IN THE SUPREME COURT OF THE STATE OF NEVADA

* * * *

ALI PIROOZI, M.D.,

Petitioner

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.

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

Real Parties in Interest.

Nevada Supreme Court Case No.: 64946

EJDC Case No.: A - 616728 - C

APPENDIX TO REAL PARTY IN INTEREST, MARTIN BLAHNIK, M.D.'S JOINDER TO ALI PIROOZI, M.D.'S EMERGENCY PETITION FOR WRIT OF MANDAMUS

RESPONSE REQUESTED PRIOR TO TRIAL COMMENCING ON FEBRUARY 18, 2014

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CERTIFICATE OF SERVICE

I hereby certify that on the 5th day of February, 2014, I forwarded a copy of the above and foregoing **APPENDIX TO REAL PARTY IN INTEREST, MARTIN BLAHNIK, M.D.'S JOINDER TO ALI PIROOZI, M.D.'S EMERGENCY PETITION FOR WRIT OF MANDAMUS** as follows:

_X_ by depositing in the United States Mail, first-class postage prepaid, at Las Vegas,Nevada, enclosed in a sealed envelope; or

_____ by facsimile transmission as indicated below;

_____ Via hand-delivery; or

_____ both U.S. Mail and facsimile TO:

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DEPOSITION
OF
MARTIN JOSEPH BLAHNIK, M.D.

Hurst, et al. v. Sunrise Hospital and Medical Center, LLC, et al.
Case No. A-10-616728-C
January 18, 2012

CONDENSED TRANSCRIPT AND KEY WORD INDEX

TURNER REPORTING & CAPTIONING SERVICES, INC.
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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.

Case No. A10616728C
Dept.No. XXIV

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

Defendants.

VIDEOTAPED DEPOSITION OF MARTIN JOSEPH BLAHNIK, M.D.
Taken on Wednesday, January 18, 2012
At 2:06 p.m.
At 2300 West Sahara Avenue, Suite 420
Las Vegas, Nevada

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

APPEARANCES:
For the Plaintiffs: JACQUELYNN D. CARMICHAEL, ESQ.
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VIDEOGRAPHER: BECKY ULREY
CERTIFIED LEGAL VIDEOGRAPHY

EXAMINATION

EXHIBITS

THE VIDEOGRAPHER: This begins the videotaped deposition of Martin Blahnik, M.D. Today's date is January 18, 2012, and the time is 2:06 p.m.

This deposition is taking place at the law offices of John H. Cotton and Associates, 2300 West Sahara Avenue, Suite 420, Las Vegas, Nevada.

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

I'm Becky Ulrey with Certified Legal Videography, and the court reporter is Karen Berry with Turner Reporting and Captioning Services.

Will counsel please identify yourselves, and then the reporter will administer the oath.

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

MS. URDAZ: Jonquil Urdaz on behalf of Sunrise Hospital.

MS. LUCERO: Laura Lucero on behalf of Doctor Conti and Foothills Pediatrics.

MR. COTTON: John Cotton on behalf of Doctor Blahnik and Doctor Piroozi.

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Thereupon--
MARTIN JOSEPH BLAHNIK, 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 current address for the record?
A Martin Joseph Blahnik, 1047 Taber Hill Avenue, Henderson, Nevada, 89074.
Q Thank you. Doctor Blahnik, have you had your deposition taken prior to this occasion?
A No.
Q Okay. I'm sure you've had an opportunity to talk to counsel about the process, but I'll just give you a few pointers.
The goal today is to have a very clear transcript. In order to do that, let me finish my whole question before you start your response. I know in normal everyday conversation we anticipate where someone's going and we might talk at the same time. But let's try not to do that here today.
And likewise, if you're giving an answer, I'll do my best not to interrupt you with another question until you're done. If you do, however, pause

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and I assume you're done but you're not, just let me know, and I'll allow you to finish.
A Okay.
Q Okay. Also, make sure that you answer audibly instead of nodding or shaking your head. And if the answer requires a yes or no response, say yes or no instead of uh-huh or huh-uh, so that again the transcript is clear. Okay?
A Okay.
Q All right. Also, if I ask a question that's unclear, which I'm prone to do at times, feel free to ask me to clarify it.
Also, if you need a break for any reason, just let me know. We can take a break. Okay?
A Okay.
Q All right. Have you ever had any lawsuits filed against you prior to this occasion?
A No.
Q Okay. What did you prepare -- or excuse me, what did you review in preparation for your deposition today?
A I sought by recollection of the case, and I looked at medical records.
Q Okay. What records specifically did you review?

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A The MayRose medical record at Sunrise.
Q The entire record?
A Not the entire record.
Q Okay. Did you review all of the NICU notes?
A I looked at NICU notes.
Q Okay. Did you review all of the labs, lab results?
A I looked at some of the labs.
Q How about the transfusion records?
A I looked at the transfusion, the, the dates of those.
Q Okay. Did you bring any of the materials that you reviewed with you today?
A No. Those are in the possession of Sunrise Hospital.
Q Okay. All right. So you reviewed them -- are they electronic copies, or hard copies?
A Hard copies.
Q So you pulled the original medical chart and spent time reviewing it while at Sunrise Hospital?
A That's correct.
Q Okay. And when did you do that?
A I don't have the dates in front of me.
Q Well, just roughly. Was it within the last month? Was it a year ago?

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A I don't recall.
Q Well, did you take a look at it recently?
A No.
Q Did you review any depositions that have been given in this case?
A Yes. The original depositions that were part of the civil complaint.
No. I misspoke. Those were -- what are they called?
MR. COTTON: Affidavits?
THE WITNESS: Yes, affidavits. No depositions.
BY MS. CARMICHAEL:
Q Okay. All right. And have you spoken with anyone regarding the claims that have been raised in this lawsuit, with the exception of your counsel?
A Counsel I spoke with.
Q Anyone else?
A No.
Q Have you discussed the claims with Doctor Piroozi?
A In, only to the extent of getting access to the medical records which we knew of.
Q Okay. On that occasion, what did you discuss with him?

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A Well, the, the Medical Records Department at Sunrise will move the records to, I think it's called Risk Management Department, or something like that. And they are categorized differently. So when they're checked out for review, they have a policy on how that works.
Q Okay. So what did you speak to Doctor Piroozi about?
A About obtaining the records.
Q Anything else?
A No.
Q Okay. Have you spoken with Doctor Conti regarding these claims?
A No. I've never talked to Doctor Conti.
Q Do you know Doctor Conti?
A I do not.
Q And you have never spoken with him?
A No.
Q Have you ever met him?
A I have not.
Q Okay. Did you do anything else in preparation for your deposition today?
A In what sense?
Q Medical research. I don't know. Anything else to prepare for today?

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A When we prepared materials for the State response to the complaint, there was some documentation regarding anemia and anemia prematurity and this kind of thing. Those documents I looked at. From like medical text kind of thing.
Q Okay, who pulled those documents?
A I can't remember if I did, part of it. I don't recall.
Q Do you still have those documents in your possession?
A Yes, I do.
Q Okay, and they are journal articles?
A No. They are from hematology textbooks.
Q Okay. And how did you come by a hematology textbook?
A Oh, they're in the library. They're in our physicians lounge.
Q Okay.
A Some of the material I have myself in textbooks on neonatology in the hematology section. That kind of thing.
Q Sure. Okay. And did you make copies of some of the text in those textbooks?
A At some point, yes.
Q Okay. And you still have those copies?

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A I have copies that were sent to the State.
Q That were sent to the State?
A The State board. Right. That's who you originally sent it, materials that the State was asking for.
Q Got it.
A Nevada State Board of Medical Examiners. That's what they're called.
Q Okay. So the Nevada State Board of Medical Examiners investigated this claim?
A Yes.
Q Okay.
A That's their standard procedure.
Q All right. And when was that proceeding held?
A Can I ask what was the date of the original complaint?
Q You can. I don't know if I can tell you. May of --
MR. COTTON: May 14, 2010.
BY MS. CARMICHAEL:
Q 2010.
A Okay. So this is probably within six months from that time.
Q Okay. And who attended those proceedings?

