison,
was deposed and testified as follows:

EXAMINATION

BY MR. COTTON:

Q. Would you please state your name.
A. Dr. Marcus Carl Hermansen.
Q. Okay. Dr. Hermansen, my name is John Cotton, and I'm representing Dr. Ali Piroozi in this lawsuit here. And to my right is Robert McBride. He's representing Dr. Martin Blahnik. To his right is Dr. Martin Blahnik.
A. Good.
Q. What's the nature of your current medical practice?
A. I'm a hospital-employed neonatologist.
Q. In terms of education do you have any residency or fellowship programs in pediatrics hematology?
A. No.
Q. Any residency in any form of hematology?
A. No.
Q. Okay. Any residency outside of neonatology?
A. My residency was in pediatrics; that was followed by a fellowship in neonatology, and that's

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all.
Q. Okay. Doctor, in looking at your curriculum vitae, and I won't go through the whole thing, the articles and the lectures that you listed in there, did any of them deal with anemia of prematurity?
A. I can't remember any that do. I don't think so. Maybe one snuck in, but I don't remember any.
Q. Did you have any articles or lectures that you've ever presented on the diagnosis of Diamond-Blackfan anemia?
A. Not specifically. That may have come up as a possible cause of newborn anemia, but the lecture would not have been on that topic exclusively.
Q. How many children in your career have you actually diagnosed as the, if you want to call it the first diagnosing doctor for a child with Diamond-Blackfan anemia?
A. I don't know. Either none or one. I really would be shocked if it were more than one, but I -- it could be one or none. I don't know.
I've been -- I've been doing newborn medicine for 30 years, and I can't remember diagnoses I made a year ago, let alone 30 years ago.
Q. Well, let me ask you this: Have you diagnosed a case of Diamond-Blackfan anemia in the

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last 10 years?
A. No.
Q. Have you diagnosed a case of Diamond-Blackfan anemia in the past 15 years going back to around '97, '98?
A. Two answers: One is I don't know, but secondly, I don't make the diagnosis. I may have had such patients. I think a hematologist makes that diagnosis. I don't think I ever have -- I've never had -- I may have had patients with it, and I may have had patients I've referred to hematologists who made that diagnosis.
I could practice for the next hundred years and have a handful of patients with that disease, but I'll never be the one to make that diagnosis.
Q. How many cases in the last 10 years or patients in the last 10 years have you treated and referred to a hematologist where the subsequent diagnosis was Diamond-Blackfan anemia?
A. Two answers: Number one, I have no way to know, and number two, it's probably a very small number.
Q. As you sit here today are you able to state that there's even been one in the last 10 years?
A. I have no way to know. I don't make the

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diagnosis.
Q. Doctor, are you in charge of a neonatal intensive care unit back in New Hampshire?
A. Yes.
Q. And what's the name of that unit?
A. Southern New Hampshire Medical Center.
Q. And what level unit is the NICU back there at Southern New Hampshire?
A. Three.
Q. How many patients are normally in your NICU unit on any given day?
A. Eight to ten.
Q. Have you in the past described your NICU unit as small?
A. Yes.
Q. Have you represented in various articles that you don't have adequate staff specialists in order to fill up all the spots for cardiology, endocrinology, things of that nature?
A. I don't understand your question.
Q. Did you write an article in the Hospitalist at any point in time?
A. Yes.
Q. Did you describe your unit and the lack of subspecialists at your institution in that article?

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A. I don't remember if I said that or not.
Q. Do you have a peds hematologist who is, if you will, attached to your department there?
A. I'm not sure how to answer that. I have access to him. I can be on the phone with him. I can send patients to him. We share institutional affiliations. And yet, I don't know how to answer your question.
Q. Okay. I'll get back to that. Doctor, other than the documents that you've set forth in your expert report of August 28th, 2012 have you reviewed any additional documents in arriving at your opinions or conclusions? And feel free to look at your report.
A. Yes, I have.
Q. Tell me what else you've reviewed in addition to the items set forth on page 1 of your report.
A. Again, a two-part answer. Part one, expert disclosures on behalf of both the plaintiff and two expert disclosures for defendants. So there were three expert disclosures altogether: One for the plaintiff, two for the defendants.
Part two is I've reviewed the medical literature.
Q. Any specific medical literature, articles that you feel is supportive of your position on the

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standard of care?
A. Yes. And I brought a -- a one-page summary that lists eight references.
Q. Maybe we -- if you could give that to the court reporter and have her mark that, and then we'll get a copy made for everyone, then.
A. So I made three copies. I'm going to keep one. I'll give one to the court reporter and one to the two attorneys who are in the room with me.
Q. That's fine.
MR. COTTON: And Ms. Reporter, if you could just mark that as Exhibit 1, please.
(Exhibit 1 was marked.)
Q. BY MR. COTTON: And Doctor, correct me if I'm wrong, Exhibit 1, you described that as a summary of the medical literature that you feel is supportive of your opinions?
A. It's supportive of one specific opinion.
Q. Which one is that?
A. Not all my opinions of which there aren't that many. But I made a statement in my report. It's about two or three sentences. And it is in conflict with defense experts' opinions. And I'll tell you my opinion -- and I'm going to read from my report. This is on page 2 near the bottom. There's a section

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called, "Failure to recognize and evaluate." And I'm going to the second bullet. It says, "Few newborns of 28 and 6/7th weeks' gestation with anemia of prematurity require one transfusion. Fewer yet requires a second transfusion."
Now, I have read defense experts that say something like these babies require eight to ten transfusions. That seems to be a pretty significant discrepancy. And Exhibit 1 supports me and says that the defense experts are wrong.
Q. And just for our later record purposes when we're all split up, which of the articles on there do you believe supports your position on that?
A. All eight. There's nothing to support what they say in the medical literature that I could find. Now, maybe they're going to be able to come up with something new, but I spent about two hours looking and came up with eight references and stopped.
Q. How many times have you acted as an expert in a medical malpractice case on the standard of care?
A. Well, I would suspect I've given approximately 600 depositions in my career and -- now, that's an interesting question, because most of the time my opinion comes down to causation issues but I still say something about standard of care. I still

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am asked, "How was the newborn care?" and I usually say it was good. So probably most of those times I commented on the standard of care, and most of those times I found it to be acceptable.
Q. Let me ask you this: How many times have you been specifically retained to testify against another neonatologist on the standard of care?
A. I never view myself as testifying for or against anyone.
Q. Well, I can assure you my clients are perceiving that you're testifying against them.
A. They may.
Q. How many times -- how many times have you been retained by a plaintiff suing a physician neonatologist to testify on behalf of the plaintiff in that action on the standard of care?
A. Where a neonatologist was a defendant? If I've given 600 depositions they've probably been a defendant in 5 percent. At most there would be 30. Probably less than that. Maybe 10 to 20 cases out of the 600. There are very few instances.
Q. You've actually given presentations to NICU organizations about the proliferation of litigation in your area, correct?
A. No. No.

