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4 **IN THE SUPREME COURT OF THE STATE OF NEVADA**

Electronically Filed
Feb 06 2014 08:33 a.m.
Tracie K. Lindeman
Clerk of Supreme Court

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6 **ALI PIROOZI, M.D.,**
7 **Petitioner**

Nevada Supreme Court
Case No.: 64946

EJDC Case No.: A - 616728 - C

9 **EIGHTH JUDICIAL DISTRICT**
10 **COURT OF THE STATE OF**
11 **NEVADA, IN AND FOR THE**
12 **COUNTY OF CLARK, and THE**
HONORABLE JAMES BIXLER,
DISTRICT COURT JUDGE

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

13 **Respondent.**

RESPONSE REQUESTED PRIOR
TO TRIAL COMMENCING ON
FEBRUARY 18, 2014

14 _____
15 **TIFFANI D. HURST and BRIAN**
16 **ABBINGTON, jointly and on behalf of**
17 **their minor child, MAYROSE LILI-**
ABBINGTON HURST; MARTIN
BLAHNIK, M.D.,

18 **Real Parties in Interest.**
19 _____

20 Robert C. McBride, Esq.
21 Nevada Bar No.: 007082
22 S. Marie Ellerton, Esq.
23 Nevada Bar No.: 004581
24 MANDELBAUM, ELLERTON & McBRIDE
25 2012 Hamilton Lane
26 Las Vegas, Nevada 89106
27 (702) 367-1234
28 (702) 367-1978 (Fax)
Attorneys for Real Party in Interest
Martin Blahnik, M.D.

Deposition Transcript of Martin Joseph Blahnik, M.D.
dated January 18, 2012 Pages 1-34

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:

The Honorable James Bixler
Eighth Judicial District Court
Department 24
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89155
Respondent

Catherine Cortez Masto, Esq.
Attorney General
Nevada Department of Justice
100 North Carson Street
Carson City, Nevada 89701
Counsel for Respondent
The Honorable James Bixler

Dennis M. Prince, Esq.
Prince & Keating
3230 South Buffalo Drive, Suite 108
Las Vegas, Nevada 89117
Attorneys for Real Parties in Interest
Tiffani D. Hurst and Brian Abbington,
jointly and on behalf of their minor
child, May Rose Lili-Abbington Hurst

Jackie Carmichael, Esq.
Eisenberg, Gilchrist & Cutt
215 South State Street, Suite 900
Salt Lake City, Utah 84111
Attorneys for Real Parties in Interest
Tiffani D. Hurst and Brian Abbington,
jointly and on behalf of their minor
child, May Rose Lili-Abbington Hurst

John H. Cotton, Esq.
Christopher H. Rigler, Esq.
Cotton, Driggs, Walch, Holley, Woloson
& Thompson
400 South Fourth Street, Third Floor
Las Vegas, NV 89101
Fax (702) 791-1912
Attorneys for Petitioner
Ali Piroozi, M.D.


An Employee of Mandelbaum, Ellerton & McBride

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.
7500 W. Lake Mead Blvd., Ste. 9246
Las Vegas, Nevada 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

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 936

EXHIBITS

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2

4

1 APPEARANCES:

2 For the Plaintiffs: JACQUELYNN D. CARMICHAEL, ESQ.

EISENBERG & GILCHRIST

215 South State Street

Suite 900

Salt Lake City, Utah 84111

4 For Defendant JONQUIL L. URDAZ, ESQ.

5 Sunrise Hospital: HALL, PRANGLE & SCHOOLVELD

777 North Rainbow Boulevard

Suite 225

Las Vegas, Nevada 89107

6 For Defendants JOHN H. COTTON, ESQ.

Blahnik and Piroozi: JOHN H. COTTON & ASSOCIATES

2300 West Sahara Avenue

Suite 420

Las Vegas, Nevada 89102

10 For Defendants Conti LAURA S. F. LUCERO, ESQ.

And Foothills BONNE BRIDGES MUELLER

12 Pediatrics: O'KEEFE & NICHOLS

3441 South Eastern Avenue

Suite 402

Las Vegas, Nevada 89169

14 VIDEOPHOTOGRAPHER: BECKY ULREY

CERTIFIED LEGAL VIDEOGRAPHY

EXAMINATION

EXAMINATION BY PAGE

MS. CARMICHAEL..... 5

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

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

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

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

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

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

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

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

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

<p>1 Thereupon--</p> <p>2 MARTIN JOSEPH BLAHNIK, M.D.</p> <p>3 was called as a witness by the Plaintiffs and, having</p> <p>4 been first duly sworn, testified as follows:</p> <p>5 EXAMINATION</p> <p>6 BY MS. CARMICHAEL:</p> <p>7 Q Will you please state your full name and</p> <p>8 your current address for the record?</p> <p>9 A Martin Joseph Blahnik, 1047 Taber Hill</p> <p>10 Avenue, Henderson, Nevada, 89074.</p> <p>11 Q Thank you. Doctor Blahnik, have you had</p> <p>12 your deposition taken prior to this occasion?</p> <p>13 A No.</p> <p>14 Q Okay. I'm sure you've had an opportunity to</p> <p>15 talk to counsel about the process, but I'll just give</p> <p>16 you a few pointers.</p> <p>17 The goal today is to have a very clear</p> <p>18 transcript. In order to do that, let me finish my</p> <p>19 whole question before you start your response. I know</p> <p>20 in normal everyday conversation we anticipate where</p> <p>21 someone's going and we might talk at the same time.</p> <p>22 But let's try not to do that here today.</p> <p>23 And likewise, if you're giving an answer,</p> <p>24 I'll do my best not to interrupt you with another</p> <p>25 question until you're done. If you do, however, pause</p>	<p>5</p> <p>7</p> <p>1 A The MayRose medical record at Sunrise.</p> <p>2 Q The entire record?</p> <p>3 A Not the entire record.</p> <p>4 Q Okay. Did you review all of the NICU notes?</p> <p>5 A I looked at NICU notes.</p> <p>6 Q Okay. Did you review all of the labs, lab</p> <p>7 results?</p> <p>8 A I looked at some of the labs.</p> <p>9 Q How about the transfusion records?</p> <p>10 A I looked at the transfusion, the, the dates</p> <p>11 of those.</p> <p>12 Q Okay. Did you bring any of the materials</p> <p>13 that you reviewed with you today?</p> <p>14 A No. Those are in the possession of Sunrise</p> <p>15 Hospital.</p> <p>16 Q Okay. All right. So you reviewed them --</p> <p>17 are they electronic copies, or hard copies?</p> <p>18 A Hard copies.</p> <p>19 Q So you pulled the original medical chart and</p> <p>20 spent time reviewing it while at Sunrise Hospital?</p> <p>21 A That's correct.</p> <p>22 Q Okay. And when did you do that?</p> <p>23 A I don't have the dates in front of me.</p> <p>24 Q Well, just roughly. Was it within the last</p> <p>25 month? Was it a year ago?</p>
<p>6</p> <p>1 and I assume you're done but you're not, just let me</p> <p>2 know, and I'll allow you to finish.</p> <p>3 A Okay.</p> <p>4 Q Okay. Also, make sure that you answer</p> <p>5 audibly instead of nodding or shaking your head. And</p> <p>6 if the answer requires a yes or no response, say yes</p> <p>7 or no instead of uh-huh or huh-uh, so that again the</p> <p>8 transcript is clear. Okay?</p> <p>9 A Okay.</p> <p>10 Q All right. Also, if I ask a question that's</p> <p>11 unclear, which I'm prone to do at times, feel free to</p> <p>12 ask me to clarify it.</p> <p>13 Also, if you need a break for any reason,</p> <p>14 just let me know. We can take a break. Okay?</p> <p>15 A Okay.</p> <p>16 Q All right. Have you ever had any lawsuits</p> <p>17 filed against you prior to this occasion?</p> <p>18 A No.</p> <p>19 Q Okay. What did you prepare -- or excuse me,</p> <p>20 what did you review in preparation for your deposition</p> <p>21 today?</p> <p>22 A I sought by recollection of the case, and I</p> <p>23 looked at medical records.</p> <p>24 Q Okay. What records specifically did you</p> <p>25 review?</p>	<p>8</p> <p>1 A I don't recall.</p> <p>2 Q Well, did you take a look at it recently?</p> <p>3 A No.</p> <p>4 Q Did you review any depositions that have</p> <p>5 been given in this case?</p> <p>6 A Yes. The original depositions that were</p> <p>7 part of the civil complaint.</p> <p>8 No. I misspoke. Those were -- what are</p> <p>9 they called?</p> <p>10 MR. COTTON: Affidavits?</p> <p>11 THE WITNESS: Yes, affidavits. No</p> <p>12 depositions.</p> <p>13 BY MS. CARMICHAEL:</p> <p>14 Q Okay. All right. And have you spoken with</p> <p>15 anyone regarding the claims that have been raised in</p> <p>16 this lawsuit, with the exception of your counsel?</p> <p>17 A Counsel I spoke with.</p> <p>18 Q Anyone else?</p> <p>19 A No.</p> <p>20 Q Have you discussed the claims with Doctor</p> <p>21 Piroozi?</p> <p>22 A In, only to the extent of getting access to</p> <p>23 the medical records which we knew of.</p> <p>24 Q Okay. On that occasion, what did you</p> <p>25 discuss with him?</p>