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A None, no, no meetings were required. Just a written response.
Q I see. Okay. And did you have the assistance of counsel in preparing that response?
A Yes.
Q Okay.
MS. CARMICHAEL: Is that response protected, John, under your state laws here?
MR. COTTON: Uh-huh.
BY MS. CARMICHAEL:
Q Okay. All right. Your counsel provided me with a copy of your CV. And prior to the commencement of your depo, I asked you to review it. Is that indeed a current, up-to-date copy of your CV?
A Yeah, from what I looked at, it looks this is pretty much so.
Q Okay, great. We will mark that as Exhibit 1 to your deposition. I have just a few questions.
It appears that you attended medical school at the University of Wisconsin?
A Yes.
Q And graduated in 1993?
A Yes.
Q Okay. And you then completed a pediatric internship at the University of California at Irvine?

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A That's correct.
Q And a pediatric residency at UCLA?
A That's correct.
Q Okay. And then a neonatal fellowship at USC. Correct?
A Yes, University of Southern California.
Q Okay. And you completed that fellowship in 1999?
A That's correct.
Q Okay. Are you board certified in neonatology?
A Yes.
Q And when did you obtain your board certification?
A Soon after 1999, but I apologize, I forget the date.
Q That's okay. And how long is that certification good for?
A Nine years.
Q Are you due to renew?
A I renewed.
Q Okay. And did you pass your boards on your first attempt?
A Yes.
Q Okay. Okay. It appears that after the

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completion of your neonatal fellowship at USC, you remained there in a number of capacities for quite a few years. Is that right?
A That's correct.
Q Through 2007?
A Yes.
Q Okay. And following that, it appears that you moved to Las Vegas? Yes?
A Yes, ma'am.
Q And you've listed on your CV your current employment is with Sunrise Children's Hospital. Is that right?
A I think it's Pediatrics where I'm employed. And I'm credentialed at Sunrise.
Q Okay.
A If I have that correct.
Q Through your -- okay, you're referring to Pokroy Medical Group of Nevada?
A Yes.
Q D/b/a Pediatrics Medical Group of Nevada?
A That's correct.
Q Okay. And is that group affiliated with the Children's Healthcare Network?
A No.
Q Two separate entities?

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A That's correct.
Q All right. You were with the Children's Healthcare Network through 2009?
A Yes, ma'am.
Q And then just moved in 2009 over to Pediatrics?
A That's correct.
Q Okay. But during both of those employments, it looks like you pretty much exclusively worked at Sunrise Children's Hospital and Mountain View Hospital as a staff neonatologist. Is that right?
A That's correct.
Q Okay. In your capacity as a staff neonatologist at Sunrise Children's Hospital from 2007 to the present, who bills for your services? Who bills the patients for your services, if you know?
A Well, we generate codes, and those are reviewed. And if they're wrong, then it's brought back to us.
Q Well, and what I mean is, does the patient receive a bill for your services from Sunrise Hospital, or from Pediatrics Medical Group, if you know?
A I don't know.
Q Okay.

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A I'm just doing my job.
Q Okay. Who pays, or how are you compensated for your services?
A I'm salaried.
Q You're salaried by Pediatrics?
A Uh-huh. That's right.
Q All right. Who sets your schedule?
A The medical director.
Q Of Sunrise Hospital?
A No.
Q Of Pediatrics Medical Group?
A Of the Neonatal Intensive Care at Sunrise.
Q Okay.
A Who is also an employee of Pediatrics.
Q Okay. So the medical director of the NICU at Sunrise is an employee of Pediatrics Medical Group?
A That's correct.
Q Okay.
A But not in 2008.
Q Okay. In 2008, who was setting your schedule?
A It was the medical director, who worked for Children's Healthcare Network, just like me.
Q Got it.
A There was no Pediatrics.

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Q Okay, I understand.
A At Sunrise.
Q All right. And these medical directors that you're referring to, do they also set the schedule, your schedule for your work at Mountain View Hospital?
A That's correct.
Q Okay. Do you have a contract with Children's -- did you have a contract with Children's Healthcare Network in 2008?
A Yes, I did.
Q And do you still have a copy of that contract?
A I do not.
Q Do you have a contract, copy of your contract with Pediatrics Medical Group?
A I think so. But I would have to dig for it.
Q Okay. All right. Have you ever been paid directly by Sunrise Hospital?
A Only when my son was born, I was getting physicians, employee, employee compensation for medical bills for my wife's birth. And they extend that to all employees.
Q Okay. Sunrise extends that to all employees?
A Yes.

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Q So anyone that works at Sunrise Hospital receives a benefit in the form of employee compensation when their family members deliver at Sunrise?
A I believe that's correct, yes.
Q Okay. Any other form of compensation you receive from Sunrise?
A We get physicians lounge, food.
Q They feed you there?
A Limit, on a limited basis.
Q No steak and lobster. Okay.
Do you consider yourself an employee of Sunrise?
A Pediatrics.
Q Okay.
A I'm an employee of Pediatrics.
Q All right. But it's Sunrise Hospital that extends the benefit of the employee compensation when your wife gave birth there? Did I understand that correctly?
A That's, that's what I said, yes.
Q Okay. Okay. Do you know whether or not Pediatrics maintains the medical charts, or is it Sunrise Hospital that maintains the medical charts?
A I believe it's the latter.

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Q Okay. Have you ever appeared in any print, television, or any other kind of advertising for Sunrise Hospital?
A No.
Q Okay. Do you tell your patients -- or considering that your patients are babies -- their parents, those that you treat at Sunrise that you're not an employee of Sunrise Hospital?
A Such a conversation doesn't arise.
Q Okay. All right. In providing neonatal care to a premature infant, do you believe it is important to know what occurred during the prenatal course?
A Yes.
Q Okay. How do you go about finding that information out?
A Several ways.
Q Such as?
A We get consults from the obstetricians for us to come and speak with the families, review the obstetrical history.
Q Review the obstetrical history through conversations with the Ob-Gyn and the patient?
A Several things can happen in that regard.
Q Such as?

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A If it's a consultation, then I'll review the chart in addition to maybe or maybe not speaking with the obstetrician.
But sometimes I may receive a call from the obstetrician not requiring, not requesting a consult, but alerting me as the attending neonatologist about the issues of the delivery.
Q Okay.
A Or if there's prenatal diagnosis, particularly if it's cardiac in nature, we'll receive the fetal echo.
Q Okay.
A And maybe have a conversation with the cardiologist regarding that case.
Q All right. Do you believe it is important for you as the neonatologist to know about any abnormal test results that might have occurred during the prenatal period?
A Possibly, but not necessarily.
Q Depending on the test. Right?
A Yeah, if it's relevant.
Q Okay. If the birth mother was consulting with a perinatologist during the prenatal course, would it be important for you to know that?
A Maybe.

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Q During your education and training as a neonatologist, did you receive any training or knowledge regarding the clinical significance that an abnormal nuchal translucency or a nuchal fold test result might have?
A Yes.
Q Okay. And what did you receive in that regard?
A In, in what way do you mean that?
Q Well, what information did you receive regarding the clinical significance of an abnormal nuchal translucency or nuchal fold test?
A That it might mean nothing. Or it might be associated with trisomy 21. And there are other possibilities as well, so.
Q Trisomy 21 is Down's Syndrome?
A That's correct.
Q Okay. And so an abnormal nuchal translucency could indicate Down's. Correct?
A Yes.
Q It may also indicate other chromosomal abnormalities?
A I believe so.
Q Okay.
A I'm not certain.

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Q Are you aware of whether or not it may indicate cardiac problems?
A No.
Q Okay. Are you aware of whether or not it may indicate possible genetic birth defects?
A Well, we've already mentioned that.
Q Okay.
A We already mentioned also they may be normal.
Q Sure. Okay. Is that something you would want to know about though when you go to treat a newborn in the NICU? Would you want to know whether or not that baby had had an abnormal nuchal translucency or nuchal fold result?
A Not necessarily.
Q Okay. Did you come to know that MayRose Hurst had, was, was a child that had an abnormal nuchal translucency result?
A At what point in the pregnancy?
Q I can't remember which week.
A This baby was delivered at 28 weeks. And often these findings are 12, 13, 14 weeks, from what I call, and then they spontaneously resolve. That's why I mention that it's not necessarily indicative of pathology.