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Q. You don't recall? You don't recall giving a presentation at Johns Hopkins?
A. No. I published an article for them reviewing some recent literature on medical malpractice issues. It's an Internet article that you probably can obtain. It's listed in my CV. It was not a lecture at Hopkins but it was a continuing education program for Hopkins on the Internet.
Q. On how many occasions have you acted as an expert witness in a case that's lodged in the State of Nevada other than this one?
A. Either one or two. I remember one, and it's possible there were two.
Q. Do you remember when the last one was before this one?
A. Well, again, I only remember one. It was with Mr. Nielson, and that was probably four or five years ago. Now, if I had a second one it was with the same attorney. I just don't remember if I've had one or two with him.
MS. CARMICHAEL: Dr. Hermansen, he's in Utah.
A. Oh, I'm sorry. He's in Utah.
Q. Oh. I was talking about Nevada.
A. Oh, in Nevada? I've never done a case in Nevada.

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Q. Oh, okay.
A. I've never done a case in Nevada.
Q. Let me ask you this: How many times have you acted as an expert witness for a plaintiff in a medical malpractice action against a doctor in New Hampshire?
A. None. That would be unethical.
Q. Why would that be unethical?
A. Those are easily recognized conflicts of interest. I know those people. I work with those people. They're either friends of mine or enemies of mine and there's a conflict of interest. There would be some bias in any testimony I gave either favorable or unfavorable, or at least the appearance of bias, and I won't put myself in that situation.
If I defend people -- if I defend people in New Hampshire I could be accused of bias. If I criticize them people would claim they're competition of mine, and I have bias, and I won't put myself in a conflict of interest.
Q. And you also have to see those people around the hospital, I take it?
A. Well, around the state. We're a pretty small state. There are three hospitals in the state with newborn intensive care units, so we know each other

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pretty well.
Q. Are the other units around the state larger than yours or smaller?
A. They're both larger.
Q. How much larger?
A. Oh, Dartmouth has commonly 20 to 30 babies, and Manchester, I don't know how many babies they run.
Q. Comparable to Dartmouth?
A. I really don't know. I would think they're in that range of about 20 babies, but that's a guess, and I don't like to guess.
Q. Doctor, you've been retained to provide opinions regarding compliance or noncompliance with the standard of care by my client, Dr. Ali Piroozi, correct?
A. Yes.
Q. Would you tell us what opinions you hold regarding Dr. Piroozi's compliance or noncompliance with the standard of care?
A. I think there were two issues. I think number one is, in the management of this baby there's no consideration to diagnose this other than anemia of prematurity once we got beyond the initial newborn illness.
Now, I accept for the first few weeks of life

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the child had other medical complications that may have accounted for some of the anemia, but when I move to the months of June and July, they consider this to be anemia of prematurity and nothing else, and I think that's negligence.
And number two, there was poor discharge planning.
Q. What factual basis do you have to believe that the only diagnosis that the doctors had for this child in June and July was anemia of prematurity?
A. It's odd that everything has a two-part answer, but, again, a two-part answer. Number one, the medical records; number two, their deposition testimony.
Q. When you say "deposition testimony," whose testimony are you talking about?
A. In my report I refer to the deposition testimony of Dr. Blahnik and Dr. Piroozi.
Q. And specifically in the medical records what items contained in there support your position that the only diagnosis for this child's problems was anemia of prematurity in June and July, up to August?
A. The progress notes and discharge summary.
Q. Okay. And what in the progress notes and discharge summary do you believe supports your

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position?
A. They make that diagnosis. And every time they're talking about anemia, that's the only diagnosis that you come across. There's no consideration of other problems. There's never a differential diagnosis. There's never any thought process that something else might be going on expressed.
Q. Is it your belief and understanding after you reviewed the records that the diagnosis of anemia of prematurity was an active diagnosis all the way up to August 2nd, 2008?
A. Well, now we move into the second issue. Clearly in the discharge summary they say that that was not the problem, that that problem ended -- well, they have that having ended on July 21, and that's confusing. Now we don't know what they're thinking from July 21 until discharge.
Q. The answer to my question is it's your understanding, then, that the -- as an active diagnosis that anemia of prematurity was no longer an active diagnosis after July 21, 2008?
A. I'm going to spend a minute to look at their progress notes after July 21.
Q. Take your time, Doctor. Don't feel like I'm

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rushing you.
A. Thank you. (Witness peruses documents.)
MS. WHITEHEAD: Bob and John, while we're sitting here waiting, do you want me to see if they can fax over Exhibit 1 to Esquire out there so you can take a look at it?
MR. COTTON: No. I don't have any more questions. Thank you, Jonquil.
MS. WHITEHEAD: Okay.
A. I don't see anything after July 21 where they were considering it to be a problem at all.
Q. Do you see anything before June 16th of 2008 that it was being listed as a problem?
A. Are you asking specifically anemia of prematurity?
Q. Yes, sir.
A. Yes. Yes, I do.
Q. Tell me where it was an active diagnosis for the child before June 16th, 2008.
A. On the neonatal discharge summary, page 3, it says that that was the diagnosis from May 15 to July 21.
Q. Are you critical of including anemia of prematurity as one of the differential diagnoses for this child during the time frames we're talking about?

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A. I don't know if we're talking about -- I don't know how to answer that. I think that there may have been a role somewhere in the conversation. But if you look at the total time frame, if it's on the differential diagnosis it's not at the top. It's well down the list.
Q. Well, are you able to rule out that it was not some --
(Videoconference malfunction.)
(Discussion held off the record.)
Q. BY MR. COTTON: Doctor, are you able to rule out that anemia of prematurity was not one of the appropriate diagnoses for this child from May 2008 until August at the time of her discharge?
A. No. I think it may have had some role in the child's condition.
Q. If I heard your testimony earlier, Doctor, I think you testified that you don't believe you personally have ever diagnosed Diamond-Blackfan anemia, correct?
A. I don't think that's my role. I don't think that that's the role of a neonatologist; therefore, I doubt if I have ever, and I doubt if I ever will.
Q. Okay.
A. That's not my job.

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Q. Let me ask you this: Are you personally familiar with any physical anomalies on presentation of a child that would be associated with Diamond-Blackfan anemia?
A. My recollection is that some of them may have some anomalies, but I'd have to look it up in the book to see how common they are and what they are. If I were considering the diagnosis I'd look it up in a book, and I'd know what they were.
Q. Okay. And I take it in rendering your opinions here and preparing for the deposition you've not done so?
A. Correct.
Q. Would you agree with me, Doctor, that Diamond-Blackfan anemia is a rare condition?
A. Yes.
Q. Would you agree that it occurs in about one out of every 150,000 U.S. births?
A. I don't know the number, but I have no reason to question that. That may be right.
Q. In terms of the transfusions for this -- well, let me ask you this first: Tell me what criticisms you have first of Dr. Piroozi in terms of the discharge.
A. I'm looking at my report where I summarize

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that. I think waiting one month for a CBC or -- was too long. I think that there's poor communication with the follow-up pediatrician. I think there were multiple errors in the discharge summary that would be misleading to a pediatrician. Those three facts.
Q. Tell me why waiting one month for a CBC was too long for this child.
A. This child was needing transfusions more frequently than that. It was highly predictable the child would be a candidate for a blood transfusion prior to one month after discharge or five weeks or maybe five-and-a-half weeks after the last transfusion.
This child needed four transfusions in June, three transfusions in July. The child's sent home making no red blood cells, almost none, and yet, they're gonna say, "Oh, you can go five weeks from your last transfusion before we check it again."
That's dangerous. I don't think anyone can look at that and think that that's a safe plan, not for a child who is getting three or four transfusions a month.
Q. What were the transfusions ordered for in May?
A. I'm assuming the ones in May were

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attributable to the severe illness the child had. I believe it was necrotizing enterocolitis that we can just call NEC. But the child was sick, needed surgery, critically ill.