9

1 A Well, the, the Medical Records Department at
2 Sunrise will move the records to, I think it's called
3 Risk Management Department, or something like that.
4 And they are categorized differently. So when they're
5 checked out for review, they have a policy on how that
6 works.

7 Q Okay. So what did you speak to Doctor
8 Piroozi about?

9 A About obtaining the records.

10 Q Anything else?

11 A No.

12 Q Okay. Have you spoken with Doctor Conti
13 regarding these claims?

14 A No. I've never talked to Doctor Conti.

15 Q Do you know Doctor Conti?

16 A I do not.

17 Q And you have never spoken with him?

18 A No.

19 Q Have you ever met him?

20 A I have not.

21 Q Okay. Did you do anything else in
22 preparation for your deposition today?

23 A In what sense?

24 Q Medical research. I don't know. Anything
25 else to prepare for today?

10

1 A When we prepared materials for the State
2 response to the complaint, there was some
3 documentation regarding anemia and anemia prematurity
4 and this kind of thing. Those documents I looked at.
5 From like medical text kind of thing.

6 Q Okay, who pulled those documents?

7 A I can't remember if I did, part of it. I
8 don't recall.

9 Q Do you still have those documents in your
10 possession?

11 A Yes, I do.

12 Q Okay, and they are journal articles?

13 A No. They are from hematology textbooks.

14 Q Okay. And how did you come by a hematology
15 textbook?

16 A Oh, they're in the library. They're in our
17 physicians lounge.

18 Q Okay.

19 A Some of the material I have myself in
20 textbooks on neonatology in the hematology section.
21 That kind of thing.

22 Q Sure. Okay. And did you make copies of
23 some of the text in those textbooks?

24 A At some point, yes.

25 Q Okay. And you still have those copies?

11

1 A I have copies that were sent to the State.

2 Q That were sent to the State?

3 A The State board. Right. That's who you
4 originally sent it, materials that the State was
5 asking for.

6 Q Got it.

7 A Nevada State Board of Medical Examiners.
8 That's what they're called.

9 Q Okay. So the Nevada State Board of Medical
10 Examiners investigated this claim?

11 A Yes.

12 Q Okay.

13 A That's their standard procedure.

14 Q All right. And when was that proceeding
15 held?

16 A Can I ask what was the date of the original
17 complaint?

18 Q You can. I don't know if I can tell you.
19 May of --

20 MR. COTTON: May 14, 2010.

21 BY MS. CARMICHAEL:

22 Q 2010.

23 A Okay. So this is probably within six months
24 from that time.

25 Q Okay. And who attended those proceedings?

12

1 A None, no, no meetings were required. Just a
2 written response.

3 Q I see. Okay. And did you have the
4 assistance of counsel in preparing that response?

5 A Yes.

6 Q Okay.

7 MS. CARMICHAEL: Is that response protected,
8 John, under your state laws here?

9 MR. COTTON: Uh-huh.

10 BY MS. CARMICHAEL:

11 Q Okay. All right. Your counsel provided me
12 with a copy of your CV. And prior to the commencement
13 of your depo, I asked you to review it. Is that
14 indeed a current, up-to-date copy of your CV?

15 A Yeah, from what I looked at, it looks this
16 is pretty much so.

17 Q Okay, great. We will mark that as Exhibit 1
18 to your deposition. I have just a few questions.

19 It appears that you attended medical school
20 at the University of Wisconsin?

21 A Yes.

22 Q And graduated in 1993?

23 A Yes.

24 Q Okay. And you then completed a pediatric
25 internship at the University of California at Irvine?

13

15

1 A That's correct.
2 Q And a pediatric residency at UCLA?
3 A That's correct.
4 Q Okay. And then a neonatal fellowship at
5 USC. Correct?
6 A Yes, University of Southern California.
7 Q Okay. And you completed that fellowship in
8 1999?
9 A That's correct.
10 Q Okay. Are you board certified in
11 neonatology?
12 A Yes.
13 Q And when did you obtain your board
14 certification?
15 A Soon after 1999, but I apologize, I forget
16 the date.
17 Q That's okay. And how long is that
18 certification good for?
19 A Nine years.
20 Q Are you due to renew?
21 A I renewed.
22 Q Okay. And did you pass your boards on your
23 first attempt?
24 A Yes.
25 Q Okay. Okay. It appears that after the

1 A That's correct.
2 Q All right. You were with the Children's
3 Healthcare Network through 2009?
4 A Yes, ma'am.
5 Q And then just moved in 2009 over to
6 Pediatrics?
7 A That's correct.
8 Q Okay. But during both of those employments,
9 it looks like you pretty much exclusively worked at
10 Sunrise Children's Hospital and Mountain View Hospital
11 as a staff neonatologist. Is that right?
12 A That's correct.
13 Q Okay. In your capacity as a staff
14 neonatologist at Sunrise Children's Hospital from 2007
15 to the present, who bills for your services? Who
16 bills the patients for your services, if you know?
17 A Well, we generate codes, and those are
18 reviewed. And if they're wrong, then it's brought
19 back to us.
20 Q Well, and what I mean is, does the patient
21 receive a bill for your services from Sunrise
22 Hospital, or from Pediatrics Medical Group, if you
23 know?
24 A I don't know.
25 Q Okay.

14

16

1 completion of your neonatal fellowship at USC, you
2 remained there in a number of capacities for quite a
3 few years. Is that right?
4 A That's correct.
5 Q Through 2007?
6 A Yes.
7 Q Okay. And following that, it appears that
8 you moved to Las Vegas? Yes?
9 A Yes, ma'am.
10 Q And you've listed on your CV your current
11 employment is with Sunrise Children's Hospital. Is
12 that right?
13 A I think it's Pediatrics where I'm employed.
14 And I'm credentialed at Sunrise.
15 Q Okay.
16 A If I have that correct.
17 Q Through your -- okay, you're referring to
18 Pokroy Medical Group of Nevada?
19 A Yes.
20 Q D/b/a Pediatrics Medical Group of Nevada?
21 A That's correct.
22 Q Okay. And is that group affiliated with the
23 Children's Healthcare Network?
24 A No.
25 Q Two separate entities?

1 A I'm just doing my job.
2 Q Okay. Who pays, or how are you compensated
3 for your services?
4 A I'm salaried.
5 Q You're salaried by Pediatrics?
6 A Uh-huh. That's right.
7 Q All right. Who sets your schedule?
8 A The medical director.
9 Q Of Sunrise Hospital?
10 A No.
11 Q Of Pediatrics Medical Group?
12 A Of the Neonatal Intensive Care at Sunrise.
13 Q Okay.
14 A Who is also an employee of Pediatrics.
15 Q Okay. So the medical director of the NICU
16 at Sunrise is an employee of Pediatrics Medical Group?
17 A That's correct.
18 Q Okay.
19 A But not in 2008.
20 Q Okay. In 2008, who was setting your
21 schedule?
22 A It was the medical director, who worked for
23 Children's Healthcare Network, just like me.
24 Q Got it.
25 A There was no Pediatrics.

17

1 Q Okay, I understand.

2 A At Sunrise.

3 Q All right. And these medical directors that
4 you're referring to, do they also set the schedule,
5 your schedule for your work at Mountain View Hospital?

6 A That's correct.

7 Q Okay. Do you have a contract with
8 Children's -- did you have a contract with Children's
9 Healthcare Network in 2008?