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Q Okay. But did you, did you ever learn -- I'm asking you from your memory now. Do you remember finding out or learning, when you assumed MayRose's care, that she had had an abnormal nuchal translucency result?
A I don't remember.
Q You don't remember? Okay.
During your medical education and training, did you receive any information regarding the diagnosis and treatment of blood disorders?
A Yes.
Q Okay. And what did you receive in that regard? How extensive was that?
A At what point in my training are you referring?
Q At any point in your training.
A That would include during medical school, during residency, and during fellowship.
Q Okay. So during all three of those you received training regarding the diagnosis and treatment of blood disorders?
A Yes.
Q Okay. Did you receive any education or training with respect to how to differentiate between anemia due to prematurity and anemia caused by a

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specific blood disorder or genetic defect?
A Yes.
Q Okay. And other than MayRose, have you ever cared for an infant in the NICU who had anemia as a result of a genetic defect or a specific blood disorder?
A Yes.
Q On how many occasions?
A It's impossible for me to say.
Q Are they numerous?
A I don't recall.
Q Okay. Well, on any of those occasions, were you the physician that diagnosed the blood disorder?
A Possibly.
Q You don't remember?
A I don't recall specifically.
Q Okay. All right. What are the most common symptoms of anemia due to prematurity?
A There may be no symptoms. Or there may be some mild symptoms.
Q Such as?
A That could include tachycardia. That could include pallor. That could include inadequate oxygen delivery to tissues.
Q Which would manifest in what way?

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A Metabolic acidosis, lactic acidemia.
Q Okay. Low hematocrit, is that a symptom of anemia due to prematurity?
A That's a, a lab finding.
Q Okay. Is it -- all right. Anything else you want to include in that?
A Yeah, there are other things, too.
Q What are the most common symptoms of thalassemia?
A Which type of thalassemia?
Q Let's go with alpha.
A Alpha thalassemia?
Q Uh-huh.
A It depends on the type of alpha thalassemia you're referring to.
Q Okay. Well, what are some common symptoms of that disease condition?
A Like I said, it depends on the type of alpha thalassemia you're referring to.
Q Well, you can differentiate that for me in your response.
A And it also depends on at what age you're looking at the disease condition.
Q Okay. In an infant that has thalassemia, what symptoms would you expect to see?

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A Well, if alpha thalassemia involves abnormality in the alpha genes, and there's four alpha genes, if all four are gone, all four are mutations, then the child is not going to make it to term.
If there's three missing, then there can be some -- there probably won't be any signs in that as well.
But if you've got only one good alpha gene, then as a result of that they can have hemoglobin Bart's, which is four bated chains, and those don't carry oxygen very well, and they have abnormalities in the shape of the...
Q Hemoglobin?
A The, well, the red blood cell.
Q Okay. What about the beta version of thalassemia? What are the symptoms, most common symptoms in that?
A You wouldn't see anything because there would be the gamma and the fetal hemoglobin present, which is alpha 2, gamma 2.
Q Okay. Would you expect to see a low hematocrit with thalassemia?
A It depends.
Q Well, are there occasions when you would?
A Yes.

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Q Okay, what about tachycardia?
A If it's associated with significant anemia, yes.
Q Okay. What are the most common symptoms of Diamond-Blackfan anemia?
A Bone marrow failure, I believe.
Q Which manifests in what way?
A If there's profound anemia, then the child would have symptoms of anemia.
Q Which would include a low hematocrit?
A Yes.
Q Pallor?
A Yes.
Q Tachycardia?
A Yes.
Q So essentially the same symptoms that are common to anemia due to prematurity. Correct?
A No. That's incorrect.
Q Well, I asked you what are the most common symptoms of anemia due to prematurity, and I believe you told me tachycardia --
A No.
Q -- pallor --
A You didn't. That's not correct.
Q -- low hematocrit.

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A No. You asked me when there are symptoms present, what are those symptoms. And I listed those symptoms.
Anemia prematurity most commonly is not going to be associated with any symptoms.
Q Okay.
A There's a big difference there.
Q So what you're telling me is that generally, in most cases, anemia of prematurity will have no symptoms?
A Let me put it this way: Somewhere between 90 to 100 percent, at least in the neonatal practice I'm at now, and I know this is true historically, in, with respect to other NICU's I've worked and the colleagues I've worked with, 90 to 100 percent of very low birth weight, which is a specific category, and extremely low birth rate babies get this diagnosis of anemia prematurity.
Q Based on what?
A Based on the fact that they're only one to two pounds, two and a half pounds, and have very little blood volumes, and require repeated phlebotomy. So their ability to compensate by producing red blood cells is limited. So they're all going to go through a phase of anemia prematurity.

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So there's nothing spectacular about ever having that diagnosis.
Q Okay. And just so I can be sure then, are you saying that generally, not always, but generally, babies with anemia of prematurity are not going to have tachycardia, or pallor, or low hematocrit? They're not going to have those things present?
A In the majority of cases, what you want to do is look at the clinical situation that the child's in. And that makes a big difference. Okay? Because one baby may have a hematocrit of 25 and is ready to go home, another baby may have a hematocrit of 35 and needs to have a blood transfusion.
Q Okay.
A So there's a lot to consider when you're asking that kind of question.
Q Okay. Understood. But this deposition will literally take until midnight if you -- I just need you to answer the question put to you. If you would do that, that would be great.
So my question to you is, are you telling me that the majority of babies diagnosed with anemia due to prematurity do not have symptoms of tachycardia, pallor, or low hematocrit?
A That's right -- well, low hematocrit maybe.

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But that doesn't imply they have symptoms. That's a lab value. Talking about, there's two things here. So, they have -- by definition, if you're saying this child has anemia, the hematocrit is low.
Q By definition?
A And it becomes a relative thing of how low is low.
Q Okay. All right. Okay. What symptoms or lab values would a premature infant in your NICU, that you're caring for, have to have in order for you to begin to suspect that their anemia may not just be due to their prematurity? In other words, that there's some more serious cause at work?
A That's a good question. This is going to depend as well. But looking for an actual value, I would definitely say any hematocrit less than 20 is very abnormal and needs to seek an explanation.
Q Okay.
A But if I can qualify in another way. A hematocrit that, for that age, gestational age and postnatal age, two standard deviations below the norm, by definition, is anemia, with or without symptoms. And that can be very different values depending on what specific patient you're looking at.
Q Okay. But I would, I would suspect that if

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you have an infant in your NICU that has been having low hematocrits, you're never going to let them get below 20 before you transfuse, are you? I mean you'll transfuse them before they ever get below 20, wouldn't you?
A Your question was what value is, would I consider significant anemia requiring transfusion. Twenty is the value.
Q Oh, so you don't even think transfusion is necessary until they get below 20?
A I didn't say that. Some patients need to be transfused when their hematocrit is 35 or even 40. Some babies can go home if their hematocrit is 25.
Q Okay.
A Okay?
Q And where we started with all of this was I asked you what symptoms an infant in your NICU would have to have for you to suspect that something more than anemia and prematurity was going on. And I believe your answer was they would have to have a hematocrit lower than 20. Is that what you told me?
A I'm not sure.
Q Well, is that true?
A Can you restate that, please?
Q Yeah. What symptoms would a premature

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infant that you're caring for in your NICU have to have in order, symptoms or lab values, in order for you to suspect that their anemia is not simply due to prematurity, that there's a more serious cause?
A There's, this is such a difficult question to answer, because there are multiple scenarios that would require me as a clinician to consider different aspects of why that child may be having some symptoms. And for me to just give a single blanket answer is really not possible.
Q If the child's birth parent has a genetic history of thalassemia and the child is showing up with low hematocrits, is that factor, the parent with thalassemia in their history, is that going to lead you to conduct, to test for thalassemia?
A Absolutely. As a general rule, this is correct. Because that's an inheritable condition. Yes.
Q Okay. And do you know whether or not MayRose Hurst was tested for thalassemia?
A She had a State blood standard newborn screen that looks for hemoglobinopathies, and that's one of them.
Q Okay. And do you know the results of that test?