I'm going to assume all those were attributable to -- and it was reasonable to attribute them to the extreme critical illness of the child. I have no problems with the month of May.

Q. So those four -- correct me if I'm wrong, Doctor, those four transfusions for this little girl were within the standard of care based upon the little child's presentation?

A. Absolutely. And there was no reason to think she had a blood disorder going into the month of June.

Q. And whether the child had anemia of prematurity or not, these would have been appropriate orders of transfusions?

A. Absolutely.

Q. What was the transfusion for on June 7th of 2008?

A. I don't understand your question. Are you asking what did -- why did they do it? What was their indication for it?

Q. Yes, sir.

A. Or now --

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Q. Yes, sir.

A. -- today what was it for? Those may be different --

Q. I want to know -- I want to know what your understanding is of why the doctors ordered a transfusion on June 7th, 2008.

A. Well, maybe -- it's odd. I've got daily progress notes. And I've got one from the 6th that says, "Stable hematocrit," and then I have one on June 8, but I don't have a progress note from June 7. So either --

Q. Let me ask you --

A. Either it didn't make its way into my chart or they didn't put one in the medical records that day.

Q. Let me ask you this, Doctor: I want you to assume for a moment that the transfusion on June 7th, 2008 was ordered responsive to clinical sepsis. If that was the case would you agree that that was within the standard of care to order a transfusion?

A. Marginal. Some people would say yes, and some people would say no. I'll give them the benefit of the doubt. If the child was septic at that time -- most people don't think that blood transfusions treat neonatal sepsis, but let's put that on the table.

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It's an unusual therapy for neonatal sepsis. At least we have to agree it's an unusual therapy for sepsis.

Q. Would you agree with me it's judgmental on the doctor's part?

A. I'll give them the benefit of the doubt and agree to that.

Q. It wouldn't necessarily be below the standard of care to treat clinical sepsis with transfusion, correct?

A. But let me take -- while I will agree with that, the problem is there's no note on the 6th or the 8th saying they thought they were treating sepsis. I don't see why -- where you're getting the thought the child was septic on the 7th, because they don't write that on either the 6th or the 8th.

MR. COTTON: And for purposes of the record I just want a notation, Ms. Court Reporter, of move to strike the last portion of his testimony as nonresponsive.

Q. Doctor, I want you to assume that the June 25th transfusion was ordered to rule out fungemia. Would that be an appropriate reason to order a transfusion under the standard of care?

A. No.

Q. Why not?

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A. Because you rule out a fungal infection by sending the blood to the lab and having them grow it for a fungus. It's a culture test. You don't transfuse the baby to rule out a fungal infection.

Q. Are you aware of the fact that that transfusion was ordered by Dr. Greg Miller and not by Dr. Piroozi and not by Dr. Blahnik?

A. I don't remember who ordered which ones.

Q. You're not going to hold these doctors responsible for orders issued by other physicians not a party to this suit, are you?

A. I'm not faulting anyone for their orders for any transfusion. I'm not faulting -- whoever ordered the one on the 25th, I have no faults with them ordering that transfusion. Nowhere in my report or in my opinions do I fault them for giving a transfusion for any indication they wanted. That's not part of what I'm here to say.

Q. Doctor, if the doctors ordered up transfusions to rule out a GI bleed, is that an appropriate order for a transfusion under the standard of care?

A. No.

Q. If the doctor orders a transfusion for a surgery, ostomy take-down, in this particular child is

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that an appropriate order under the standard of care?
A. Maybe. That's beyond my field of expertise. I would ask either a surgeon or an anesthesiologist about that. I don't know. That one might be.
Q. That's outside your bailiwick?
A. Well, surgical preparation. Preparing a baby for surgery and what kind of numbers they want, you should ask the surgeon or the anesthesiologist.
Q. In your level-three NICU unit do you folks, the neonatologists, do surgical ostomy take-downs?
A. No.
Q. So you refer those out to surgeons?
A. Yes.
Q. Okay. Doctor, when ordering a transfusion for a Broviac placement surgery, would it be an appropriate order under the standard of care for this child?
A. It could be. It could be.
Q. Are you able to -- now, Doctor, I've gone through, in essence, 11 different transfusions that were given to this child. Are you able to point us to any transfusion that was specifically ordered to, if you will, address a condition of anemia of prematurity?
A. Well, in the discharge summary under

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"Hematology" they say she received transfusions, and for a diagnosis they say it was for anemia of prematurity. They don't give any other reason. That's one place to look. We can look at --
Q. Give us, Doctor, if you could, give us the page on that.
A. That's the discharge summary, page 3.
Q. Do you have Bates stamp numbers on them?
A. No. I'm sorry.
Q. Okay. So it would be page 3 of the discharge summary, then?
A. Correct.
Q. Doctor, in your review of this entire chart of Sunrise Hospital did you ever conclude that there was a point in time when this child was suffering from profound anemia?
A. No. I wouldn't call it profound.
Q. How would you define profound anemia?
A. I don't have a strict number. I think it would be an extremely low number, usually associated with clinical symptoms of anemia. I don't have an exact cutoff. I'll give you a number today, and I might say something different a week from now, so I'm a little afraid to do that.
I don't carry a number with me. I don't use

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that term is what it comes down to. If I use it I use it rarely and inconsistently.
Q. I take it you wouldn't use it for this child's condition?
A. I don't think I ever applied that term to this case, and I think we know why.
Q. I'm asking you as you sit here today, you're not applying that term to this case as you sit here today, are you?
A. No. I think they avoided profound anemia until -- that's until the ultimate problem happened when the child came back after being home for a while. That was profound anemia. But we're not talking about that. We're talking in the newborn intensive care unit there was not profound anemia.
Q. So the first time that you can see any -- anything that would document a condition of profound anemia would have been while the child was under the care of Dr. Ralph Conti not under the care of Dr. Blahnik or Dr. Piroozi, correct?
A. Correct.
Q. Doctor, what's a retic count?
A. You mean retic?
Q. You say tomato; I say tomato. R-e-t-i-c.
A. I'll call it retic.

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Q. Okay.
A. Retics are --
Q. Retics are what I get up in Minnesota, so...
A. It's good. Retics are young immature partially developed but not yet fully developed red blood cells. You can look in a blood count and determine how many retics are present. There are two different ways it can be presented, both of which would be considered a retic count.
You can either look at what percent of all the red cells are retics and give it a percent. It might be one, two, three, four, five, something like that. Or you can say within a certain volume of blood, let's say a milliliter or a liter, how many retics are there? That number is going to be big. It's going to be in the hundreds or thousands or millions.
So a retic count can be either of those two. It turns out both are presented in this medical record. Both methods are used in this case.
Q. Is there a particular level of which a retic count is too low for a child endangering a child?
A. No, not the retic count by itself. Just as an isolated number it's not harmful.
Q. Can a retic count drop after a transfusion?