10 A Yes, I did.

11 Q And do you still have a copy of that
12 contract?

13 A I do not.

14 Q Do you have a contract, copy of your
15 contract with Pediatrics Medical Group?

16 A I think so. But I would have to dig for it.

17 Q Okay. All right. Have you ever been paid
18 directly by Sunrise Hospital?

19 A Only when my son was born, I was getting
20 physicians, employee, employee compensation for
21 medical bills for my wife's birth. And they extend
22 that to all employees.

23 Q Okay. Sunrise extends that to all
24 employees?

25 A Yes.

18

1 Q So anyone that works at Sunrise Hospital
2 receives a benefit in the form of employee
3 compensation when their family members deliver at
4 Sunrise?

5 A I believe that's correct, yes.

6 Q Okay. Any other form of compensation you
7 receive from Sunrise?

8 A We get physicians lounge, food.

9 Q They feed you there?

10 A Limit, on a limited basis.

11 Q No steak and lobster. Okay.

12 Do you consider yourself an employee of
13 Sunrise?

14 A Pediatrics.

15 Q Okay.

16 A I'm an employee of Pediatrics.

17 Q All right. But it's Sunrise Hospital that
18 extends the benefit of the employee compensation when
19 your wife gave birth there? Did I understand that
20 correctly?

21 A That's, that's what I said, yes.

22 Q Okay. Okay. Do you know whether or not
23 Pediatrics maintains the medical charts, or is it
24 Sunrise Hospital that maintains the medical charts?

25 A I believe it's the latter.

19

1 Q Okay. Have you ever appeared in any print,
2 television, or any other kind of advertising for
3 Sunrise Hospital?

4 A No.

5 Q Okay. Do you tell your patients -- or
6 considering that your patients are babies -- their
7 parents, those that you treat at Sunrise that you're
8 not an employee of Sunrise Hospital?

9 A Such a conversation doesn't arise.

10 Q Okay. All right. In providing neonatal
11 care to a premature infant, do you believe it is
12 important to know what occurred during the prenatal
13 course?

14 A Yes.

15 Q Okay. How do you go about finding that
16 information out?

17 A Several ways.

18 Q Such as?

19 A We get consults from the obstetricians for
20 us to come and speak with the families, review the
21 obstetrical history.

22 Q Review the obstetrical history through
23 conversations with the Ob-Gyn and the patient?

24 A Several things can happen in that regard.

25 Q Such as?

20

1 A If it's a consultation, then I'll review the
2 chart in addition to maybe or maybe not speaking with
3 the obstetrician.

4 But sometimes I may receive a call from the
5 obstetrician not requiring, not requesting a consult,
6 but alerting me as the attending neonatologist about
7 the issues of the delivery.

8 Q Okay.

9 A Or if there's prenatal diagnosis,
10 particularly if it's cardiac in nature, we'll receive
11 the fetal echo.

12 Q Okay.

13 A And maybe have a conversation with the
14 cardiologist regarding that case.

15 Q All right. Do you believe it is important
16 for you as the neonatologist to know about any
17 abnormal test results that might have occurred during
18 the prenatal period?

19 A Possibly, but not necessarily.

20 Q Depending on the test. Right?

21 A Yeah, if it's relevant.

22 Q Okay. If the birth mother was consulting
23 with a perinatologist during the prenatal course,
24 would it be important for you to know that?

25 A Maybe.

21

1 Q During your education and training as a
2 neonatologist, did you receive any training or
3 knowledge regarding the clinical significance that an
4 abnormal nuchal translucency or a nuchal fold test
5 result might have?

6 A Yes.

7 Q Okay. And what did you receive in that
8 regard?

9 A In, in what way do you mean that?

10 Q Well, what information did you receive
11 regarding the clinical significance of an abnormal
12 nuchal translucency or nuchal fold test?

13 A That it might mean nothing. Or it might be
14 associated with trisomy 21. And there are other
15 possibilities as well, so.

16 Q Trisomy 21 is Down's Syndrome?

17 A That's correct.

18 Q Okay. And so an abnormal nuchal
19 translucency could indicate Down's. Correct?

20 A Yes.

21 Q It may also indicate other chromosomal
22 abnormalities?

23 A I believe so.

24 Q Okay.

25 A I'm not certain.

22

1 Q Are you aware of whether or not it may
2 indicate cardiac problems?

3 A No.

4 Q Okay. Are you aware of whether or not it
5 may indicate possible genetic birth defects?

6 A Well, we've already mentioned that.

7 Q Okay.

8 A We already mentioned also they may be
9 normal.

10 Q Sure. Okay. Is that something you would
11 want to know about though when you go to treat a
12 newborn in the NICU? Would you want to know whether
13 or not that baby had had an abnormal nuchal
14 translucency or nuchal fold result?

15 A Not necessarily.

16 Q Okay. Did you come to know that MayRose
17 Hurst had, was, was a child that had an abnormal
18 nuchal translucency result?

19 A At what point in the pregnancy?

20 Q I can't remember which week.

21 A This baby was delivered at 28 weeks. And
22 often these findings are 12, 13, 14 weeks, from what I
23 call, and then they spontaneously resolve. That's why
24 I mention that it's not necessarily indicative of
25 pathology.

23

1 Q Okay. But did you, did you ever learn --
2 I'm asking you from your memory now. Do you remember
3 finding out or learning, when you assumed MayRose's
4 care, that she had had an abnormal nuchal translucency
5 result?

6 A I don't remember.

7 Q You don't remember? Okay.

8 During your medical education and training,
9 did you receive any information regarding the
10 diagnosis and treatment of blood disorders?

11 A Yes.

12 Q Okay. And what did you receive in that
13 regard? How extensive was that?

14 A At what point in my training are you
15 referring?

16 Q At any point in your training.

17 A That would include during medical school,
18 during residency, and during fellowship.

19 Q Okay. So during all three of those you
20 received training regarding the diagnosis and
21 treatment of blood disorders?

22 A Yes.

23 Q Okay. Did you receive any education or
24 training with respect to how to differentiate between
25 anemia due to prematurity and anemia caused by a

24

1 specific blood disorder or genetic defect?

2 A Yes.

3 Q Okay. And other than MayRose, have you ever
4 cared for an infant in the NICU who had anemia as a
5 result of a genetic defect or a specific blood
6 disorder?

7 A Yes.

8 Q On how many occasions?

9 A It's impossible for me to say.

10 Q Are they numerous?

11 A I don't recall.

12 Q Okay. Well, on any of those occasions, were
13 you the physician that diagnosed the blood disorder?

14 A Possibly.

15 Q You don't remember?

16 A I don't recall specifically.

17 Q Okay. All right. What are the most common
18 symptoms of anemia due to prematurity?

19 A There may be no symptoms. Or there may be
20 some mild symptoms.

21 Q Such as?

22 A That could include tachycardia. That could
23 include pallor. That could include inadequate oxygen
24 delivery to tissues.

25 Q Which would manifest in what way?

25

1 A Metabolic acidosis, lactic acidemia.
 2 Q Okay. Low hematocrit, is that a symptom of
 3 anemia due to prematurity?
 4 A That's a, a lab finding.
 5 Q Okay. Is it -- all right. Anything else
 6 you want to include in that?
 7 A Yeah, there are other things, too.
 8 Q What are the most common symptoms of
 9 thalassemia?
 10 A Which type of thalassemia?
 11 Q Let's go with alpha.
 12 A Alpha thalassemia?
 13 Q Uh-huh.
 14 A It depends on the type of alpha thalassemia
 15 you're referring to.
 16 Q Okay. Well, what are some common symptoms
 17 of that disease condition?
 18 A Like I said, it depends on the type of alpha
 19 thalassemia you're referring to.
 20 Q Well, you can differentiate that for me in
 21 your response.
 22 A And it also depends on at what age you're
 23 looking at the disease condition.
 24 Q Okay. In an infant that has thalassemia,
 25 what symptoms would you expect to see?

