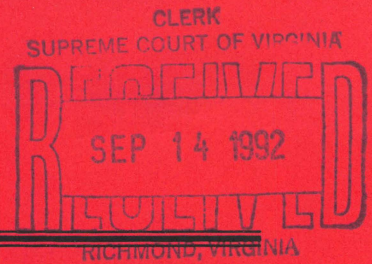


245VA60



IN THE
Supreme Court of Virginia

RECORD NO. 920529

**NIKOLAOS AND SANDRA PANOUSOS,
Administrator and Administratrix of the Estate of
NICOLE PANOUSOS,**

Appellants,

V.

**ROBERT ALLEN, M.D. AND FAIRFAX RADIOLOGICAL
CONSULTANTS, P.C.,**

Appellees.

**JOINT APPENDIX
VOLUME I**

**John D. Quinn
FEHRENBACHER, SALE,
QUINN & DEESE, P.C.
910 16th Street, N.W.
Suite 500
Washington, D.C. 20006
(202) 833-4170**

Counsel for Appellants

**Gary A. Godard
George A. McAndrews
GODARD, WEST & ADELMAN, P.C.
3975 University Drive, Suite 220
Post Office Box 1287
Fairfax, Virginia 22030
(703) 273-4800**

Counsel for Appellees

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VIRGINIA:

FILED

IN THE CIRCUIT COURT OF JUDGE
FAIRFAX COUNTY

NIKOLAOS AND SANDRA PANOUSOS,
Administrator and Administratrix
of the Estate of NICOLE PANOUSOS

Plaintiffs,

v.

ROBERT ALLEN, M.D.
8316 Arlington Boulevard
Suite 206
Fairfax, VA 22031

and

FAIRFAX RADIOLOGICAL CONSULTANTS, P.C.
c/o Its Registered Agent
John H. Rust
4165 Chain Bridge Road
Fairfax, VA 22030
Defendants.

At Law No. 98695

MOTION FOR JUDGMENT

COME NOW, Plaintiffs, Nikolaos and Sandra Panousos, Administrator and Administratrix of the Estate of Nicole Panousos, ("Plaintiffs") by and through their attorney, John D. Quinn, and for their complaint against Defendant, Robert Allen, M.D., and Fairfax Radiological Consultants, P.C. ("Defendants"), state as follows:

PARTIES

1. The Plaintiffs, Nikolaos Panousos and Sandra Panousos, reside at 1641 Lakeside Oak Court, Burke Virginia, 22015.

2. Defendant Robert Allen, M.D., is a medical doctor and Fairfax Radiological Consultants, P.C., is a professional corporation that conduct their practice of providing health care

services to the public for pay, and at all relevant times were practicing medicine in the Commonwealth of Virginia. As used herein, the name Dr. Allen includes Robert Allen, M.D., and Fairfax Radiological Consultants, P.C.

COMPLAINT

MEDICAL MALPRACTICE, NEGLIGENCE, WRONGFUL DEATH

3. At about 11:00 p.m. on March 4, 1987, Nicole Panousos, daughter of the Plaintiffs, was brought to the Emergency Room of Fairfax Hospital. Nicole was then approximately four months old and had been suffering from flu-like symptoms. Nicole was admitted to Fairfax Hospital in the early hours of March 5, 1987.

4. During her time at Fairfax Hospital, Nicole was, at various times, under the medical care and treatment of the Defendants herein.

5. Upon being admitted to Fairfax Hospital, Nicole was examined by Dr. Allen, who performed an ultrasound examination which identified two masses in Nicole's abdomen.

6. Dr. Allen concluded that the upper, and larger mass, was a tumor and that the lower mass was the urinary bladder.

7. To this diagnosis, Dr. Allen attempted to catheterize Nicole's bladder. Dr. Allen did not obtain a flow of urine when he performed the catheterization, nor did he inject sterile water into the catheter as an ultrasound contrast. Instead, Dr. Allen relied solely on visual interpretation of the sonogram.

8. Based on this information, Dr. Allen presented a radiology report to the attending Pediatric Surgeon, Earl Hodin,

M.D., in which Dr. Allen "confirmed" that the lower mass was the urinary bladder.

9. Dr. Allen failed to insert the urinary catheter into the urethra and/or into the bladder of patient Nicole Panousos.

10. Dr. Allen failed to confirm communication of the catheter with the urinary bladder by following the normal procedures for a successful catheterization, including production of urine, insertion of the catheter until it produces urine or comes back out because it is not in the bladder, or injection of a contrast solution.