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A. Yes.
Q. How does that happen?
A. It usually doesn't happen after one single transfusion, but after multiple transfusions the body will be -- will turn off its own red cell production. It will more or less become dependent on the transfusions. So it's not going to make new red blood cells, and your retic count will fall after multiple transfusions.
Q. Doctor, in looking at this chart here did you see anything to indicate that there was any manifestation of a bone marrow failure?
A. That's beyond my field of expertise.
Q. Whose field of expertise would that be, in your opinion?
A. A hematologist.
Q. I take it being outside your area of expertise you're not able to answer that question?
A. Well, let's hear the question again and see if I can give it a shot.
Q. Did you see any manifestation -- in the record did you see any manifestations of bone marrow failure in this child while she was at Sunrise Hospital?
A. I don't know what's meant by "bone marrow

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failure," so I don't know how to answer that. I think that the child was not producing red cells. I think many people would say that's bone marrow failure.
Q. Tell you what -- tell me what in the record you have to support your position that the child was not producing red blood cells.
A. Here's another two-part answer: Number one, 11 transfusions. Eleven. That's a shockingly high number. And number two are the retic counts at the time of discharge. Whether you measure it by either of the two techniques, this baby's not producing red cells at the time of discharge.
So you have a baby with multiple transfusions -- and that should raise a few red flags to people. That really is of concern. And then you say, "Well, let's look and see if the baby is making cells," and you see virtually none. I think that tells us that there's a red cell production problem.
Q. Can it tell you anything else based on this presentation and this course of treatment?
A. No. I think that the only conclusion you can draw looking at this case is that at the time of discharge there should have been a concern that the baby was not making red cells.
Q. By the way, to address that concern is to ask

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the follow-up doctor to perform tests to make sure that there isn't a concern, correct?
A. Yes.
Q. And do you believe you have the right to rely upon the professionalism of a board-certified pediatrician when you refer a patient out of the NICU?
A. I think that it's -- it's still a team approach. I'm going to give that clinician good information and a good plan and then turn it over to them and let them run with the ball.
Q. Is it your position that once you've transferred the patient out of the NICU and into the hands of a pediatrician that you remain responsible for the day-to-day care of that patient?
A. I'm responsible if I've produced a bad plan for them to work with.
Q. If you produced what you perceived to be a good plan, do you believe that you're responsible for the ongoing care of that patient?
A. I need to produce a good plan and communicate it to the pediatrician, and then once they take over it's theirs. But I have to produce a good plan and make sure I've communicated that in some way to the pediatrician.
Q. And in -- that can be either verbally or in

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writing, correct, Doctor?
A. I think so. I think so.
Q. Unless you have some basis to believe that the physician you're referring it to will not be responsive to your written communication?
A. I need to communicate to the pediatrician. If they're not going to respond -- if I know they're not going to respond to the written then I need to find another way. I think it would be wrong to know that they're not responding to the written and just send them written communication anyway and assume that was good enough if I knew they weren't going to respond to it.
But basically the answer is, if I've come up with a good plan and get that plan into the pediatrician's functions, to get the pediatrician aware of the plan, agreeing to the plan and taking it over, I think the neonatologist is off the case at that point.
Q. Okay. And once you've done that and gotten the plan into the hands of the pediatrician, if subsequently the pediatrician decides to ignore portions of your plan but doesn't tell you, do you think you're responsible for that conduct?
A. Not if I've given him a good plan and

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communicated it. If I've done those then -- and -- no, I don't feel responsible if they go on their own route.

Q. Doctor, as you sit here today, I think I know the answer to this from what you said earlier, do you know what the treatment is for Diamond-Blackfan anemia on initial diagnosis?

A. No.

Q. That's a one-part no not a two-part no, right?

Doctor, are you able to tell us how prevalent a condition of anemia of prematurity is in an infant as ill as Mayrose was when she came into Sunrise?

A. Well, traditionally, we don't make that diagnosis on admission. That diagnosis would be made after they're through the acute problems. I think on admission what you would say is she has a very high risk of developing that problem in the subsequent weeks and months.

Q. And why is that?

A. There are many reasons for anemia of prematurity. Number one, they're growing very fast. So whatever red cell production they have going on, they're trying to make cells, but they're growing so fast they can't keep up with their body growth. If

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their body doubles in size the red cell production can't keep up with that growth. That's why.

Number two, there's frequent blood sampling taking place. Now, in the last 20 years we've taken steps to minimize that. There's a lot less blood drawing taking place. Here we've got this baby trying to grow and make blood, and then we try and take it from the baby to do a laboratory analysis. That's another reason for it.

Number three, they just have an immature system, and they don't make blood very well.

Q. Doctor, correct me if I'm wrong, I'm safe in assuming that you yourself have been a treating physician for infants, premature infants who have been diagnosed with anemia of prematurity?

A. Yes.

Q. And in that situation I'm assuming that in most instances you were able to normally discharge those patients, correct?

A. Yes.

Q. And have you in the past discharged patients on multivitamins plus iron who had suffered at some point from anemia of prematurity?

A. Yes. It's very common.

Q. Is that within the standard of care to

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prescribe that on an out -- outpatient basis?

A. Yes.

Q. Have you ever discharged a patient who you at some point diagnosed with anemia of prematurity with a hematocrit of 30 or less?

A. Yes.

Q. Was that below the standard of care to do so?

A. No. I have -- I have no criticisms about them discharging the baby when they did and in the condition that she was.

Q. When you've had a child with anemia of prematurity as a diagnosis during your care, have you ever recommended to the pediatrician that you were transferring care to to have blood tests taken post discharge?

A. Yes.

Q. Have you ever recommended that a transferring pediatrician follow up with retic counts on a patient that you were transferring out? Retic, I should say. Retic.

A. I think if I look at my career, in the middle part of it maybe -- I did a lot of retic counts, and we believed in them. We used them, and we followed them. And in the latter part of my career we don't -- we rarely check them. They really aren't very useful.

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So I don't even check them in the nursery very often anymore. I don't think I recommend it to pediatricians very often, if at all.

Now, maybe -- but your question was have I ever done it? I may have done that 10 or 20 years ago. Then I believed in them. I followed them. We thought we were using them. But we're just as well off without that test it turns out.

Q. What do you order now when you want them to have some follow-up blood testing?

A. Just a measurement of the red blood cells. Usually the hematocrit. Or you could get a CBC, which would include the hematocrit.

Q. When you discharge your NICU patients out to the pediatrician for follow-up care do you generally see those patients again?

A. No.

Q. When you discharge a patient out for care to a known pediatrician do you explain the discharge plan to the parents themselves?

A. Yes, absolutely.

Q. And that's the standard of care to do so?

A. I don't know.

Q. Do you believe that the standard requires you to explain the discharge plan to the parents?

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A. Parts of it, yes, but not all of it. There's some parts of the discharge plan for which I know they should be aware and other parts they probably don't have to be.

Q. In this specific case were there any parts of the discharge plan that you believe the parents should have been made aware of?

A. Yes.

Q. And specifically what portions?

A. Well, I'm -- on the discharge summary, it's the last page of the discharge summary -- my discharge summary is actually five pages long and it's the fifth page. And this has one section called "Plans." And it says the family's instructed to call the pediatrician for an appointment in three days. Yes, they have to be told that. That's appropriate to tell them that.