26

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

27

1 Q Okay, what about tachycardia?
 2 A If it's associated with significant anemia,
 3 yes.
 4 Q Okay. What are the most common symptoms of
 5 Diamond-Blackfan anemia?
 6 A Bone marrow failure, I believe.
 7 Q Which manifests in what way?
 8 A If there's profound anemia, then the child
 9 would have symptoms of anemia.
 10 Q Which would include a low hematocrit?
 11 A Yes.
 12 Q Pallor?
 13 A Yes.
 14 Q Tachycardia?
 15 A Yes.
 16 Q So essentially the same symptoms that are
 17 common to anemia due to prematurity. Correct?
 18 A No. That's incorrect.
 19 Q Well, I asked you what are the most common
 20 symptoms of anemia due to prematurity, and I believe
 21 you told me tachycardia --
 22 A No.
 23 Q -- pallor --
 24 A You didn't. That's not correct.
 25 Q -- low hematocrit.

28

1 A No. You asked me when there are symptoms
 2 present, what are those symptoms. And I listed those
 3 symptoms.
 4 Anemia prematurity most commonly is not
 5 going to be associated with any symptoms.
 6 Q Okay.
 7 A There's a big difference there.
 8 Q So what you're telling me is that generally,
 9 in most cases, anemia of prematurity will have no
 10 symptoms?
 11 A Let me put it this way: Somewhere between
 12 90 to 100 percent, at least in the neonatal practice
 13 I'm at now, and I know this is true historically, in,
 14 with respect to other NICU's I've worked and the
 15 colleagues I've worked with, 90 to 100 percent of very
 16 low birth weight, which is a specific category, and
 17 extremely low birth rate babies get this diagnosis of
 18 anemia prematurity.
 19 Q Based on what?
 20 A Based on the fact that they're only one to
 21 two pounds, two and a half pounds, and have very
 22 little blood volumes, and require repeated phlebotomy.
 23 So their ability to compensate by producing red blood
 24 cells is limited. So they're all going to go through
 25 a phase of anemia prematurity.

29

1 So there's nothing spectacular about ever
2 having that diagnosis.

3 Q Okay. And just so I can be sure then, are
4 you saying that generally, not always, but generally,
5 babies with anemia of prematurity are not going to
6 have tachycardia, or pallor, or low hematocrit?
7 They're not going to have those things present?

8 A In the majority of cases, what you want to
9 do is look at the clinical situation that the child's
10 in. And that makes a big difference. Okay? Because
11 one baby may have a hematocrit of 25 and is ready to
12 go home, another baby may have a hematocrit of 35 and
13 needs to have a blood transfusion.

14 Q Okay.

15 A So there's a lot to consider when you're
16 asking that kind of question.

17 Q Okay. Understood. But this deposition will
18 literally take until midnight if you -- I just need
19 you to answer the question put to you. If you would
20 do that, that would be great.

21 So my question to you is, are you telling me
22 that the majority of babies diagnosed with anemia due
23 to prematurity do not have symptoms of tachycardia,
24 pallor, or low hematocrit?

25 A That's right -- well, low hematocrit maybe.

30

1 But that doesn't imply they have symptoms. That's a
2 lab value. Talking about, there's two things here.
3 So, they have -- by definition, if you're saying this
4 child has anemia, the hematocrit is low.

5 Q By definition?

6 A And it becomes a relative thing of how low
7 is low.

8 Q Okay. All right. Okay. What symptoms or
9 lab values would a premature infant in your NICU, that
10 you're caring for, have to have in order for you to
11 begin to suspect that their anemia may not just be due
12 to their prematurity? In other words, that there's
13 some more serious cause at work?

14 A That's a good question. This is going to
15 depend as well. But looking for an actual value, I
16 would definitely say any hematocrit less than 20 is
17 very abnormal and needs to seek an explanation.

18 Q Okay.

19 A But if I can qualify in another way. A
20 hematocrit that, for that age, gestational age and
21 postnatal age, two standard deviations below the norm,
22 by definition, is anemia, with or without symptoms.
23 And that can be very different values depending on
24 what specific patient you're looking at.

25 Q Okay. But I would, I would suspect that if

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1 you have an infant in your NICU that has been having
2 low hematocrits, you're never going to let them get
3 below 20 before you transfuse, are you? I mean you'll
4 transfuse them before they ever get below 20, wouldn't
5 you?

6 A Your question was what value is, would I
7 consider significant anemia requiring transfusion.
8 Twenty is the value.

9 Q Oh, so you don't even think transfusion is
10 necessary until they get below 20?

11 A I didn't say that. Some patients need to be
12 transfused when their hematocrit is 35 or even 40.
13 Some babies can go home if their hematocrit is 25.

14 Q Okay.

15 A Okay?

16 Q And where we started with all of this was I
17 asked you what symptoms an infant in your NICU would
18 have to have for you to suspect that something more
19 than anemia and prematurity was going on. And I
20 believe your answer was they would have to have a
21 hematocrit lower than 20. Is that what you told me?

22 A I'm not sure.

23 Q Well, is that true?

24 A Can you restate that, please?

25 Q Yeah. What symptoms would a premature

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1 infant that you're caring for in your NICU have to
2 have in order, symptoms or lab values, in order for
3 you to suspect that their anemia is not simply due to
4 prematurity, that there's a more serious cause?

5 A There's, this is such a difficult question
6 to answer, because there are multiple scenarios that
7 would require me as a clinician to consider different
8 aspects of why that child may be having some symptoms.
9 And for me to just give a single blanket answer is
10 really not possible.

11 Q If the child's birth parent has a genetic
12 history of thalassemia and the child is showing up
13 with low hematocrits, is that factor, the parent with
14 thalassemia in their history, is that going to lead
15 you to conduct, to test for thalassemia?

16 A Absolutely. As a general rule, this is
17 correct. Because that's an inheritable condition.
18 Yes.

19 Q Okay. And do you know whether or not
20 MayRose Hurst was tested for thalassemia?

21 A She had a State blood standard newborn
22 screen that looks for hemoglobinopathies, and that's
23 one of them.

24 Q Okay. And do you know the results of that
25 test?

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1 A I don't know the result of that test.
2 Q Is that a test result that would come back
3 to you?
4 A Yes, we would know it's abnormal.
5 Q Okay. Incidentally, I can't find that test
6 result in the medical chart. Do you know where it
7 would be?
8 A Yeah, it's usually at the beginning of the
9 chart. The nurses keep all of that in there. At
10 least now.
11 Q Okay.
12 A But this state has an obligation to, to
13 contact us when we have an abnormality they find in
14 that test.
15 Q Okay. What about knowing that the infant
16 had an abnormal nuchal translucency test result, would
17 that lead you to consider testing for a genetic blood
18 disorder in lieu of assuming that the anemia was due
19 to prematurity?
20 A I don't understand the connection between
21 the nuchal translucency and anemia prematurity.
22 Q That's what I'm asking you is if in your
23 view there is a connection between a nuchal, an
24 abnormal nuchal translucency result and the
25 possibility that the child might have a genetic blood

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

35

1 cells break down, and there are new cells coming into
2 the circulation.
3 Q Right. So what is the clinical significance
4 of a low reticulocyte count?
5 A It depends on the clinical scenario that
6 you're referring to.
7 Q Okay. Are you aware that a low reticulocyte
8 count is consistent with Diamond-Blackfan anemia?
9 A Yes.
10 Q Okay. Are you aware that a low hematocrit
11 is consistent with Diamond-Blackfan anemia?
12 A Yes.
13 Q Okay. Now, I assume that there are lots of
14 testing, or various tests that can be done to get to
15 the bottom of the actual cause of an infant's anemia.
16 Yes?
17 A Yes.
18 Q Okay. Bone marrow aspiration is one such
19 test? Yes?
20 A Yes.
21 Q Okay. Analyzing red blood cells under a
22 microscope might be one?
23 A Yes.
24 Q Okay. Bringing in a hematologist to consult
25 might be another avenue?

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1 A Yes.
2 Q Okay. Would you agree with me that some
3 forms of anemia are not particularly dangerous to a
4 patient, while other forms can be potentially life
5 threatening?
6 A It's a very broad question. It's hard to
7 answer.
8 Q Well, you can disagree, I mean. Are some
9 anemias more serious than others?
10 A Absolutely.
11 Q Okay. And are some anemias in fact
12 potentially life threatening if not properly treated?
13 A Yes.
14 Q Okay. When a physician is faced with
15 several possibilities regarding a patient's diagnosis,
16 the physician generally uses a tool called
17 differential diagnosis. Right?
18 A That's correct.
19 Q Okay. And if that differential diagnosis
20 includes any conditions that may be life threatening,
21 then the whole purpose of the differential is to rule
22 out those potentially life-threatening conditions
23 first in order to preserve the health and well-being
24 of the patient. Right?
25 A No.