11. Dr. Allen informed Dr. Hodin that the large cystic mass was confirmed not to be the bladder by catheterization, when no urine was produced and no contrast was injected.

12. Dr. Allen informed Dr. Hodin intraoperatively that Dr. Allen was certain that the large mass was not the urinary bladder and that he had injected contrast when in fact Dr. Allen had not injected contrast solution.

13. Based on Dr. Allen's radiology report and the belief that Nicole had a large abdominal tumor, Dr. Hodin initiated emergency exploratory surgery, whereupon he discovered that Dr. Allen's diagnosis was completely wrong. The small, lower mass which Dr. Allen had identified as the urinary bladder in fact was a tumor which was blocking the urinary bladder from below, causing it to become the large and distended mass which Dr. Allen had identified as a tumor. Dr. Hodin proceeded to drain one liter of urine from Nicole's bladder.

14. Dr. Hodin has testified that he would not have performed the emergency surgery if the radiology report had properly identified the large upper mass as the urinary bladder. Instead, Dr. Hodin would have properly catheterized the bladder, would have allowed any fluid imbalances to be rectified, and would have conducted elective surgery on Nicole 24 hours later.

15. Subsequent to her surgery, Nicole was transferred to the Fairfax Hospital Pediatric Intensive Care Unit (PICU). From 11:45 p.m. on March 5 until 8:25 a.m. on March 6, 1987, the day after the surgery, Nicole experienced dramatic fluid shifts. The shifts were the result of the emergency nature of Nicole's surgery.

16. At 8:30 a.m. on March 6, 1987, Nicole suffered respiratory and/or cardiac arrest. Although she was revived after approximately 30 minutes, her condition remained critical and she lost any chance of survival. Nicole died on March 7, 1987.

17. Dr. Allen failed to uphold the standard of care for a radiologist diagnosing a patient with a large abdominal cystic mass.

18. Dr. Allen was negligent and engaged in medical malpractice in the manner in which he performed his examination of Nicole Panousos.

19. Dr. Allen was further negligent in his failure to communicate properly the results of his examination to Dr. Hodin.

20. Dr. Allen was further negligent in his failure to evaluate properly Nicole's condition, given the information that he had at the time of his examination.

21. Dr. Allen was further negligent in his failure to exercise the professional level of care which would be so exercised by an ordinary radiologist in good standing.

22. Dr. Allen was further negligent in his misdiagnosis of Nicole's condition based on his examination of her ultrasound tests.

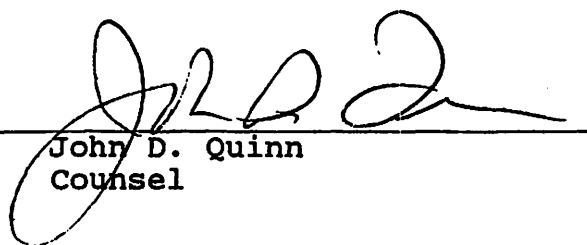
23. Nicole Panousos' death was a direct and proximate result of Defendant's aforesaid negligence and failure to meet the applicable standard of care.

PRAYER

WHEREFORE, Plaintiffs, Nikolaos Panousos and Sandra Panousos, Administrator and Administratrix of the Estate of Nicole Panousos, demand judgment against the Defendant, Dr. Robert Allen, in the sum of \$1,000,000, together with costs and interest.

Nikolaos Panousos and Sandra Panousos

By



John D. Quinn
Counsel

Counsel for Plaintiff
Fehrenbacher, Sale, Quinn & Deese, P.C.
125 South Royal Street
Alexandria, VA 22314
Telephone: 833-4170

Dated: July 20, 1990

V I R G I N I A :

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

NIKOLAOS AND SANDRA PANOUSOS,
Administrator and Administratrix
of the Estate of NICOLE PANOUSOS

Plaintiffs,

v.

ROBERT ALLEN, M.D.
and
FAIRFAX RADIOLOGICAL CONSULTANTS,
P.C.

Defendants.

AT LAW NO. 98695

ANSWERS OF DEFENDANT FAIRFAX RADIOLOGICAL CONSULTANTS, P.C.