Additional appointments, that's number two, three -- one, two, three, and four. Yes, they should know what the other appointments are. That's good to tell them.

Feeding at discharge. Yes, I think they should know the feeding plan at discharge.

Pending results. The child requires a sweat chloride by three months of age. That's optional.

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You can either tell the family or tell the pediatrician.

The infant requires a head ultrasound at one month after discharge. That's optional. I'd like to tell the family, but if the pediatrician wants to, that's fine.

Follow-up tests: Sweat chloride, head ultrasound, CBC one month after discharge. Again, we said sweat test and head ultrasound were optional. I guess then we should say CBC is optional. A lot of people would like to tell the family that these tests needed to be done. Some people would let the pediatrician do that.

Discharge medication, yes, the family should know that.

Special instructions, when to come to the emergency room, yes, the family should be told that.

So these plans, the family should know most of these. I don't care if they know the follow-up testing or not.

Q. If, in fact, Dr. Piroozi verbally explained these plans to the parents and gave them a written copy of the plans, would that comply with the standard of care?

A. Well, that's a hard question. I'm not sure,

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because, obviously, you know how I feel about what's in these plans. I think the plans are not good.

Q. I'm aware of what --

A. I'm glad the doctor talked to the family. I'm glad the doctor gave them something in writing. That's all good. The problem is the plans themselves are bad.

Q. Okay. Without regard to that -- and I understand that's your opinion. The fact that he discussed the plan with them and gave them a written copy, that complies with the standard of care for communication, if you will, correct?

A. Yes.

Q. And if, in fact, he gave that -- sent and then was found in the file of Dr. Conti those plans and that the mother said she actually hand-delivered a set of those plans to Dr. Conti, that would comply with the standard of care in communicating the plan, whether you like the plan or not, communicating the plan to the pediatrician, correct?

A. Probably. Probably.

Q. Are you familiar with guidelines for transfusions for asymptomatic anemic infants put out by the Vermont Oxford Network?

A. I know there's such a document. I know I've

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seen it at one time, but I don't know what's in it.

Q. As you sit here today do you believe that those guidelines set the standard of care for physicians?

A. I don't know. I'd have to look at it. They might.

Q. So you don't know?

A. If somebody shows it to me I could answer that. I'd have to look at it.

Q. All right. Doctor, other than the opinions that you've got in your expert report of August 28th, 2012 and those you've shared with us today, do you hold any other opinions regarding Dr. Piroozi's compliance or noncompliance with the standard of care?

A. No.

Q. Okay. And finally, Doctor, do you have -- separate and apart from that notebook that I find to be too heavy to carry around, do you have separate notes that you've kept and articles that you've kept as part of your expert services here?

A. I received electronically the documents with the expert disclosures. I've made no notes on those. I haven't highlighted them electronically or tagged them electronically. They're just as clean as they came to me. So number two, I do have electronic

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disclosures, and number three are the eight articles that I've referred to. And that would be all that I have.

Q. Do you actually have sticky notes on pages on the records themselves?

A. About six of them.

Q. If you could just copy those pages with the sticky note and give them to Ms. Carmichael, then she can give those to us. Okay?

A. That's fine with me.

Q. Do you have the actual articles with you that are on that sheet there or just the sheet?

A. There are eight references. For two of them I have almost nothing. Those articles are back in the 19 -- one published in 1989 and one in '91. And I couldn't get easy access to them.

That leaves us with six. Of those six I have the full article, I think, for four, and I have the abstract for two.

Q. And do you have those with you today?

A. Yes.

Q. If you could give those to the court reporter. She'll make copies of them for us and then send you yours back with you when she sends the deposition for your review. All right?

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A. That's fine.

MR. COTTON: I think at this point, Doctor, that's all I've got. I think Mr. McBride may have some, and the hospital's counsel may have some, too. I don't know if anyone wants to take a five-minute break or what.

MR. MCBRIDE: Doctor, is it all right to take a five-minute break to use the restroom?

THE WITNESS: Anything is fine with me.

MR. MCBRIDE: Okay.

MR. COTTON: We'll be back, guys.

(Exhibits 2-6 were marked.)

(Recess taken.)

EXAMINATION

BY MR. MCBRIDE:

Q. Dr. Hermansen, my name is Robert McBride. I introduced myself before, or rather, Mr. Cotton introduced me. I represent Dr. Blahnik in this case, and Dr. Blahnik is here seated to my right. I just have a few questions for you, if I can.

Of the approximate 600 cases in which you've testified in a medical-legal action, you've testified that only 10 to 20 of those cases were on behalf of a plaintiff as a plaintiff's expert; is that correct?

A. No, not at all.

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Q. Okay. Could you explain that answer a little bit more? How many of the 600 depositions you've given have you testified on behalf of the plaintiff in a medical-malpractice action?

A. Ninety percent.

Q. Okay.

A. The 10 -- the small number was how many cases did I find that the neonatologist provided negligent or substandard care.

Q. Okay. In those other cases were you testifying against another specialty, another area of specialty, a physician?

A. I don't view myself as testifying for or against anyone.

Q. In what states have you testified as an expert other than Utah -- other than Utah?

A. Well, that's good. When we go through the states, if we went through them all, it's about 35 states, and with today's deposition we would now say it's about 36.

So I've never testified in Nevada before, but we're up around 36 states. Not much in New England, northern New England. In fact, maybe nothing in northern New England. That's Vermont, New Hampshire, and Maine. And relatively little in the west. West

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of the Mississippi much less.

For example, I don't think I've ever testified in Oregon, Montana, Idaho, Wyoming, Alaska, Hawaii, and Nevada before today. North Dakota -- no, I did one case in North Dakota, but South Dakota. So those are states I have not.

Q. Okay. And Doctor, approximately what percentage of your annual income is devoted to doing expert medical-legal work?

A. Twenty percent.

Q. And has that been the same over the past 35 years?

A. No.

Q. Okay. How much do you charge an hour for review of records?

A. $350.

Q. Do you have an estimate of the total amount of time you spent reviewing the records in this case?

A. Well, there have been three different periods of activity. When I first looked at the case, that would have been two or three hours. Then when I wrote my report in August of 2012 that would have been 10 to 15 hours, because I spent a lot of time on it including reading depositions and writing a good report, what I thought was good. I might be the only

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person that thought so. That was 10 to 15 hours. And then preparation for this deposition is the third time period, and that was probably between five to eight hours this week.

Q. And Doctor, what is your hourly -- what is your fee for testifying at trial?

A. It's $2,500 per half day. Now, if I came to Nevada to testify that's a two half-day trial period or $5,000. If I could convince people to let me do it by video we'd have it down to one half day.

Q. Is it your current intention to testify in person at trial, at the trial of this matter?

A. I've expressed my willingness to do that, yes.

Q. And Doctor, are there any documents which you've asked for from plaintiff's counsel which you have not been provided?

A. No. No.

Q. Have you asked -- have you asked if you have been provided with all of the medical records from Sunrise Hospital?

A. No. And that's a good question since just now today we came across one day's progress notes that I don't have, so there may be others. I didn't ask for more. I assumed I had all the medical records,

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but we found something missing today.