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1 Q Okay. Tell me how you disagree with that.

2 A Well, you bring up -- If that were true, we
3 would bring up scenarios that both would not be
4 practical as well as potentially invasive and costly.
5 So clinical decision-making has to be prudent first
6 and foremost.

7 Q Okay. If you have in your differential
8 diagnosis a potentially life-threatening condition,
9 are you telling me then that it would not be
10 appropriate to rule it out?

11 A No, I'm not saying that.

12 Q Okay, what are you saying?

13 A The issue is whether or not I'm going to put
14 that diagnosis in my differential in the first place.

15 Q Okay. And that would be based on whether it
16 would be costly to test for?

17 A Based on a number of scenarios. Not costly,
18 per se. But if you're talking, what you said,
19 potentially life-threatening diagnosis, that's, needs
20 to be considered to be put in the differential
21 diagnosis. There are many that are just not prudent,
22 it's not -- not not practical, but they're not high in
23 the radar, as we say.

24 Q Okay.

25 A With respect to likelihood given the

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1 information for that case.

2 You could not practice medicine if you're
3 going to include 20 things on your differential
4 diagnosis every day that you look at the patient.
5 Because there's lots of things that could be
6 potentially life threatening.

7 Q Okay. But if you have an infant in your
8 neonatal unit that has anemia, and continues to have
9 anemia throughout her course in your neonatal unit,
10 and as of the time of her discharge shows a pattern
11 that her hematocrit is continuing on the downward
12 trend based on the last several CBC's that were done,
13 and also has a very low and falling reticulocyte
14 count, don't you think it would be important to get to
15 the bottom of what was going on?

16 MR. COTTON: Form objection, argumentative,
17 assumes facts not remotely in evidence.

18 Go ahead. Go ahead and answer if you can.

19 BY MS. CARMICHAEL:

20 Q You can answer.

21 A That assumes a lot of different things in
22 this scenario. I would have to specifically look at
23 the numbers you're referring to, to make a proper
24 judgment about whether that's the case.

25 Q You, of course, know and understand that

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1 there are many different types of anemia? Yes?

2 A Yes.

3 Q And there are also many different causes for
4 anemia? Yes?

5 A Yes.

6 Q Okay. And that notwithstanding in MayRose
7 Hurst's case, it was assumed that her anemia was due
8 to her prematurity. Is that your understanding?

9 A No, that's incorrect.

10 Q Okay. Correct me then.

11 A Like I mentioned before, anemia of
12 prematurity in critically ill, very low birth weight,
13 extreme low birth rate babies that have long
14 hospitalizations is a diagnosis that's in the chart
15 probably 90 to 100 percent of the time. So there's
16 nothing surprising about that. But that doesn't
17 explain other things that can happen to patients,
18 specifically MayRose. So we have other reasons for
19 her anemia and her choices that were made by
20 clinicians to give her blood transfusions.

21 Q Okay. Do you dispute that the diagnosis of
22 anemia due to prematurity appears throughout her
23 medical chart?

24 A No.

25 Q You're just disagreeing with that diagnosis?

40

1 A No. I'm saying that's not the reason
2 necessarily that she received blood transfusions.

3 Q Well, in your opinion, did she or did she
4 not have anemia due to prematurity?

5 A Yes.

6 Q She did?

7 A Yes.

8 Q Okay. A differential diagnosis regarding
9 the cause of her anemia was never undertaken by your
10 NICU staff, was it?

11 A Yes, it was.

12 Q In, in what way?

13 A Well, when you look at the day-to-day
14 management of this patient, this child was reviewed in
15 great detail by systems: Neurologic, respiratory,
16 cardiovascular, fluids, nutrition, infectious
17 diseases, hematology, renal, all these different
18 systems on a day-to-day basis. And orders were
19 written to take care of this child, maintaining the
20 standard of care. So she got excellent care.

21 Q I'm talking about testing to determine what
22 the cause of her anemia was. I'm not talking about,
23 you know, what Doctor Scheidler did during his
24 necrotizing enterocolitis surgery. I'm not talking
25 about, you know, what Infectious Disease did to treat

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

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

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1 A No.
 2 Q And why not?
 3 A The use of EPO, as we call it, to make it
 4 easier --
 5 Q I like that.
 6 A -- fell out of significant use relative to
 7 what it was ten years ago because of high cost, its
 8 ineffectiveness, and third its association with
 9 significant eye disease.
 10 Q Okay. You've said a couple of times that
 11 you -- we, we knew what the cause of her anemia was.
 12 So what, what was it that you knew? What was the
 13 cause of her anemia?
 14 A There's two phases you want to break it down
 15 into.
 16 Q Go ahead.
 17 A The baby received 11 blood transfusions
 18 during the course of an 80-day hospitalization.
 19 Q Uh-huh.
 20 A And four of those, which is, what,
 21 40 percent or so, were received within the first 72
 22 hours. And we know why that is.
 23 A And now you've got seven blood transfusions
 24 in 77 days, if my math is correct, which for a baby
 25 that's only two and a half, a little more than two and

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

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1 THE WITNESS: We know that giving a blood
2 transfusion suppresses endogenous erythropoietin
3 production, which means they don't have
4 reticulocytosis until the blood level goes down again.
5 So it's expected that the hematocrit -- the retic
6 count would be low.

7 BY MS. CARMICHAEL:

8 Q For about eight days after the transfusion.
9 Right?

10 A I don't know.

11 Q You don't know?

12 A I'm not certain. It's a, it's a, it's a
13 gradual process. So that's, so to be specific, I
14 don't know.

15 Q Okay.

16 A It's not like all of a sudden the bone
17 marrow starts making all these cells and the
18 reticulocyte count might be normal. It's a gradual
19 process.

20 Q Was it, is it -- I understand you weren't
21 treating her there at the end. But knowing the
22 information now, that on July 14 her reticulocyte
23 count was .9, and on August 1 it was .5, is that kind
24 of a decrease in that short amount of time, does that
25 have any clinical significance to you?

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1 A I don't know.

2 Q You don't know. Might a hematologist know
3 if that has clinical significance?

4 A The hematologist would say that it's
5 expected.

6 Q A hematologist would say that that is
7 expected?

8 A Yes. And that's consistent with published
9 data of levels that go down to .2, .1, this kind of
10 thing.

11 Q You're talking about in the face of blood
12 transfusions?

13 A Not necessarily.

14 Q In the aftermath --

15 A No, it's what's called a nadir. The
16 endogenous production of erythropoietin does not kick
17 in, so to speak, until the nadir is reached, which may
18 be a hematocrit of 20 to 22.

19 So the level of the reticulocyte count is
20 expected to be on the lower side. Especially in the
21 case of transfusions. So it doesn't have a great deal
22 of, of meaning in signifying disease processes.

23 Q Okay. Well. Are you aware of types of
24 anemia where the reticulocyte count would actually be
25 high?

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1 A Yes.

2 Q Because of the anemia?

3 A Yes.

4 Q Okay. What, when does that occur?

5 A When you got rapid red blood cell
6 destruction. Hemolysis, it's called.

7 Q Okay.

8 A And hemolysis occurs in a number of
9 conditions.

10 Q Do you know whether or not MayRose's anemia
11 was microcytic, normocytic, or macrocytic?

12 A Yes.

13 Q What was it?

14 A It was macrocytic which is consistent with
15 prematurity. The MCV was high. But after multiple
16 transfusions, because she was of course bleeding
17 internally, then it becomes an impossible value to
18 follow.

19 So this question is only relevant at the
20 time of birth.

21 Q Are you familiar with medical literature
22 that says that anemia due to prematurity is
23 characterized by normocytic cells?

24 A There's lots of types of prematurity.

25 There's a spectrum of prematurity. So you have to be

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1 specific when you ask that kind of question.

2 Q Okay. Are you aware that Diamond-Blackfan
3 anemia, that macrocytic is consistent with
4 Diamond-Blackfan anemia?

5 A Yes. Yes.

6 Q Okay. A low reticulocyte count is also
7 potentially indicative of bone marrow disorders, or
8 aplastic crisis, isn't it?