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A I don't know the result of that test.
Q Is that a test result that would come back to you?
A Yes, we would know it's abnormal.
Q Okay. Incidentally, I can't find that test result in the medical chart. Do you know where it would be?
A Yeah, it's usually at the beginning of the chart. The nurses keep all of that in there. At least now.
Q Okay.
A But this state has an obligation to, to contact us when we have an abnormality they find in that test.
Q Okay. What about knowing that the infant had an abnormal nuchal translucency test result, would that lead you to consider testing for a genetic blood disorder in lieu of assuming that the anemia was due to prematurity?
A I don't understand the connection between the nuchal translucency and anemia prematurity.
Q That's what I'm asking you is if in your view there is a connection between a nuchal, an abnormal nuchal translucency result and the possibility that the child might have a genetic blood

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disorder, is there any connection in your mind?
A That's a different question. Anemia prematurity is not a blood disorder.
Q Yes, I understand that. I'm asking you if you knew that your patient had an abnormal nuchal translucency test result during the prenatal period, you knew that, and she's demonstrating low hematocrits after birth, is the fact that she had the abnormal nuchal translucency test going to create in your mind a consideration that this low hematocrit might be related to a genetic blood disorder, and might not just be due to prematurity?
A Not necessarily.
Q Okay. What about a low reticulocyte count? Would that cause you to believe that a newborn's hematocrit, the cause for it might be something more serious than just prematurity?
A That depends.
Q On what?
A It depends on the clinical scenario of the patient's history and status. Lots of factors.
Q Well, what is the clinical significance of a low reticulocyte count?
A Well, reticulocytes are produced by the bone marrow in response to erythropoietin as red blood

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cells break down, and there are new cells coming into the circulation.
Q Right. So what is the clinical significance of a low reticulocyte count?
A It depends on the clinical scenario that you're referring to.
Q Okay. Are you aware that a low reticulocyte count is consistent with Diamond-Blackfan anemia?
A Yes.
Q Okay. Are you aware that a low hematocrit is consistent with Diamond-Blackfan anemia?
A Yes.
Q Okay. Now, I assume that there are lots of testing, or various tests that can be done to get to the bottom of the actual cause of an infant's anemia. Yes?
A Yes.
Q Okay. Bone marrow aspiration is one such test? Yes?
A Yes.
Q Okay. Analyzing red blood cells under a microscope might be one?
A Yes.
Q Okay. Bringing in a hematologist to consult might be another avenue?

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A Yes.
Q Okay. Would you agree with me that some forms of anemia are not particularly dangerous to a patient, while other forms can be potentially life threatening?
A It's a very broad question. It's hard to answer.
Q Well, you can disagree, I mean. Are some anemias more serious than others?
A Absolutely.
Q Okay. And are some anemias in fact potentially life threatening if not properly treated?
A Yes.
Q Okay. When a physician is faced with several possibilities regarding a patient's diagnosis, the physician generally uses a tool called differential diagnosis. Right?
A That's correct.
Q Okay. And if that differential diagnosis includes any conditions that may be life threatening, then the whole purpose of the differential is to rule out those potentially life-threatening conditions first in order to preserve the health and well-being of the patient. Right?
A No.

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Q Okay. Tell me how you disagree with that.
A Well, you bring up -- if that were true, we would bring up scenarios that both would not be practical as well as potentially invasive and costly. So clinical decision-making has to be prudent first and foremost.
Q Okay. If you have in your differential diagnosis a potentially life-threatening condition, are you telling me then that it would not be appropriate to rule it out?
A No, I'm not saying that.
Q Okay, what are you saying?
A The issue is whether or not I'm going to put that diagnosis in my differential in the first place.
Q Okay. And that would be based on whether it would be costly to test for?
A Based on a number of scenarios. Not costly, per se. But if you're talking, what you said, potentially life-threatening diagnosis, that's, needs to be considered to be put in the differential diagnosis. There are many that are just not prudent, it's not -- not not practical, but they're not high in the radar, as we say.
Q Okay.
A With respect to likelihood given the

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information for that case.
You could not practice medicine if you're going to include 20 things on your differential diagnosis every day that you look at the patient. Because there's lots of things that could be potentially life threatening.
Q Okay. But if you have an infant in your neonatal unit that has anemia, and continues to have anemia throughout her course in your neonatal unit, and as of the time of her discharge shows a pattern that her hematocrit is continuing on the downward trend based on the last several CBC's that were done, and also has a very low and falling reticulocyte count, don't you think it would be important to get to the bottom of what was going on?
MR. COTTON: Form objection, argumentative, assumes facts not remotely in evidence.
Go ahead. Go ahead and answer if you can.
BY MS. CARMICHAEL:
Q You can answer.
A That assumes a lot of different things in this scenario. I would have to specifically look at the numbers you're referring to, to make a proper judgment about whether that's the case.
Q You, of course, know and understand that

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there are many different types of anemia? Yes?
A Yes.
Q And there are also many different causes for anemia? Yes?
A Yes.
Q Okay. And that notwithstanding in MayRose Hurst's case, it was assumed that her anemia was due to her prematurity. Is that your understanding?
A No, that's incorrect.
Q Okay. Correct me then.
A Like I mentioned before, anemia of prematurity in critically ill, very low birth weight, extreme low birth rate babies that have long hospitalizations is a diagnosis that's in the chart probably 90 to 100 percent of the time. So there's nothing surprising about that. But that doesn't explain other things that can happen to patients, specifically MayRose. So we have other reasons for her anemia and her choices that were made by clinicians to give her blood transfusions.
Q Okay. Do you dispute that the diagnosis of anemia due to prematurity appears throughout her medical chart?
A No.
Q You're just disagreeing with that diagnosis?

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A No. I'm saying that's not the reason necessarily that she received blood transfusions.
Q Well, in your opinion, did she or did she not have anemia due to prematurity?
A Yes.
Q She did?
A Yes.
Q Okay. A differential diagnosis regarding the cause of her anemia was never undertaken by your NICU staff, was it?
A Yes, it was.
Q In, in what way?
A Well, when you look at the day-to-day management of this patient, this child was reviewed in great detail by systems: Neurologic, respiratory, cardiovascular, fluids, nutrition, infectious diseases, hematology, renal, all these different systems on a day-to-day basis. And orders were written to take care of this child, maintaining the standard of care. So she got excellent care.
Q I'm talking about testing to determine what the cause of her anemia was. I'm not talking about, you know, what Doctor Scheidler did during his necrotizing enterocolitis surgery. I'm not talking about, you know, what Infectious Disease did to treat

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her sepsis. I'm talking about efforts, testing, efforts made to determine the cause of her anemia.
A We knew the cause of her anemia.
Q You knew she had Diamond-Blackfan anemia?
A No. But we knew the cause of her anemia.
Q Well, how can you say that when you -- well, let me ask you this: No efforts were made to conduct any testing to determine if she had a genetic blood disorder. Correct?
A There was a State screen.
Q By you and your staff, any --
A That's, that's done by state law. It's required.
Q In that test for thalassemia?
A Yes.
Q Does it test for Diamond-Blackfan anemia?
A It does not. It's too rare.
Q No tests were conducted of her bone marrow?
A No. That's very invasive to do that.
Q Okay. No efforts were made to bring in a hematologist to consult on the case. Correct?
A Maybe, maybe not. But from my perspective, I don't know of any indication to have a hematologist involved.
Q Okay. No outpatient follow-up with a

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hematologist was ever recommended. Correct?
A I didn't generate the discharge summary, but I looked at it and I didn't see it in there, that's correct.
Q Okay. No tests were conducted in the NICU to determine if her hemoglobin was abnormal. Correct?
A The State screen was done. Yeah, State screen, hemoglobin.
Q So there was no workup though on the cause of her anemia?
A It wasn't necessary. We knew the cause of her anemia.
Q Well, we've been through this before. You've testified you did not know she had Diamond-Blackfan anemia. Correct?
A That's correct.
Q Okay.
A But we know why she had anemia, nonetheless.
Q Maybe you knew of some contributing factors to anemia. But you did not know that she had bone marrow problems, did you?
A It didn't manifest with bone marrow failure.
Q Okay. Okay. Did you ever consider giving, I'm going to slaughter this word again, erythropoietin injections to MayRose?