COMES NOW Defendant Fairfax Radiological Consultants, P.C.,
by and through its attorneys, GODARD, WEST & ADELMAN, P.C., and
for its Answer and Grounds of Defense to the Motion for Judgment,
states as follows:

1. Upon information and belief, the allegations of
paragraph 1 are admitted.

2. Regarding the allegations of paragraph 2, this
defendant admits that defendant Robert Allen, M. D. is a medical
doctor; that defendant Fairfax Radiological Consultants, P.C.,
is a professional corporation; that Dr. Allen conducts his
practice of providing health care services to the public for pay;
and that, at all times relevant herein, Dr. Allen practiced
medicine in the Commonwealth of Virginia. The remaining
allegations of paragraph 2 are denied, as currently phrased in
the Motion for Judgment.

3. The allegations of paragraph 3 are admitted.

4. Regarding the allegations of paragraph 4, this defendant denies that Dr. Allen rendered medical "treatment" to Nicole Panousos, and further denies that Nicole was under his care "at various times." This defendant affirmatively asserts that Dr. Allen saw Nicole on only one occasion during her 1987 hospitalization at Fairfax Hospital. The remaining allegations of paragraph 4 are denied.

5. The allegations of paragraph 5 are admitted, albeit this defendant affirmatively asserts that Dr. Allen performed the ultrasound examination of Nicole's abdomen several hours after she had been admitted.

6. Regarding the allegations of paragraph 6, this defendant admits that Dr. Allen concluded that the larger, anteriorly located mass was a cyst and that the smaller, posteriorly located mass was Nicole's urinary bladder. Any remaining allegations of paragraph 6 are denied.

7. Regarding the allegations of paragraph 7, this defendant admits that Dr. Allen attempted to confirm the identification of Nicole's urinary bladder by inserting an infant feeding tube, or catheter, through Nicole's urethra into her urinary bladder. This defendant affirmatively asserts that some urine flowed out through the catheter, and denies all allegations to the contrary. This defendant further admits that Dr. Allen did not inject sterile water through the catheter. The remaining allegations of paragraph 7 are denied.

8. Regarding the allegations of paragraph 8, this defendant admits that Dr. Allen orally communicated his findings, from the ultrasound examination, to the attending pediatric surgeon, Earl Hodin, M.D. This defendant affirmatively asserts that the written "radiology report" was not available prior to Nicole's March 5, 1987 surgery. The remaining allegations of paragraph 8 are denied.

9. The allegations of paragraphs 9 and 10 are denied.

10. Regarding the allegations of paragraph 11, this defendant admits that Dr. Allen informed Dr. Hodin pre-operatively that the larger cystic mass did not appear to be urinary bladder; and that no "contrast" was injected through the catheter. The remaining allegations of paragraph 11 are denied.

11. The allegations of paragraph 12 are denied.

12. Regarding the allegations of paragraph 13, this defendant admits that, based upon his belief that Nicole had a large abdominal mass, Dr. Hodin initiated emergency exploratory surgery; that Dr. Hodin discovered intraoperatively that the lower, posterior mass was a cystic mass which had obstructed the bladder neck and thereby distended the bladder; that the larger cystic mass was, in fact, Nicole's urinary bladder; and that Dr. Hodin drained a total of one liter of urine from Nicole's urinary bladder. The remaining allegations of paragraph 13 are denied.

13. The allegations of paragraph 14 are denied.

14. This defendant is without information sufficient to form a belief as to the truth of the allegations contained in

paragraph 15, and generally denies same.

15. Regarding the allegations of paragraph 16, this defendant admits, upon information and belief, that Nicole suffered cardiopulmonary arrest on the morning of March 6, 1987, and was resuscitated. This defendant further admits that Nicole Panousos died on March 7, 1987. The remaining allegations of paragraph 16 are denied.

16. The allegations of paragraphs 17, 18, 19, 20, 21, 22, and 23 are denied, and strict proof demanded for all injuries and damages alleged.

17. This defendant affirmatively asserts that any alleged injury or damages sustained by Nicole Panousos individually, or by plaintiffs, were solely and proximately caused by the medical condition and/or illness that prompted her hospitalization, and not by any act or omission of this defendant, its agents or employees.

WHEREFORE defendant Fairfax Radiological Consultants, P. C., respectfully moves this Court for dismissal of the Motion for Judgment and for an award of costs expended on its behalf.

FAIRFAX RADIOLOGICAL
CONSULTANTS, P.C.
By Counsel

LAW OFFICES
GODARD, WEST
375 UNIVERSITY DRIVE
SUITE 220
P.O. BOX 1287
FAIRFAX, VIRGINIA 22030
(703) 273-4800

GODARD, WEST & ADELMAN, P.C.