9 A That's a rare thing. It's not common.

10 MS. CARMICHAEL: Let's go ahead and mark
11 that as 1.

12 (Plaintiffs' Exhibits 1 and 2 marked for
13 identification.)

14 BY MS. CARMICHAEL:

15 Q Okay, Doctor Blahnik, Exhibit 2 to your
16 deposition will be the Neonatal Admission History and
17 Physical. Did you prepare this document?

18 A Yes.

19 Q Okay. It's my understanding that you were
20 actually the admitting -- MayRose's admitting
21 physician? Is that correct?

22 A I'm the admitting physician of record, yes.

23 Q Okay. In several places throughout the
24 medical record, it refers to you as the attending
25 physician as well. Was, was that your understanding

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1 of your role in MayRose's care?

2 **A** I was the physician of record. I was the
3 neonatologist that was on the day the child was born.

4 **Q** Okay. Does that mean then that she's
5 essentially your patient and you are going to follow
6 her all the way through to discharge?

7 **A** Absolutely not.

8 **Q** Okay. Tell me what it means then to be the
9 admitting physician?

10 **A** It's, it's required in the multiple NICU's
11 where I've worked, there always must be an attending
12 neonatologist as a physician of record.

13 The way it works at Sunrise, whether it's
14 under the new medical director in Pediatrics, the old
15 medical director at Children's Healthcare Network, or
16 the NICU's I worked with when I was on faculty at USC,
17 I've come across the same thing. There must be a
18 physician of record at the time the child is admitted.

19 If a new neonatologist comes in the next
20 day, technically, that should be changed. And the day
21 after that. It would become a logistic secretarial
22 nightmare to change 50 patients on an almost daily
23 basis.

24 Now, when I was at Children's Hospital in
25 Los Angeles, we would have an attending, as you call

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1 It, attending hematologist who might be on two weeks,
2 three weeks, and maybe four weeks, once upon a time.
3 We went through changing that by the secretary. But
4 even they abandoned it because it's just too
5 cumbersome to switch that name.

6 **A** And in our practice where we may be on three
7 days, four days, one day, two days, and multiple
8 patients, to change the neonatologist physician of
9 record for that day is not possible. So our medical
10 director did the correct thing by just leaving it
11 alone.

12 So it means nothing other than I admitted
13 the patient that day. And the responsibility from one
14 day to the next came upon the group.

15 **Q** Got it. Okay. So reviewing your neonatal
16 admission history and physical for MayRose, it appears
17 that she was born at 28 and 6/7 weeks. So one day
18 short of being 29 weeks. Correct?

19 **A** Yes.

20 **Q** Okay. Tell me, in your experience and with
21 your training, what is the viability generally of an
22 infant of that age?

23 **A** In the 21st Century in this day and age?

24 **Q** Yes.

25 **A** It's very good.

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1 **Q** Okay.

2 **A** So when you mean viability, I assume you
3 mean survival?

4 **Q** Yes.

5 **A** Yeah. So it's going to be 90 percent.

6 **Q** Okay. And when you look at her birth
7 weight, the 1280 grams, is that, for a premature baby
8 of her age, is that a fairly typical weight? Is it
9 lower than you would expect for that age? Is it
10 higher than you would expect?

11 **A** This is what we would call AGA, which is
12 appropriate for gestational age.

13 **Q** Okay. All right. Knowing that -- well,
14 were you present for the delivery of the baby?

15 **A** Yes.

16 **Q** Okay. You were standing by ready to address
17 whatever issues she may have?

18 **A** Let me restate that. I'm not a hundred -- I
19 remember that night. But I'm not a hundred percent
20 sure I was actually at the delivery.

21 Our policy at the time was 27 weeks and
22 younger the neonatologist would attend the delivery.
23 We are always on -- this is at night, you know, just
24 after midnight -- we're always on with either a
25 hospitalist or a neonatal nurse practitioner. In this

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1 case, it was Katherine Felongco, if I remember
2 correct.

3 It's entirely possible that she went to the
4 delivery, brought the child down, called me, middle of
5 the night kind of thing, and I came out of my call
6 room, because I remember being by the bedside. But I
7 don't want to misspeak and say I was actually at the
8 C-section.

9 **Q** Okay. Fair enough. So knowing though that
10 you were about to assume the care of a premature baby
11 of this age, before we get specifically to MayRose's
12 issues, what types of concerns or issues would you be
13 anticipating in a child of this age?

14 **A** Again, we look at our children by systems.
15 So there's neurologic, respiratory, cardiovascular,
16 going down the line, head to toe, so to speak. And
17 number one in this age group is, generally speaking is
18 going to be the respiratory status.

19 **Q** Okay.

20 **A** Then we go through what we call A, B, C's,
21 which is part of that airway, breathing, circulation,
22 circulate, critical. That means is the heart doing
23 what it's supposed to? If the lung is doing what it's
24 supposed to, we can assist the lung, but we need to
25 make sure the heart is as well. Receiving blood

53

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

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

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

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

19 A No.

20 Q -- from any of the --

21 A No, the obstetrician --

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

24 BY MS. CARMICHAEL:

25 Q Any of the mother's physicians?

54

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

3 Q Okay. Did you obtain that history later?

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

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

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

10 Q That the nurses have taken orally from the
11 mother?

12 A No, it's in her chart.

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

16 A I don't recall.

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

19 A I don't recall.

20 Q Okay --

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

23 Q Go ahead.

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

55

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

8 Q Okay.

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

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

16 A Yeah, a little bit.

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

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

22 Q Where are you referring?

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

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

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

6 Q Okay.

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

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

13 A Neonatal world.

14 Q Okay.

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

19 Q Are you critical of the administration of
20 those medications?

21 A I'm not an obstetrician.

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

24 A Yes.

25 Q What was that?

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1 A Indocin is used as a tocolytic, and steroids
2 are used to accelerate lung maturation.

3 Q Okay. But it's your position that the
4 steroid and the tocolytic should not have been
5 administered together, that they're contraindicated?

6 A They're, we don't use them in neonatology
7 because of the risk for GI pathology. And I know that
8 the FDA has warnings on the use of these medications
9 during pregnancy because of these issues.

10 Q Okay. Okay. There's a coding summary in
11 the chart that indicates that you, at some point you
12 gave MayRose an influenza type B vaccination. How
13 long does that vaccination last? How long is that
14 good for?

15 A I'm not certain. I believe it's once per
16 season. But it's possible that infectious disease in
17 prematurity it's not as effective.

18 Q Okay. Okay. Did you ever speak with
19 Mrs. Hurst about any of the testing that had been done
20 during the prenatal period?

21 A What testing are you referring to?

22 Q She was tested for cystic fibrosis. The
23 perinatologist had her do some chromosomal abnormality
24 testing. Were you aware of --

25 A Oh, she's advanced maternal age, yeah. I

58

1 don't recall.

2 Q Okay. Do you have an independent memory of
3 MayRose?

4 A I remember the bed she was at. I remember
5 she was very low birth weight, small baby.

6 Q Okay.

7 A And I remember her being sick. But I don't
8 remember like what her face looked like, so to speak.

9 Q I'm sure you see a lot of baby faces between
10 now and then.

11 A Yeah.

12 Q Okay. From your review of the record, what
13 do you recall were May's issues when she was born?

14 A Well, one of the, you'll notice that the
15 baby was intubated and received surfactant. So was on
16 a respiratory and was getting this medicine for the
17 lungs.

18 And then the breathing tube was pulled out
19 fairly quickly. And if it was a colleague instead of
20 me, they probably would have kept it in a little
21 longer. Because I push the idea of early extubation.
22 So that's my bias.

23 And then of course the next day she got
24 really sick. That didn't come into play with, you
25 know, obviously, her GI pathology. But that's what

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1 was going on. So we had, she was back on the
2 respirator within that first day.

3 Q But it was not due to lung issues, it was
4 due to her need to go to surgery. Right?

5 A That's incorrect. It was really both.

6 Q Okay.

7 A Yeah.

8 Q All right. So you had perhaps extubated her
9 prematurely?

10 A You can say that in retrospect. It's okay,
11 because the ventilator has risk factors to injuring
12 the lung with inflation. So it's a good practice to
13 get the tube out. There's nothing controversial about
14 that.

15 Q Okay. Not taking issue with that.

16 What -- so you were telling me about her
17 issues?

18 A Yes. The impressive thing about this case
19 is a perforation through the bowel wall and
20 necrotizing enterocolitis. So those two diagnoses she
21 had in less than 24 hours from birth.