Q. Do you feel that you have reviewed all the materials you need in order to render your complete opinions here today?

A. Yes.

Q. Okay. Now, specifically with regard to Dr. Blahnik, if you can, in what -- what opinions have you formulated specifically about Dr. Blahnik and whether he met the standard of care?

A. There's a fail -- I'll read from my report. There's a failure to recognize and evaluate the pathological aspect of Mayrose's anemia. He didn't recognize that he had a pathological process going on.

Q. Okay. And Doctor, at what point in your opinions was the first point that Dr. Blahnik should have recognized the pathological diagnosis?

A. I didn't attempt to make that determination, and I -- I'm not sure it happens as a one point in time. I think it's -- it's a process that developed over time; that first it just sort of pops into your mind, and then you begin thinking about it and taking it more seriously, and then you come to the realization it really is a problem. But it doesn't happen at just one point in time.

Q. Okay. Yeah. With that in mind when was the

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earliest that Dr. Blahnik, in your opinion, should have recognized the pathological diagnosis?

A. I don't -- I don't think I can pinpoint any point in time. And it wasn't important to me to do that, because I'm saying collectively he could have done it any time during his involvement, and we would have been okay.

If he'd done it any time during the child's care, during his involvement in the care, whether it was in May or June or July, any time in there could have saved this baby. And so I don't know the first time he could have.

Q. All right. And as you sit here today you're not able to tell me any particular dates, as I see your testimony, that Dr. Blahnik should have recognized the pathological diagnosis; is that right?

A. Well, I can't put one date on it. I think by the end of June -- by the end of June most people would be thinking that we have pathology going on, because we -- we've gotten the baby through the early problems in May, and even in June we've given four more transfusions and things aren't getting any better, and there's no end in sight. I think it's time to realize that something's going on.

Now, when I say it that way I don't want to

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say, "Well, okay, so June 30 at 11:59 p.m. he better have the diagnosis." Maybe before then. Even if he makes it a week or two after that, end of July or any time in July would be okay. But I think most providers would know that something abnormal and pathologic was going on by the end of June.

Q. And, again, what is your medical basis for that opinion, Doctor?

A. The fact that this child has now received eight transfusions and the baby's only about, what, six weeks old? That should be of concern. That should raise some red flags and make people ask about the baby's ability to make blood.

Q. Is it your opinion, Doctor, that any of the transfusions that Mayrose received were required?

A. I -- I'm going to assume they all were required. I have no trouble with them having given any of these transfusions. I said that earlier.

Q. Okay.

A. I think that that's the reason we could avoid profound anemia it turns out. If you want to say, "Well, they were required to avoid profound anemia," that's -- that's valid. They were successful. It kept this child from going into heart failure and shock. So with that in mind you could say they all

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were required. They just didn't know what they were treating when they were giving those transfusions.
Q. And what makes you say that?
A. The medical record and the deposition testimony.
Q. Okay. And specifically in the medical record what makes you believe that Dr. Blahnik did not know what he was -- what he was treating?
A. His only notes talking about anemia talk about anemia of prematurity. There's no consideration, no thoughts of other conditions going on.
Q. Okay. When were those notes that -- when -- the dates of those notes that you're referring to?
A. Well, if we go through, we're going to find the same, whatever day he wrote notes, but let's go through some. Okay. He writes a note on June 5. He writes the note --
Q. Doctor, on June 5 -- let me interrupt you. On June 5 where does he say -- does he specifically say "anemia of prematurity"?
A. No.
Q. Okay. How do you -- how do you arrive at that conclusion, then, that Dr. Blahnik was referring to anemia of prematurity on June 5?

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A. I think you have to look collectively at the medical records and his depositions. You don't find him ever expressing any other consideration. In deposition on page 43, 44 he says subsequent transfusions after the first few days were, quote, typical and expected for a premature baby. He said these are typical and expected for prematurity.
Now, that's from his deposition. But from the record you don't find anything to contradict that. He has no --
Q. Doctor --
A. He has nothing in the record to say, "What's going on here? Why has this baby needed eight transfusions? Are we dealing with more than anemia of prematurity?" And in deposition he says, "We're dealing with anemia of prematurity." That's all.
Q. Doctor, I want you to find for me, if you can, continue on, where Dr. Blahnik specifically makes a notation that in his opinion this child was suffering anemia of prematurity and that there was no consideration for anything else.
A. I think we're twisting it. Maybe I'm at fault for this. The issue really is more important than did he say it's anemia of prematurity. It's more important, did he realize there was pathology? The

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question should be: Can you show us anywhere in here where he's considering a pathological process? That's even more important, and the answer is no.
Now, does he say it's anemia of prematurity? We can look. But what's more important is that he never considered a pathological process. That's more important. And that's what's not in here that we should be looking for.
Now I'll look for anemia of prematurity.
Q. Now, Doctor -- because, Doctor, I'm just using your words that you said to me just a little while ago. You testified that Dr. Blahnik only referred to this child's condition as anemia of prematurity. And I -- that's why I want you to find for me where he specifically identifies that.
A. On his deposition, page 43 and 40 -- 43 and 44, he says these transfusions were, quote, typical and expected for a premature newborn.
Q. Okay. Doctor, I'm asking you now -- I understand you're looking at the deposition. I want you to find it for me in the medical records.
A. (Witness peruses documents.) Well, here's where I run into a problem. He wrote -- he wrote the note on June 8, and he wrote the note on June 6th, but June 7 was a transfusion day, and we don't have that

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note, at least I don't have it.
So I would like to see the note from June 7th as for what the transfusion was -- his thoughts about that transfusion. I'm going to go ahead, but I do have to put in the disclaimer that I'd like to see June 7.
Q. And before today you have not asked plaintiff's counsel for a copy of that note; is that right?
A. That's right, because it's not important to me.
Q. Is it -- Doctor, is it important for you in your work as an expert to review all of the significant medical records on a patient?
A. I think it's important to look at everything that's sent to me.
Q. Okay. If you don't know what was in that note, assuming there was a note of June 7th, how do you know as you sit here whether it was significant or not?
A. I know the records that were sent to me, those don't show any consideration. And, again, from his testimony it's not like he said, "Everything was from prematurity except June 7th, and I knew on June 7th, that one day, something else was going on."

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I think it's reasonable to assume he didn't make the diagnosis of pathology -- or it's not a diagnosis, but the conclusion that there was pathology going on on June 7th. I think it's unreasonable to think he did even without seeing that note. I would be interested in seeing that note, though.

Here's a note that -- it's not his. I'm sorry.

Okay. I'm through the month of June, and I don't see where he's made a diagnosis for the child's anemia at all of anything. He has not declared this to be anemia of prematurity nor has he shown any concern about the problem, and we're at the end of June.

Q. And Doctor, why do you say that he doesn't seem to have any concern for this child's problems?

A. Well, I'm talking about the anemia. He hasn't expressed any concern about the anemia. Generally his notes just say, "Stable, stable, stable." If he --

Q. Would you disagree --

A. If he showed concern you should show it to me, because I'm missing it.

Q. Doctor, my question goes back to the original. I was just asking you for you to identify

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for me where you saw in the medical records where Dr. Blahnik had referred to it specifically as anemia of prematurity.