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A No.
Q And why not?
A The use of EPO, as we call it, to make it easier --
Q I like that.
A -- fell out of significant use relative to what it was ten years ago because of high cost, its ineffectiveness, and third its association with significant eye disease.
Q Okay. You've said a couple of times that you -- we, we knew what the cause of her anemia was. So what, what was it that you knew? What was the cause of her anemia?
A There's two phases you want to break it down into.
Q Go ahead.
A The baby received 11 blood transfusions during the course of an 80-day hospitalization.
Q Uh-huh.
A And four of those, which is, what, 40 percent or so, were received within the first 72 hours. And we know why that is.
And now you've got seven blood transfusions in 77 days, if my math is correct, which for a baby that's only two and a half, a little more than two and

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a half pounds at birth, and only has this much blood volume to begin with, that's what I would refer to as typical and expected.
Q What about the low reticulocyte count? Is that typical, expected?
A Who said it's a low reticulocyte count?
Q Your lab values and your lab report.
A No, it didn't say that.
Q It didn't say that?
A No. No. That's a reference range. It doesn't say abnormal, normal, high. It's a reference range.
Q Okay.
A And those values were within the reference range.
Q Point five is within the reference range?
A In the low values.
Q Okay. And you know that only two weeks earlier it was .9. Right?
A That's correct.
Q So it fell from a .9 to .5 in two weeks. Is this something that would be anticipated and expected by you for a child like MayRose?
MR. COTTON: Form objection.
Go ahead and answer.

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THE WITNESS: We know that giving a blood transfusion suppresses endogenous erythropoietin production, which means they don't have reticulocytosis until the blood level goes down again. So it's expected that the hematocrit -- the retic count would be low.
BY MS. CARMICHAEL:
Q For about eight days after the transfusion. Right?
A I don't know.
Q You don't know?
A I'm not certain. It's a, it's a, it's a gradual process. So that's, so to be specific, I don't know.
Q Okay.
A It's not like all of a sudden the bone marrow starts making all these cells and the reticulocyte count might be normal. It's a gradual process.
Q Was it, is it -- I understand you weren't treating her there at the end. But knowing the information now, that on July 14 her reticulocyte count was .9, and on August 1 it was .5, is that kind of a decrease in that short amount of time, does that have any clinical significance to you?

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A I don't know.
Q You don't know. Might a hematologist know if that has clinical significance?
A The hematologist would say that it's expected.
Q A hematologist would say that that is expected?
A Yes. And that's consistent with published data of levels that go down to .2, .1, this kind of thing.
Q You're talking about in the face of blood transfusions?
A Not necessarily.
Q In the aftermath --
A No, it's what's called a nadir. The endogenous production of erythropoietin does not kick in, so to speak, until the nadir is reached, which may be a hematocrit of 20 to 22.
So the level of the reticulocyte count is expected to be on the lower side. Especially in the case of transfusions. So it doesn't have a great deal of, of meaning in signifying disease processes.
Q Okay. Well. Are you aware of types of anemia where the reticulocyte count would actually be high?

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A Yes.
Q Because of the anemia?
A Yes.
Q Okay. What, when does that occur?
A When you got rapid red blood cell destruction. Hemolysis, it's called.
Q Okay.
A And hemolysis occurs in a number of conditions.
Q Do you know whether or not MayRose's anemia was microcytic, normocytic, or macrocytic?
A Yes.
Q What was it?
A It was macrocytic which is consistent with prematurity. The MCV was high. But after multiple transfusions, because she was of course bleeding internally, then it becomes an impossible value to follow.
So this question is only relevant at the time of birth.
Q Are you familiar with medical literature that says that anemia due to prematurity is characterized by normocytic cells?
A There's lots of types of prematurity. There's a spectrum of prematurity. So you have to be

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specific when you ask that kind of question.
Q Okay. Are you aware that Diamond-Blackfan anemia, that macrocytic is consistent with Diamond-Blackfan anemia?
A Yes. Yes.
Q Okay. A low reticulocyte count is also potentially indicative of bone marrow disorders, or aplastic crisis, isn't it?
A That's a rare thing. It's not common.
MS. CARMICHAEL: Let's go ahead and mark that as 1.
(Plaintiffs' Exhibits 1 and 2 marked for identification.)
BY MS. CARMICHAEL:
Q Okay, Doctor Blahnik, Exhibit 2 to your deposition will be the Neonatal Admission History and Physical. Did you prepare this document?
A Yes.
Q Okay. It's my understanding that you were actually the admitting -- MayRose's admitting physician? Is that correct?
A I'm the admitting physician of record, yes.
Q Okay. In several places throughout the medical record, it refers to you as the attending physician as well. Was, was that your understanding

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of your role in MayRose's care?
A I was the physician of record. I was the neonatologist that was on the day the child was born.
Q Okay. Does that mean then that she's essentially your patient and you are going to follow her all the way through to discharge?
A Absolutely not.
Q Okay. Tell me what it means then to be the admitting physician?
A It's, it's required in the multiple NICU's where I've worked, there always must be an attending neonatologist as a physician of record.
The way it works at Sunrise, whether it's under the new medical director in Pediatrics, the old medical director at Children's Healthcare Network, or the NICU's I worked with when I was on faculty at USC, I've come across the same thing. There must be a physician of record at the time the child is admitted.
If a new neonatologist comes in the next day, technically, that should be changed. And the day after that. It would become a logistic secretarial nightmare to change 50 patients on an almost daily basis.
Now, when I was at Children's Hospital in Los Angeles, we would have an attending, as you call

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it, attending hematologist who might be on two weeks, three weeks, and maybe four weeks, once upon a time. We went through changing that by the secretary. But even they abandoned it because it's just too cumbersome to switch that name.
And in our practice where we may be on three days, four days, one day, two days, and multiple patients, to change the neonatologist physician of record for that day is not possible. So our medical director did the correct thing by just leaving it alone.
So it means nothing other than I admitted the patient that day. And the responsibility from one day to the next came upon the group.
Q Got it. Okay. So reviewing your neonatal admission history and physical for MayRose, it appears that she was born at 28 and 6/7 weeks. So one day short of being 29 weeks. Correct?
A Yes.
Q Okay. Tell me, in your experience and with your training, what is the viability generally of an infant of that age?
A In the 21st Century in this day and age?
Q Yes.
A It's very good.

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Q Okay.
A So when you mean viability, I assume you mean survival?
Q Yes.
A Yeah. So it's going to be 90 percent.
Q Okay. And when you look at her birth weight, the 1280 grams, is that, for a premature baby of her age, is that a fairly typical weight? Is it lower than you would expect for that age? Is it higher than you would expect?
A This is what we would call AGA, which is appropriate for gestational age.
Q Okay. All right. Knowing that -- well, were you present for the delivery of the baby?
A Yes.
Q Okay. You were standing by ready to address whatever issues she may have?
A Let me restate that. I'm not a hundred -- I remember that night. But I'm not a hundred percent sure I was actually at the delivery.
Our policy at the time was 27 weeks and younger the neonatologist would attend the delivery. We are always on -- this is at night, you know, just after midnight -- we're always on with either a hospitalist or a neonatal nurse practitioner. In this

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case, it was Katherine Felongco, if I remember correct.
It's entirely possible that she went to the delivery, brought the child down, called me, middle of the night kind of thing, and I came out of my call room, because I remember being by the bedside. But I don't want to misspeak and say I was actually at the C-section.
Q Okay. Fair enough. So knowing though that you were about to assume the care of a premature baby of this age, before we get specifically to MayRose's issues, what types of concerns or issues would you be anticipating in a child of this age?
A Again, we look at our children by systems. So there's neurologic, respiratory, cardiovascular, going down the line, head to toe, so to speak. And number one in this age group is, generally speaking is going to be the respiratory status.
Q Okay.
A Then we go through what we call A, B, C's, which is part of that airway, breathing, circulation, circulate, critical. That means is the heart doing what it's supposed to? If the lung is doing what it's supposed to, we can assist the lung, but we need to make sure the heart is as well. Receiving blood

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that's got oxygen in it, sending it to all the organs of the body to keep the child safe and protected. That's blood pressure, heart rate, acid base status, urine output, capillary refill, these types of things that are the way we approach it. Consider infection, of course. And whatever else might be relevant to the particular case at that time.