22 The impressive thing about that is that's
23 not really how that disease really occurs. NEC is
24 associated with feedings. MayRose was never fed. NEC
25 is associated with after day ten, or two weeks, even

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1 three, four weeks. This is very early.

2 So I put it in the note, and that's my
3 original thinking, especially because the hematocrit
4 was on the low side, is this could be a gastric
5 perforation. Isolated gastric perforation.

6 But that's not what it was. It was NEC.

7 And why is that? And so we have to go back
8 to these medications. This combination that we don't
9 use in neonatology. Both of these drugs readily cross
10 the placenta. We know that. And so she was bleeding
11 internally.

12 Q Okay. And that is what caused the NEC, the
13 N-E-C?

14 A The, I don't know what caused it. But we
15 know these are risk factors.

16 Q Okay.

17 A And the FDA has warnings about those drugs.

18 Q Okay. So --

19 A We would presume that that's, that's -- It's
20 risk/benefit. There's benefits to stopping preterm
21 labor. There's benefits to steroids. They do a great
22 job in improving lung function, issues with the brain,
23 and this kind of thing.

24 Q Okay.

25 A So it's a risk/benefit decision-making tree

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1 that, you know, the obstetrician was making.

2 Q Okay. What other issues were you aware of
3 that May experienced during her stay in the NICU?

4 A Well, this one issue stands out. Because of
5 the 11 transfusions, four of them occurred in the
6 first 72 hours. And we know why. She was bleeding
7 internally. And that stands out as being one of the
8 most impressive things. Because it's unusual. NEC
9 doesn't behave this way, like I said. Gastric
10 perforations we know are an issue. But that's
11 impressive.

12 And then after that what stands out in my
13 mind is, you know, her critical status over and over.

14 Q For?

15 A Multiple medical problems.

16 Q Such as? Just keep going. Lay it out.

17 A Well, she had recurrent infections. She
18 had --

19 Q What kind of infections?

20 A Rule out sepsis. Sometimes they couldn't
21 prove it, but there was clinical symptoms and lab
22 abnormalities. Line infections, possibly in, in the
23 breathing tube, bacteria growing. Urine. I don't
24 remember everything.

25 Q Okay. Taking you back to your rule out

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1 sepsis couldn't prove it statement. The NICU
2 thoroughly tested her for bacteria, viruses, fungal
3 causes for the sepsis. Correct?

4 A Let me put it this way: Preterm babies,
5 very low birth weight, will undergo multiple sepsis
6 workups during the course of their long
7 hospitalization. That's expected. And it's not
8 uncommon, despite blood tests and antibiotics, that we
9 actually don't grow something out of the blood.

10 Q Well, in MayRose's case, you never did grow
11 anything out of the blood. Correct?

12 A I don't remember.

13 Q Okay. You say though that she, there were
14 lab values that were indicative of sepsis. You're
15 referring to her elevated CRP?

16 A That's one thing.

17 Q Okay. And an elevated CRP indicates an
18 inflammatory process?

19 A That may be, yes, that may be infectious or
20 noninfectious.

21 Q Okay. All right. Okay. All right. Okay,
22 so we've talked about the GI issues. We talked about
23 the sepsis. Was there any, anything else of note that
24 comes to your mind regarding MayRose's course in the
25 NICU?

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1 A She had checks for retinopathy prematurity.

2 She had feeding issues recurrently. I recall her
3 heart function was an issue, where we had the
4 cardiologist involved. Her lungs were always a
5 concern. Her growth was a concern. And, of course,
6 her hematologic system was always a concern. Her
7 renal function, from what I recall, was good.

8 Q Okay. She -- now, as far as the cardiology
9 consult goes, you did have a cardiologist consult, but
10 he found her heart to be in good condition, didn't he?

11 A Yes.

12 Q Okay.

13 A From what I remember.

14 Q So she didn't have any cardiac issues, did
15 she?

16 A Not that I remember.

17 Q Okay. You indicate her lungs were always a
18 concern. She was, received some oxygen via nasal
19 cannula. Correct?

20 A She received various forms of respiratory
21 support.

22 Q Okay.

23 A Long term, yes.

24 Q Then you said her growth was always a
25 concern. She gained weight and was discharged at a

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1 very satisfactory healthy weight, wasn't she?

2 A That's the way our group practices. I
3 didn't do the discharge.

4 Q Okay.

5 A I know that that's how they practice.

6 Q Well, how was her growth a concern? Are
7 you --

8 A Our growth.

9 Q -- indicating that she was not growing?

10 A Sorry. Our growth is always a concern in
11 very low birth weight babies. It's a challenge to
12 have them feed appropriately. So it takes a great
13 deal of attention to care, to address their
14 nutritional needs.

15 Q Okay. But you're not telling me that she
16 wasn't growing properly?

17 A It's possible. I don't recall.

18 Q You don't know. Okay.

19 A It's not uncommon that we struggle with
20 growth issues in very low birth weight babies that are
21 critically ill.

22 MS. CARMICHAEL: Go ahead.

23 She's going to change the tape. If you
24 would like to take a break, bathroom break.

25 THE VIDEOGRAPHER: The time is 3:27 p.m.

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1 This concludes digital tape number one. Off the
2 record.

3 (A short break was taken.)

4 THE VIDEOGRAPHER: We're back on the record
5 at 3:34 p.m. This begins digital tape number two.

6 You may proceed.

7 BY MS. CARMICHAEL:

8 Q Doctor Blahnik, following your admission of
9 MayRose to the NICU, you, on May 14, you continued to
10 treat her off and on as her neonatologist through to
11 what date?

12 A I believe it was mid-July.

13 Q Okay. And I believe the last progress note
14 I have from you is July 12 -- oh, excuse me, July 13.
15 Does that sound right?

16 A Yes.

17 Q Okay. And do you have a memory of, without
18 looking at your records, I mean do you have a sense of
19 how she was doing during that timeframe, and her
20 status when you ended your treatment of her?

21 A Yes.

22 Q Tell me what you remember.

23 A I remember that, you know, given her
24 complicated history, she was lucky. Because she
25 didn't have any Interventricular hemorrhage in the

66

1 brain.

2 She didn't have any eye disease, which is
3 associated with very low birth weight babies, called
4 retinopathy prematurity.

5 She didn't have bad BPD, which is
6 bronchopulmonary dysplasia.

7 And even though she had multiple infections
8 or concerns for infections on and off, she never went
9 into septic shock, as an example. Or had infection
10 in, in the brain, like a meningitis.

11 She struggled with feeds. I remember having
12 recurrent feeding intolerance. But she was, you know,
13 as far as I remember, she was growing quite well.

14 She had, you know, lots of issues, but was
15 showing steady improvement.

16 Q Okay. And after your last, the last time
17 that you prepared a NICU progress note on July 13, did
18 you see MayRose after that?

19 A No, I was out of state, on vacation for
20 three weeks.

21 Q Okay. And do you recall when you returned
22 from vacation?

23 A I don't recall.

24 Q Okay. Do you, at any point in time did you
25 review her discharge summary?

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1 A Not until the case.

2 Q Okay. Did you discuss with Doctor Piroozi,
3 prior to the case being filed, did you ever discuss
4 with him MayRose's discharge?

5 A No.

6 Q Did you ever review her labs after you
7 returned from vacation? Did you take a look at her
8 labs?

9 A No, she was discharged.

10 Q Okay. So you didn't, after July 13, you
11 didn't look at her records, or review anything that
12 the other NICU doctors had done?

13 A No.

14 Q Okay. Do you remember any of the
15 conversations that you had with either her mother or
16 father during the treatment -- the time that you
17 provided care to her?

18 A I remember conversations. And I remember
19 them being the way I treat all parents, you know,
20 equally, sensitively, and that kind of thing,
21 providing, you know, information about their baby's
22 clinical status, and answering their questions.

23 Q Okay.

24 A That's how I approach all my families, with
25 lots of experience, of course. There's nothing, few

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1 things, but not a great deal stands out with these
2 parents. Obviously, they're educated people. That
3 makes a difference in the nature of the conversations
4 that we have with our, our families. It makes a
5 difference what type of questions they may ask.