A. I'm now into July. I see he wrote the note on July 5th. Again, he doesn't put any label on the problem. He says the baby got a transfusion two days ago, but he doesn't have any comments about what was going on. He has note after note in July, but, again, he's not putting any label on the problem. No diagnosis. No differential diagnosis. Nothing.

I think I made it to the end of July. No. He never called it -- well, he never -- he never called it anything, did he? And that's the problem. There's no thought behind this.

Q. Okay. Doctor, he never called what anything?

A. The anemia and the frequent transfusions that the -- the anemia, the -- he calls it hematologic -- the hematologic problem.

Q. What problem? What anemia are you referring to?

A. The fact that this is a baby that had 11 transfusions, that anemia. Eleven. Most 28-weekers have zero. A lot of them have one. Very few have two. This baby had 11. That's a problem.

Q. Doctor, in your experience what are some of

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the reasons a very low-birth-weight child may need transfusions in a hospital in the NICU?

A. A single transfusion or 11? Because it's a different list. It's a different list.

Q. All right. I'm asking for all of the reasons why a transfusion might be required in a very low-birth-weight child in the NICU.

A. Again, I need clarification; otherwise, we'll be here for the rest of the afternoon. Are we talking about the first day of life? Are we talking -- because that's a whole different baby than the second month of life. Are we talking about just red cell transfusions? I mean, I -- I don't even know where to begin with that. It's too broad.

Q. Okay. You're not able to give me any of the reasons why a child might require a transfusion --

A. No.

Q. -- in the NICU?

A. No. I can give you too many is the problem. I want to know, are we talking about a child that requires one transfusion, because that's a list, or a child that requires 11 transfusions? That's a different list.

Q. Doctor, just give me as many reasons why a child might require a transfusion that you're aware

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of.

A. Did you say "a" transfusion? A single transfusion?

Q. Any reason for any transfusions. Give me all the reasons you're aware of, Doctor.

A. Are we talking about red cells or other types of transfusions?

Q. Let's talk about the transfusions that Mayrose received.

A. Well, she received red cells. She received plasmas. She received platelets. You've taken a big question and tripled it.

Q. Okay. Tell me, what were the reasons for those transfusions?

A. Well, okay, let's begin with platelets. You give platelets if the count is too low, dangerously low.

Q. Who did?

A. I don't know who ordered it. They were given early. We can look and see. If I can tell you when, then we'd look at the orders. She received platelets, I think, at around May 15 when she was first born.

Q. I'm sorry. Anything else, Doctor?

A. For the platelets? No. She got one platelet transfusion on May 15. I can't tell you right away

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who ordered it.
Q. Oh, I thought we were going through the reasons why those were ordered, why those transfusions were ordered?
A. The platelets on May 15 --
Q. Doctor, let's try to shortcut it. I'll try to make it as easy as I can. In your experience why have you given orders for transfusions for children in the NICU?
A. I don't remember having given a baby 11 transfusions of red cells in a NICU. I don't think that that applies to me.
Q. Doctor, forget the number. Forget 11 transfusions. Tell me the reasons why you've ordered any transfusions --
A. If the baby --
Q. -- for a baby.
A. If the baby has anemia that may be harmful I would give red cell transfusions to avoid --
Q. Okay.
A. -- complications of anemia.
Q. Okay. Anything else?
A. I'm not aware of any other indications for red cell transfusions.
Q. Any other reasons for any other kind of

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transfusions for a child in the NICU?
A. Sure. You give white cell transfusions for infections for sepsis. You give plasma sometimes for clotting factors. Sometimes to give volume into the baby you may give plasma. Platelets for low platelets. Red cells for anemia.
Q. How about for any surgeries?
A. Well, it fits into my answer, to prevent complications of anemia during the surgery. You don't do it just because you're having surgery, because if you have an adequate red cell mass in your body you wouldn't top it off with more red cells just because you're going for surgery. But if you have the potential of suffering harm from anemia during the surgery you could get red cells at that time.
Q. Anything else that you're aware of in your experience?
A. No. I think I gave a -- I think we've ultimately come up with a good answer. It's to prevent complications and harm from anemia. That's when you give red cells.
Q. Okay. Doctor, from your review of the records when was Dr. Blahnik's last involvement with this child?
A. In -- sometime in July. I don't know the

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exact day. The last day he wrote a progress note, at least. After that I don't know the degree he was interacting with the other providers. But clearly, we have his final progress note somewhere mid to late July.
Q. You didn't happen to review anywhere in his deposition of where he said his last involvement was?
A. I probably did. I just don't remember it.
Q. Okay. If I were to represent to you that the records reflect that Dr. Blahnik's last involvement with the child was on July 13th, 2008, would you have any reason to disagree with that?
A. No.
Q. Okay. And would you agree with me that Dr. Blahnik would not be responsible for what occurred with regard to Mayrose's care and treatment after that date?
A. I don't know. I don't have an opinion on that. I don't know how the group practiced and how much they interacted and what involvement he may have had with the others that doesn't show up in the records, so I don't know.
Q. Okay. And I want to represent to you: If, in fact, Dr. Blahnik had no involvement whatsoever with this child after July 13, 2008, would you agree

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that he would not be responsible for what occurred after that date?
A. Well, that's -- that's not so easy to agree to. I mean, he has perpetuated the idea that this baby does not have pathological anemia. He's missed the chance to make the diagnosis, so he's therefore somewhat responsible for that diagnosis not being present at the time of discharge.
Q. So, Doctor, is it your testimony that Dr. Blahnik is somehow responsible for the actions of other physicians after July 13, 2008?
A. That's not how I said it. I said he is somewhat responsible for there being no diagnosis and no consideration of a pathological process at the time of discharge.
Q. And, Doctor, at the time of your original opinions that you formulated in this case had you already learned that this child had been diagnosed with Diamond-Blackfan anemia?
A. I don't know. I'm looking. I have the original correspondence that came to me. Yes, I was it turns out. I'm looking at it. It's a letter from December of 2009, and in that one-page cover letter it says the child was later diagnosed with Diamond-Blackfan anemia.

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And as I recall there are some records in the back of my binder -- or are there? Maybe not. I'm not sure if I had records or not, but it is in the cover letter, so I knew it then.

Q. Doctor, you're referring to a cover letter you received from plaintiff's counsel when you initially received materials on this case?

A. Yes.

Q. Okay. If you could, what we'd like -- what I'd like to do is attach a copy of that as well as an exhibit to the deposition that's next in order.

(Exhibit 7 was marked.)

Q. BY MR. MCBRIDE: Doctor, did you happen to bring with you or do you have any e-mail correspondence that you've communicated with plaintiff's counsel regarding this case?

A. I looked to see what was there, and I actually looked through the e-mails and did a search. There were a half-dozen or dozen just about scheduling the deposition. "Where can we do it? Do you have Skype? Can we do it at 1:30? What day works for you?" Blah, blah, blah. And that's all the e-mails say so I didn't bother with them. But if you want the e-mails related to scheduling of this deposition I could produce those.

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Q. No. That's okay. Doctor, have you told me all of the opinions which you formulated in which you intend to offer at the time of trial in which you believe that Dr. Blahnik fell below the standard of care?

A. Yes.

Q. Okay. Doctor, can you tell me as you sit here in what ways Dr. Blahnik met the standard of care in your opinion in his treatment of this patient?