Q But the big ones at this age would be the respiratory, the circulation, and the infection issues?

A As a general rule, those are the major things. But we have cases that have very special circumstances based on the obstetrical history or the fetal history that can modify the priority.

Q Okay. And let me ask you, now that you bring that up. Before, before assuming care of MayRose, did you have an opportunity to get a prenatal history --

A No.

Q -- from any of the --

A No, the obstetrician --

MR. COTTON: You have to let her finish her question.

BY MS. CARMICHAEL:

Q Any of the mother's physicians?

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A No. The obstetrician did not call for a neonatal consult in this case, as far as I'm aware of.

Q Okay. Did you obtain that history later?

A We have some information, yes. You can see it in the history here.

Q Okay. Do you know how you came by that information?

A It, it comes with the, the baby from the OB nurses, they send down the obstetrical history, yes.

Q That the nurses have taken orally from the mother?

A No, it's in her chart.

Q Okay. Okay. Do you recall whether or not you spoke with Ms. Hurst's perinatologist at any point in time?

A I don't recall.

Q And do you recall whether or not you spoke with the Ob-Gyn at any point in time?

A I don't recall.

Q Okay --

A We had -- sorry. Can I answer? Just saying it's important.

Q Go ahead.

A We had a practice at the time with actually a sign-in book that the medical director wanted us to

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maintain, where admissions, all admissions to the NICU received a phone call -- given a phone call to the obstetrician after the delivery. It wouldn't happen necessarily that night, but like the next day or certainly when the surgery was required, to call the obstetrician and say this is what's going on with the baby.

Q Okay.

A We didn't, we weren't always perfect as a group, but, you know, we really strove to do a good job in keeping them updated.

Q Okay. And did you have, as you assumed the care of MayRose, did you have any knowledge regarding Tiffani Hurst's hospital course before the baby was born?

A Yeah, a little bit.

Q For example, did you have any knowledge of what medications had been administered to her prior to the C-section?

A Yes. You can see some of them I put in the note.

Q Where are you referring?

A Under, "Maternal diagnoses and procedures," there's Terbutaline, Indocin, and beta-methasone, that's the steroid.

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Q Okay. And the day after MayRose was delivered, bowel perforation was discovered. Did, did you believe that possibly the Indocin could have caused or contributed to that?

A Yeah, there's medical data that shows that.

Q Okay.

A In fact, the combination of indomethacin and cortical steroid is, is contraindicated in our world. And these are pregnancy risk factor drugs, cause bleeding.

Q Those drugs are contraindicated, when you say in your world, you mean, what do you mean?

A Neonatal world.

Q Okay.

A Yeah, they're known GI complications when those are used together. Indocin itself we know has an issue with platelets, bleeding. Of course, this is exactly what happened to MayRose.

Q Are you critical of the administration of those medications?

A I'm not an obstetrician.

Q And do you know what went into the decision-making as to why they were administered?

A Yes.

Q What was that?

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A Indocin is used as a tocolytic, and steroids are used to accelerate lung maturation.
Q Okay. But it's your position that the steroid and the tocolytic should not have been administered together, that they're contraindicated?
A They're, we don't use them in neonatology because of the risk for GI pathology. And I know that the FDA has warnings on the use of these medications during pregnancy because of these issues.
Q Okay. Okay. There's a coding summary in the chart that indicates that you, at some point you gave MayRose an influenza type B vaccination. How long does that vaccination last? How long is that good for?
A I'm not certain. I believe it's once per season. But it's possible that infectious disease in prematurity it's not as effective.
Q Okay. Okay. Did you ever speak with Mrs. Hurst about any of the testing that had been done during the prenatal period?
A What testing are you referring to?
Q She was tested for cystic fibrosis. The perinatologist had her do some chromosomal abnormality testing. Were you aware of --
A Oh, she's advanced maternal age, yeah. I

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don't recall.
Q Okay. Do you have an independent memory of MayRose?
A I remember the bed she was at. I remember she was very low birth weight, small baby.
Q Okay.
A And I remember her being sick. But I don't remember like what her face looked like, so to speak.
Q I'm sure you see a lot of baby faces between now and then.
A Yeah.
Q Okay. From your review of the record, what do you recall were May's issues when she was born?
A Well, one of the, you'll notice that the baby was intubated and received surfactant. So was on a respiratory and was getting this medicine for the lungs.
And then the breathing tube was pulled out fairly quickly. And if it was a colleague instead of me, they probably would have kept it in a little longer. Because I push the idea of early extubation. So that's my bias.
And then of course the next day she got really sick. That didn't come into play with, you know, obviously, her GI pathology. But that's what

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was going on. So we had, she was back on the respirator within that first day.
Q But it was not due to lung issues, it was due to her need to go to surgery. Right?
A That's incorrect. It was really both.
Q Okay.
A Yeah.
Q All right. So you had perhaps extubated her prematurely?
A You can say that in retrospect. It's okay, because the ventilator has risk factors to injuring the lung with inflation. So it's a good practice to get the tube out. There's nothing controversial about that.
Q Okay. Not taking issue with that.
What -- so you were telling me about her issues?
A Yes. The impressive thing about this case is a perforation through the bowel wall and necrotizing enterocolitis. So those two diagnoses she had in less than 24 hours from birth.
The impressive thing about that is that's not really how that disease really occurs. NEC is associated with feedings. MayRose was never fed. NEC is associated with after day ten, or two weeks, even

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three, four weeks. This is very early.
So I put it in the note, and that's my original thinking, especially because the hematocrit was on the low side, is this could be a gastric perforation. Isolated gastric perforation.
But that's not what it was. It was NEC.
And why is that? And so we have to go back to these medications. This combination that we don't use in neonatology. Both of these drugs readily cross the placenta. We know that. And so she was bleeding internally.
Q Okay. And that is what caused the NEC, the N-E-C?
A The, I don't know what caused it. But we know these are risk factors.
Q Okay.
A And the FDA has warnings about those drugs.
Q Okay. So --
A We would presume that that's, that's -- it's risk/benefit. There's benefits to stopping preterm labor. There's benefits to steroids. They do a great job in improving lung function, issues with the brain, and this kind of thing.
Q Okay.
A So it's a risk/benefit decision-making tree

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that, you know, the obstetrician was making.
Q Okay. What other issues were you aware of that May experienced during her stay in the NICU?
A Well, this one issue stands out. Because of the 11 transfusions, four of them occurred in the first 72 hours. And we know why. She was bleeding internally. And that stands out as being one of the most impressive things. Because it's unusual. NEC doesn't behave this way, like I said. Gastric perforations we know are an issue. But that's impressive.
And then after that what stands out in my mind is, you know, her critical status over and over.
Q For?
A Multiple medical problems.
Q Such as? Just keep going. Lay it out.
A Well, she had recurrent infections. She had --
Q What kind of infections?
A Rule out sepsis. Sometimes they couldn't prove it, but there was clinical symptoms and lab abnormalities. Line infections, possibly in, in the breathing tube, bacteria growing. Urine. I don't remember everything.
Q Okay. Taking you back to your rule out

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sepsis couldn't prove it statement. The NICU thoroughly tested her for bacteria, viruses, fungal causes for the sepsis. Correct?
A Let me put it this way: Preterm babies, very low birth weight, will undergo multiple sepsis workups during the course of their long hospitalization. That's expected. And it's not uncommon, despite blood tests and antibiotics, that we actually don't grow something out of the blood.
Q Well, in MayRose's case, you never did grow anything out of the blood. Correct?
A I don't remember.
Q Okay. You say though that she, there were lab values that were indicative of sepsis. You're referring to her elevated CRP?
A That's one thing.
Q Okay. And an elevated CRP indicates an inflammatory process?
A That may be, yes, that may be infectious or noninfectious.
Q Okay. All right. Okay. All right. Okay, so we've talked about the GI issues. We talked about the sepsis. Was there any, anything else of note that comes to your mind regarding MayRose's course in the NICU?