6 Q Okay. Anything else stand out about them?
7 You noted they were educated. Do you remember
8 anything else?

9 A About conversations?

10 Q Yes.

11 A No.

12 Q Okay. Do you remember one or both of them
13 being extra inquisitive about what was going on?

14 A Well, MayRose's mother was there more than
15 the father. I remember that.

16 Q Okay.

17 A They were there together. I don't remember
18 the father being there alone. I remember her being
19 there alone. But no.

20 Q Okay. Do you recall the father telling you
21 about his thalassemia?

22 A No.

23 Q Okay. Do you --

24 A I remember the issue of the cystic fibrosis.
25 That came up. But the thalassemia, that would have

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

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

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

9 Q Okay.

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

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

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

18 Q For example --

19 A That's State mandated.

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

25 Is there somebody like that who would be

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1 spearheading the thalassemia test?

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

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

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

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

13 Q Okay.

14 A All of those are uncommon diseases.

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

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

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

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

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

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

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

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

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

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

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

23 (Plaintiffs' Exhibit 3 marked for
24 identification.)

25 //

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1 BY MS. CARMICHAEL:

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

6 A Yes. Yes.

7 Q Okay. And then -- find it.
8 (Plaintiffs' Exhibit 4 marked for
9 identification.)

10 BY MS. CARMICHAEL:

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

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

17 Q Okay, great.
18 (Plaintiffs' Exhibit 5 marked for
19 identification.)

20 BY MS. CARMICHAEL:

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

25 And did you say that a grade one is not

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1 concerning?

2 A That's correct.

3 Q Okay. And tell me why that is?

4 A There's data that say that it's not
5 associated with any long-term neural developmental
6 outcomes. But I would actually dispute this finding.

7 Q Why?

8 A Germinal matrix involutes quickly after
9 birth, even in prematurity. There should be no
10 germinal matrix.

11 Now, this is one of our best radiologists.
12 So I would have to have a discussion with him about
13 why he says that.

14 It may have been just what we call an
15 incidental finding.

16 Q Okay.

17 A But by itself, grade one IVH just does not
18 have long-term significance. So.

19 Q Okay. Great. Okay. And, let's see. It
20 also indicates in that that it's subacute. There's no
21 acute bleed going on. Correct?

22 A Correct.

23 Q All right.

24 A It may have been just a certain kind of
25 shadowing of the, the technician who did it at the

74

1 time. Because the radiologist, they read the studies.
2 They're not there at the bedside.

3 Q Right. Okay. All right. Let's see.
4 (Plaintiffs' Exhibit 6 marked for
5 identification.)

6 BY MS. CARMICHAEL:

7 Q Doctor Blahnik, this next exhibit appears to
8 be a developmental evaluation that was done by
9 Physical Therapy, I believe.

10 A Extra copy. (Indicates.)

11 Q Oh, sorry.

12 On the day of her birth? Is that, does that
13 seem right?

14 A No.

15 Q I was wondering about that. It's dated the
16 date of her birth. And then it, you know -- I don't
17 know.

18 A I, I think this is, if I could say. Go back
19 to our original orders. It's part of the original
20 orders to do a developmental evaluation.

21 Yes, consult Developmental Team. So that
22 gets generated that way.

23 Q Okay.

24 A But the baby was too sick for this to be a
25 relevant issue at that point.

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1 Q Okay. Well, at some point, it appears that
2 the evaluation was conducted. Do you know when it
3 might have been conducted?

4 A No, I don't know.

5 Q Okay. In any event, of the 30 -- let's see,
6 not 30 -- of the various categories that they test, it
7 appeared that she was appropriate for age with the
8 exception of two of the items, being the suck, which
9 was abnormal, and the, is that m-o-r-o-?

10 A Where are you looking? Moro, yes, okay.

11 Q Moro. Everything else appeared to be
12 appropriate for age.

13 Do you recall reviewing this or being aware
14 of this result?

15 A It, it depends if this was generated after
16 or before when I went on vacation.

17 Q Okay. Based on --

18 A But I signed -- sorry. I signed it. It's
19 not dated. But that may have been a signature that
20 was generated and I had to go to Medical Records to
21 sign. So that becomes hard to identify.

22 Q Okay. Based on the results, or the physical
23 therapist's findings, what do you conclude?

24 A Well, this was a critically ill, very low
25 birth weight baby that had multiple medical problems

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1 and was on a respirator for a significant period of
2 time or had other respiratory issues. And that's
3 relevant in being able to learn the suck/swallow
4 reflex that's part of development, and often it can be
5 delayed.

6 This is not only associated with her having
7 recurrent feeding intolerance, but also being able to
8 feed by bottle. You can put a tube in the tummy and
9 you can tolerate feeds that way. But suck/swallow is
10 a much more complex skill that can take a lot of time.

11 Q Okay.

12 A So I wouldn't be surprised that you would
13 have this finding.

14 Q Okay. But do you have a memory of MayRose
15 overcoming those issues and essentially becoming
16 appropriate for age in those two areas?

17 A She would have to. Otherwise she couldn't
18 go home.

19 Q Okay.

20 A At least with respect to suck. If that, if
21 this is saying the baby, the child is unable to take
22 by bottle.

23 Q Going back to your neonatal admission
24 history and physical. It reports that her Apgar
25 scores were three -- or excuse me, one -- no, three,

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

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

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

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

81

83

1 range they're providing, both results are indicated in
2 the report as being low. Is that true?

3 A There's an "L" there. That doesn't say
4 normal. It says reference.

5 Q Okay.

6 A Which I think is significant.

7 Q In what way? I mean if you look throughout
8 this lab report, that's what they give you as
9 reference ranges?

10 A Yeah. That means it needs to be interpreted
11 in light of the clinical scenario you're dealing with.
12 I would assume.

13 Q Do you have any understanding of why these
14 results are being reported as low?

15 A Well, I wasn't involved with the patient at
16 this point. That's 7/14 and 8/1. So I was never
17 confronted with looking at these numbers.

18 Q Sure. And I understand that. I'm just
19 wondering within your practice, as a neonatologist
20 looking at these lab reports every day, if you can
21 explain to me what this particular lab finding is
22 indicating?

23 A It's telling the number of reticulocytes
24 counted under a microscope by a technologist in the
25 lab.

1 I have for you today. Thank you for your time.

2 MR. COTTON: Questions?

3 MS. URDAZ: None for me.

4 MS. LUCERO: None for me.

5 MR. COTTON: We'll read and sign.

6 THE VIDEOGRAPHER: This concludes the
7 deposition. The time is 3:59 p.m. We're off the
8 record.

9 (The deposition concluded at 3:59 p.m.)

82

84

1 Q Okay. And how then is that different from
2 the, the retic, the retic results we have on a
3 different page in here, I don't know that I can find
4 that right away, of .9 and .5?

5 A Well, like I said, this is probably the
6 calculation to get to that number.

7 Q But --

8 A This is the same date the retic counts were
9 done.

10 Q Correct.

11 A And the same time. Right?

12 Q Yes. And you're saying it's probably the
13 calculation. So does that mean you're unsure?

14 A That's correct. Because I'm not usually
15 seeing them reported this way.

16 Q Okay.

17 A I know what they mean. They're reported as
18 a percentage.

19 Q Okay. And you think that rather than being
20 reported as a percentage, those are actually the
21 number of cells they visualized?

22 A I'm not sure.

23 Q Okay.

24 A Talk to the lab.

25 MS. CARMICHAEL: Those are all the questions

1 CERTIFICATE OF DEPONENT
2 PAGE LINE CHANGE

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20 I, MARTIN JOSEPH BLAHNIK, M.D., deponent
21 herein, do hereby certify and declare under penalty of
22 perjury the within and foregoing transcription to be
23 my testimony in said action, that I have read,
24 corrected, and do hereby affix my signature to said
25 transcript.

MARTIN JOSEPH BLAHNIK, M.D.
Deponent

85

1 REPORTER'S CERTIFICATE

2 STATE OF NEVADA)

) ss:

3 COUNTY OF CLARK)

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

6 That I reported the taking of the deposition of the
7 witness, MARTIN JOSEPH BLAHNIK, M.D., commencing on
8 January 18, 2011, at 2:06 p.m.

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

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

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

22 IN WITNESS WHEREOF, I have hereunto set my hand and
23 affixed my official seal in my office in the County of
24 Clark, State of Nevada, this ____ day of ____ 2012.

25

Karen J. Berry, CCR 836, RMR

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