A. Well, we'll have to go through each note. Yeah. The truth is I can't do it easily, because I knew this was a case about anemia and I focused on anemia, so I don't really know how he managed things like nutrition, respiratory support, and the like.

I'm assuming he met the other standards of care. My assumption is everything other than relating to anemia was okay, but I guess we could look. We might find some other problems. I wasn't looking for them.

Q. Doctor, you said -- let me ask you -- refer you to your report. You said that a consultation by a hematologist -- this is on page 2 of your report. A consultation by a hematologist would have been helpful. Do you remember that?

A. Yes.

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Q. And at what point in your opinion was the earliest that Dr. Blahnik should have consulted with a hematologist?

A. Once he realized he had a pathological process. Now, in this case it appears he never came to that realization, so it's hard to expect him to get a hematologist involved.

Q. Okay. You say it would have been helpful, a consultation by a hematologist. Is it your opinion that Dr. Blahnik's failure to consult with a hematologist was below the standard of care?

A. No. If you keep reading that same paragraph I imply he does not have to do that consultation as long as he does it well himself.

MR. MCBRIDE: Okay. Doctor, I think that's all the questions I have right now. I might have some follow-ups later.

THE WITNESS: Thank you.

MS. WHITEHEAD: I have just a few questions, guys. Can you hear me okay?

MR. COTTON: Yeah, we can.

EXAMINATION

BY MS. WHITEHEAD:

Q. Okay. Dr. Hermansen, I was looking through your CV and I noticed that you'd given, I believe, a

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lecture for the New England fall Nursing Conference regarding anemia of prematurity.

A. I don't remember that lecture.

Q. It was quite some time ago back in November of 1998.

A. It's 14 years.

Q. Do you have any recollection of that conference or what you may have discussed?

A. No. I forgot that completely. I'm surprised it's in there.

Q. Have you ever given any other lectures on anemia of prematurity?

A. If so it would have been to medical students and residents just part of an educational program but not to any graduate education program or continuing education. Never as a guest speaker but maybe medical students or residents.

Q. Do you keep any slides or PowerPoint presentations for that purpose?

A. Not for 14 years.

Q. Okay.

A. I wouldn't have that from 14 years ago.

Q. Even for this -- the lectures you've just spoken of?

A. I haven't given that lecture for a long time.

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Q. Okay. I believe one of the opinions that we've gone through quite a bit this afternoon is that you believe, and correct me if I'm wrong, that Dr. Blahnik and Dr. Piroozi should have evaluated or determined the pathological process for Mayrose's anemia; is that correct?

A. The wording here I have to be very careful of. I'm not sure that they can actually make a definitive diagnosis, but they should have known there was pathology going on and taken steps in that direction.

Q. What specifically should Dr. Blahnik or Dr. Piroozi had done to evaluate Mayrose's anemia to determine it was a pathological process?

A. Oh, it's pathologic once you realize this baby had 11 blood transfusions. In fact, before then, I said by the end of June you should know it's pathologic just reviewing the medical records and looking at all the transfusions this baby needs. That should tell you you're dealing with the potential for pathology.

Q. So the amount of transfusions alone should have put them under that belief that this was pathological?

A. Yes.

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Q. So there's nothing else in Mayrose's chart that should have raised any red flags that it was something other than one of her other numerous problems?

A. Correct.

Q. Okay.

A. Well, let's back up. You do have the absence of retics at the time of discharge. That would reinforce your concern about the pathology.

Q. At the time of discharge?

A. At discharge. I'd be concerned about the retic in light of a child who's had 11 transfusions who has modest anemia at discharge and has almost no retic.

Q. Okay. So then the retic count at discharge and the number of transfusions --

A. Right.

Q. -- those two factors should have caused an evaluation as to the pathological cause?

A. Yes.

Q. And those two alone?

A. Yes.

Q. Okay. Have we covered based on your report and this deposition today all the opinions you have, I guess, of the defendants in this case?

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A. Yes.

MS. WHITEHEAD: Okay. I have no further questions.

MR. COTTON: I've just got a couple more questions, Doctor.

FURTHER EXAMINATION

BY MR. COTTON:

Q. I want you to exclude for a moment the 11 transfusions from your equation for just one moment. All right?

A. Yes.

Q. Excluding those 11 transfusions, in your review of the record, the chart here, were there any objective findings, labs, showing any concern of anemia?

A. Well, to a lesser degree are the absence of retics at the time of discharge. That would be the only other issue that might, and that's pretty soft compared to the transfusions, but you should mention that there are no retic at the time of discharge.

Q. Anything in the hematocrit values that would cause concern for anemia?

A. That's impossible to do what you're asking me. It's impossible to look at those hematocrit values and comment on them without realizing that

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they're acceptable only because of the transfusions. They were what they were, and they're good numbers, but that's only because of the transfusions.

You can't take the transfusions out of it. You can't say, "All of those blood count values were okay, so everything's okay." They're only okay because of 11 transfusions. You can't separate the two.

Q. Are you critical of Dr. Miller or Dr. Nager in ordering transfusions on this child?

A. I have said -- now, this is the third time. I'm not going to criticize any of the transfusions that were given. I have no criticisms for transfusions. I'm going to assume that they had a valid medical indication.

Q. Okay. Doctor, do you advertise your services as an expert witness in any publications or by any expert services?

A. No.

Q. Do you have any idea how the plaintiffs here came to find you in the woods of New Hampshire?

A. Yes.

Q. How?

A. Attorney Carmichael told me that she got my name from the other attorney in Salt Lake City with

whom I acknowledged earlier today. Dr. Nielson --
Q. Okay.
A. -- provided my name.
MR. COTTON: Okay. Thank you. That's all I've got. Thanks a lot, Doctor.
MS. WHITEHEAD: No questions, Doctor. Thank you.
MR. COTTON: Dr. Hermansen, you have the right to read and review your transcript for errors if you would like to do so.
THE WITNESS: I'm okay with it. I'll pass.
MR. COTTON: Thank you.
(Discussion held off the record.)
MR. COTTON: This is John Cotton. I'll take a mini and an E-tran.
MR. MCBRIDE: Robert McBride. I would like a regular copy, a mini, and an E-tran as well.
MS. WHITEHEAD: Just a regular and an E-tran.
MS. CARMICHAEL: Regular and an E-tran.
(At 3:30 p.m. the deposition concluded.)
* * *

CERTIFICATE OF WITNESS

I, MARCUS HERMANSEN, M.D., do hereby swear/affirm that I have read the foregoing transcript of my testimony, and further certify that it is a true and accurate record of my testimony (with the exception of the corrections listed below):

Page Line Correction

MARCUS HERMANSEN, M.D.

Subscribed and sworn to before me this day of 2013.

Notary Public/Justice of the Peace
My commission expires

CERTIFICATE

I, Michele M. Allison, a Licensed Court Reporter, Registered Professional Reporter and Certified Realtime Reporter, N.H. Notary Public, do hereby certify that the foregoing is a true and accurate transcript of my stenotype notes of the deposition of MARCUS HERMANSEN, M.D., who was duly sworn, taken at the place and on the date hereinbefore set forth.

I further certify that I am neither attorney nor counsel for, nor related to or employed by any of the parties in the action to which this deposition was taken, and further that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in this action.

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