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A She had checks for retinopathy prematurity. She had feeding issues recurrently. I recall her heart function was an issue, where we had the cardiologist involved. Her lungs were always a concern. Her growth was a concern. And, of course, her hematologic system was always a concern. Her renal function, from what I recall, was good.
Q Okay. She -- now, as far as the cardiology consult goes, you did have a cardiologist consult, but he found her heart to be in good condition, didn't he?
A Yes.
Q Okay.
A From what I remember.
Q So she didn't have any cardiac issues, did she?
A Not that I remember.
Q Okay. You indicate her lungs were always a concern. She was, received some oxygen via nasal cannula. Correct?
A She received various forms of respiratory support.
Q Okay.
A Long term, yes.
Q Then you said her growth was always a concern. She gained weight and was discharged at a

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very satisfactory healthy weight, wasn't she?
A That's the way our group practices. I didn't do the discharge.
Q Okay.
A I know that that's how they practice.
Q Well, how was her growth a concern? Are you --
A Our growth.
Q -- indicating that she was not growing?
A Sorry. Our growth is always a concern in very low birth weight babies. It's a challenge to have them feed appropriately. So it takes a great deal of attention to care, to address their nutritional needs.
Q Okay. But you're not telling me that she wasn't growing properly?
A It's possible. I don't recall.
Q You don't know. Okay.
A It's not uncommon that we struggle with growth issues in very low birth weight babies that are critically ill.
MS. CARMICHAEL: Go ahead.
She's going to change the tape. If you would like to take a break, bathroom break.
THE VIDEOGRAPHER: The time is 3:27 p.m.

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This concludes digital tape number one. Off the record.
(A short break was taken.)
THE VIDEOGRAPHER: We're back on the record at 3:34 p.m. This begins digital tape number two. You may proceed.
BY MS. CARMICHAEL:
Q Doctor Blahnik, following your admission of MayRose to the NICU, you, on May 14, you continued to treat her off and on as her neonatologist through to what date?
A I believe it was mid-July.
Q Okay. And I believe the last progress note I have from you is July 12 -- oh, excuse me, July 13. Does that sound right?
A Yes.
Q Okay. And do you have a memory of, without looking at your records, I mean do you have a sense of how she was doing during that timeframe, and her status when you ended your treatment of her?
A Yes.
Q Tell me what you remember.
A I remember that, you know, given her complicated history, she was lucky. Because she didn't have any interventricular hemorrhage in the

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brain.
She didn't have any eye disease, which is associated with very low birth weight babies, called retinopathy prematurity.
She didn't have bad BPD, which is bronchopulmonary dysplasia.
And even though she had multiple infections or concerns for infections on and off, she never went into septic shock, as an example. Or had infection in, in the brain, like a meningitis.
She struggled with feeds. I remember having recurrent feeding intolerance. But she was, you know, as far as I remember, she was growing quite well.
She had, you know, lots of issues, but was showing steady improvement.
Q Okay. And after your last, the last time that you prepared a NICU progress note on July 13, did you see MayRose after that?
A No, I was out of state, on vacation for three weeks.
Q Okay. And do you recall when you returned from vacation?
A I don't recall.
Q Okay. Do you, at any point in time did you review her discharge summary?

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A Not until the case.
Q Okay. Did you discuss with Doctor Piroozi, prior to the case being filed, did you ever discuss with him MayRose's discharge?
A No.
Q Did you ever review her labs after you returned from vacation? Did you take a look at her labs?
A No, she was discharged.
Q Okay. So you didn't, after July 13, you didn't look at her records, or review anything that the other NICU doctors had done?
A No.
Q Okay. Do you remember any of the conversations that you had with either her mother or father during the treatment -- the time that you provided care to her?
A I remember conversations. And I remember them being the way I treat all parents, you know, equally, sensitively, and that kind of thing, providing, you know, information about their baby's clinical status, and answering their questions.
Q Okay.
A That's how I approach all my families, with lots of experience, of course. There's nothing, few

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things, but not a great deal stands out with these parents. Obviously, they're educated people. That makes a difference in the nature of the conversations that we have with our, our families. It makes a difference what type of questions they may ask.
Q Okay. Anything else stand out about them? You noted they were educated. Do you remember anything else?
A About conversations?
Q Yes.
A No.
Q Okay. Do you remember one or both of them being extra inquisitive about what was going on?
A Well, MayRose's mother was there more than the father. I remember that.
Q Okay.
A They were there together. I don't remember the father being there alone. I remember her being there alone. But no.
Q Okay. Do you recall the father telling you about his thalassemia?
A No.
Q Okay. Do you --
A I remember the issue of the cystic fibrosis. That came up. But the thalassemia, that would have

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been something we would automatically get attuned to from the, the newborn screen. So it kind of happens blindly. A hundred percent of those cases must be done, they have to be documented by the State.

Q Do you have a memory of seeing that test result come back?

A Generally, we don't look at them unless they're abnormal.

Q Okay.

A It's in their record -- well, we do see them, but it gets in the medical record. At least based on the program we have now.

Q Is there someone that spearheads the, the screening for the thalassemia at the hospital?

A It's automatic that the nursing staff gets an order to test for the newborn screen on every single patient admitted to the NICU.

Q For example --

A That's State mandated.

Q Okay. For example, with regard to the CF test, there was a Doctor Michael Wall that kept coming up as, as far as, you know, asking that a follow-up CF test be done because of a, of a abnormal result, screening result.

Is there somebody like that who would be

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spearheading the thalassemia test?

A Yes, there's a, a State director of the newborn screening program. And rarely, when an, a unique finding is in the newborn screening they will call us, for a specific concern they will call us.

More commonly, especially in preterm babies, we get lots of false negatives. So repeat testing is necessary. Or sometimes it's even impossible to do the testing until later times.

Q Okay. Do you know who was in charge of that in '08 for the State?

A No. I don't know that person now.

Q Okay.

A All of those are uncommon diseases.

Q Okay. It's noted in MayRose's records that she had a normal suck, root and grasp. Is there any specific clinical significance that that would signify?

A That signifies that neurologically she would be intact, depending on her gestational age.

Q Okay. All right. And while you provided care to her, you didn't see any neurological abnormalities or things that would cause you concern about her neurologically, did you?

A I don't know. I know that her, from what I

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recall the studies of her brain, her head ultrasounds were okay. I don't recall her being on phenobarbital for seizures.

But the most common thing is head ultrasound early on in these types of admissions. That's routine looking for interventricular hemorrhage.

Q And there were two of them done early on, and both of them were normal. Is that your memory?

A I don't know. It's possible she had a grade one IVH, as we call it, which is germinal matrix hemorrhage. It generally speaking doesn't have significance.

But a grade three or grade four is something that I would know and would stick in my mind. And she didn't have those. Because those would have long-term significance for neural developmental defects.

Q Sure. And the germinal matrix finding was late in her NICU stay. It was the day before she went home.

But let me, let's just go through these, to be thorough. I thought there were two of them. Let's see. Okay.

(Plaintiffs' Exhibit 3 marked for identification.)

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BY MS. CARMICHAEL:

Q Okay, so Exhibit 3 is an ultrasound of the brain that was done on the day of her birth. And it appears that it was unremarkable or normal. Is that true?

A Yes. Yes.

Q Okay. And then -- find it.

(Plaintiffs' Exhibit 4 marked for identification.)

BY MS. CARMICHAEL:

Q Okay. And then Exhibit 4 is another ultrasound of the brain that I believe you ordered four days later. And again, there's no hemorrhage seen. Is that correct?

A Yes, I would call this a reassuring head ultrasound.

Q Okay, great.

(Plaintiffs' Exhibit 5 marked for identification.)

BY MS. CARMICHAEL:

Q Okay, and then on August 1, the day before her discharge, there was another follow-up head ultrasound done. And this is the one that shows the grade one germinal matrix bleed.

And did you say that a grade one is not

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concerning?
A That's correct.
Q Okay. And tell me why that is?
A There's data that say that it's not associated with any long-term neural developmental outcomes. But I would actually dispute this finding.
Q Why?
A Germinal matrix involutes quickly after birth, even in prematurity. There should be no germinal matrix.
Now, this is one of our best radiologists. So I would have to have a discussion with him about why he says that.
It may have been just what we call an incidental finding.
Q Okay.
A But by itself, grade one IVH just does not have long-term significance. So.
Q Okay. Great. Okay. And, let's see. It also indicates in that that it's subacute. There's no acute bleed going on. Correct?
A Correct.
Q All right.
A It may have been just a certain kind of shadowing of the, the technician who did it at the

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time. Because the radiologist, they read the studies. They're not there at the bedside.
Q Right. Okay. All right. Let's see.
(Plaintiffs' Exhibit 6 marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Blahnik, this next exhibit appears to be a developmental evaluation that was done by Physical Therapy, I believe.
A Extra copy. (Indicates.)
Q Oh, sorry.
On the day of her birth? Is that, does that seem right?
A No.
Q I was wondering about that. It's dated the date of her birth. And then it, you know -- I don't know.
A I, I think this is, if I could say. Go back to our original orders. It's part of the original orders to do a developmental evaluation.
Yes, consult Developmental Team. So that gets generated that way.
Q Okay.
A But the baby was too sick for this to be a relevant issue at that point.

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Q Okay. Well, at some point, it appears that the evaluation was conducted. Do you know when it might have been conducted?
A No, I don't know.
Q Okay. In any event, of the 30 -- let's see, not 30 -- of the various categories that they test, it appeared that she was appropriate for age with the exception of two of the items, being the suck, which was abnormal, and the, is that m-o-r-o-?
A Where are you looking? Moro, yes, okay.
Q Moro. Everything else appeared to be appropriate for age.
Do you recall reviewing this or being aware of this result?
A It, it depends if this was generated after or before when I went on vacation.
Q Okay. Based on --
A But I signed -- sorry. I signed it. It's not dated. But that may have been a signature that was generated and I had to go to Medical Records to sign. So that becomes hard to identify.
Q Okay. Based on the results, or the physical therapist's findings, what do you conclude?
A Well, this was a critically ill, very low birth weight baby that had multiple medical problems

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and was on a respirator for a significant period of time or had other respiratory issues. And that's relevant in being able to learn the suck/swallow reflex that's part of development, and often it can be delayed.
This is not only associated with her having recurrent feeding intolerance, but also being able to feed by bottle. You can put a tube in the tummy and you can tolerate feeds that way. But suck/swallow is a much more complex skill that can take a lot of time.
Q Okay.
A So I wouldn't be surprised that you would have this finding.
Q Okay. But do you have a memory of MayRose overcoming those issues and essentially becoming appropriate for age in those two areas?
A She would have to. Otherwise she couldn't go home.
Q Okay.
A At least with respect to suck. If that, if this is saying the baby, the child is unable to take by bottle.
Q Going back to your neonatal admission history and physical. It reports that her Apgar scores were three -- or excuse me, one -- no, three,

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six, and seven. Are those scores what you would expect to see from a 28-and-six-day preemie?
A There's no expectation. Baby could be born dead. Baby could be born with Apgars of eight and nine. Across the spectrum.
Q Okay.
A So there's no expectation, except for the worst.
Q Are those Apgars alarming to you?
A No. They're actually reassuring, because a three Apgar is quite low, telling me this child needs assistance. By five minutes, as long as we're six or higher, that tells us the resuscitation team did their job.
Q Great. Okay. And what is the clinical significance of a seven? Is that, is that a relatively good score at ten minutes?
A Yes, it's great. Especially for prematurity because they're neurologic tone is expected to be decreased. So they get points off for that already.
Q Okay.
A So that's a good, that's a good sign.
Q Okay. Thank you. All right.
As of the time that you stopped seeing MayRose, what were your expectations for her going

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forward?
A Well, we go back to, you know, her internal bleeding. She required an ostomy, surgeries, and all of that.
And she's lucky, and she didn't have significant bowel resection, where a lot of her GI tract had to be removed. It gets pretty scary to have what's called short gut syndrome. Sometimes they can't even survive.
And she didn't have bleeding into her brain. That was significant. That's a good sign.
She didn't have significant lung disease. That's a good sign.
So I think that the team group, you know, did a good job with this baby.
Q Would you have expected MayRose to be able to go on and, and -- well, would you, would you have expected that she would have had some developmental delays?
A It's always possible.
Q Okay.
A Prematurity is high risk by itself. There's no question. Especially when you're talking about this degree of prematurity, 1200 grams, only two and a half pounds. It's a small, small human being.

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Q And by developmental delays, tell me what you are meaning by that?
A Well, there's multiple things that they can have. They can develop cerebral palsy later on.
They can develop learning defects. Have poor growth. And the learning defects can be variable. They need to be followed potentially through a pediatrician through a developmentalist, if that's available.
Q I suppose they can also go on to have no problems?
A Yes.
Q Given what you saw in your treatment of MayRose up through July 13, did you have any specific expectations as far as she was concerned about what she would experience post discharge?
A I thought she would do okay.
Q Okay. I'm just going to ask you. On this -- let's see.
(Plaintiffs' Exhibit 7 marked for identification.)
BY MS. CARMICHAEL:
Q Doctor Blahnik, Exhibit 7 to your deposition is the, the comprehensive lab report for MayRose's NICU stay. And I wanted to ask you if you could shed

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some light on a value for me.
If you would turn to page 57 of that report. And it's Bates numbered, let's see, so at the bottom it's 1083.
And down towards the bottom, do you see on the left-hand side where it says retic number? Retic number?
A Yes.
Q Do you know what those values, where they came from and what they mean?
A There's different dates here. Are you referring to a particular date?
Q The 8/1 date and the 7/14 date. Those two lab values. The reference range, the results. Do you understand, do you understand what those lab values are indicating?
A Yes. I think I do.
Q Okay.
A They're not usually reported that way. But I think this is just the precursor to what's finally reported. This is where they do the calculation.
Q Okay. This is where they're doing the calculation?
A I would assume so.
Q Okay. Well, according to the reference

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range they're providing, both results are indicated in the report as being low. Is that true?
A There's an "L" there. That doesn't say normal. It says reference.
Q Okay.
A Which I think is significant.
Q In what way? I mean if you look throughout this lab report, that's what they give you as reference ranges?
A Yeah. That means it needs to be interpreted in light of the clinical scenario you're dealing with. I would assume.
Q Do you have any understanding of why these results are being reported as low?
A Well, I wasn't involved with the patient at this point. That's 7/14 and 8/1. So I was never confronted with looking at these numbers.
Q Sure. And I understand that. I'm just wondering within your practice, as a neonatologist looking at these lab reports every day, if you can explain to me what this particular lab finding is indicating?
A It's telling the number of reticulocytes counted under a microscope by a technologist in the lab.

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Q Okay. And how then is that different from the, the retic, the retic results we have on a different page in here, I don't know that I can find that right away, of .9 and .5?
A Well, like I said, this is probably the calculation to get to that number.
Q But --
A This is the same date the retic counts were done.
Q Correct.
A And the same time. Right?
Q Yes. And you're saying it's probably the calculation. So does that mean you're unsure?
A That's correct. Because I'm not usually seeing them reported this way.
Q Okay.
A I know what they mean. They're reported as a percentage.
Q Okay. And you think that rather than being reported as a percentage, those are actually the number of cells they visualized?
A I'm not sure.
Q Okay.
A Talk to the lab.
MS. CARMICHAEL: Those are all the questions

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I have for you today. Thank you for your time.
MR. COTTON: Questions?
MS. URDAZ: None for me.
MS. LUCERO: None for me.
MR. COTTON: We'll read and sign.
THE VIDEOGRAPHER: This concludes the deposition. The time is 3:59 p.m. We're off the record.
(The deposition concluded at 3:59 p.m.)

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CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE

I, MARTIN JOSEPH BLAHNIK, 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.

MARTIN JOSEPH BLAHNIK, 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, MARTIN JOSEPH BLAHNIK, M.D., commencing on January 18, 2011, at 2:06 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.

_____
Karen J. Berry, CCR 836, RMR