George M'Andrews

Gary A. Godard, Esquire #014712
George McAndrews, Esquire #023618
Counsel for Fairfax Radiological
Consultants, P.C.
3975 University Drive
Suite #220
Post Office Box 1287
Fairfax, Virginia 22030-1287
(703) 273-4800

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing was mailed,
postage prepaid, this 20th day of August, 1990 to:

John D. Quinn, Esquire
124 South Royal Street
Alexandria, Virginia 22314
Counsel for Plaintiff

George M'Andrews

Gary A. Godard

V I R G I N I A:

FILED

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

NIKOLAOS AND SANDRA PANOUSOS, :
Administrator and :
Administratrix of the Estate of: :
NICOLE PANOUSOS, :
:

Plaintiffs :
:

v. :
:

ROBERT ALLEN, M.D. :
:

and :
:

FAIRFAX RADIOLOGICAL :
CONSULTANTS, P.C., :
:

Defendants :
:

AT LAW NO. 98695

ANSWER OF DEFENDANT ROBERT ALLEN, M.D.

COMES NOW Defendant Robert Allen, M.D., by and through his attorneys, GODARD, WEST & ADELMAN, P.C., and for his Answer and Grounds of Defense to the Motion for Judgment, states as follows:

1. Upon information and belief, the allegations of Paragraph 1 are admitted.
2. Regarding the allegations of Paragraph 2, this defendant admits that he is a medical doctor; that Defendant Fairfax Radiological consultants, P.C., is a professional corporation; that Dr. Allen conducts his practice of providing health care services to the public for pay; and that, at all times relevant herein, he practiced medicine in the Commonwealth of Virginia. The remaining allegations of Paragraph 2 are denied, as currently phrased in the Motion for Judgment.
3. The allegations of Paragraph 3 are admitted.

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GODARD, WEST
& ADELMAN, P.C.
10-A MONROE STREET
SUITE 310
KVILLE, MARYLAND 20850
(301) 340-1140

4. Regarding the allegations of Paragraph 4, this defendant denies that he rendered medical "treatment" to Nicole Panousos and further denies that Nicole was under his care "at various times." This defendant affirmatively asserts that he saw Nicole on only one occasion as a consultant during her 1987 hospitalization at Fairfax Hospital. The remaining allegations of Paragraph 4 are denied.

5. The allegations of Paragraph 5 are admitted, albeit this defendant affirmatively asserts that he performed the ultrasound examination of Nicole's abdomen several hours after she had been admitted.

6. Regarding the allegations of Paragraph 6, this defendant admits that he concluded that the larger, anteriorly located mass was a cyst and that the smaller, posteriorly located mass was Nicole's urinary bladder. Any remaining allegations of Paragraph 6 are denied.

7. Regarding the allegations of Paragraph 7, this defendant admits that he attempted to confirm the identification of Nicole's urinary bladder by inserting an infant feeding tube, or catheter, through Nicole's urethra into her urinary bladder. This defendant affirmatively asserts that some urine flowed out through the catheter, and denies all allegations to the contrary. This defendant further admits that he did not inject sterile water through the catheter. The remaining allegations of Paragraph 7 are denied.

8. Regarding the allegations of Paragraph 8, this defendant admits that he orally communicated his impressions from the

ultrasound examination to the attending pediatric surgeon, Earl Hodin, M.D. This defendant affirmatively asserts that the written "radiology report" was not available prior to Nicole's March 5, 1987, surgery. The remaining allegations of Paragraph 8 are denied.

9. The allegations of Paragraphs 9 and 10 are denied.

10. Regarding the allegations of Paragraph 11, this defendant admits that he informed Dr. Hodin preoperatively that the larger cystic mass did not appear to be urinary bladder; and admits that no "contrast" was injected through the catheter. The remaining allegations of Paragraph 11 are denied.

11. The allegations of Paragraph 12 are denied.

12. Regarding the allegations of Paragraph 13, this defendant admits, upon information and belief, that based in part upon his belief that Nicole had a large abdominal mass, Dr. Hodin initiated emergency exploratory surgery; that Dr. Hodin discovered intra-operatively that the lower, posterior mass was a cystic mass which had obstructed the bladder neck and thereby distended the bladder; that the larger cystic mass was, in fact, Nicole's urinary bladder; and that Dr. Hodin drained a total of one liter of urine from Nicole's urinary bladder. The remaining allegations of Paragraph 13 are denied.

13. The allegations of Paragraph 14 are denied.

14. This defendant is without information sufficient to form a belief as to the truth of the allegations contained in Paragraph 15, and generally denies same.

15. Regarding the allegations of Paragraph 16, this defendant admits, upon information and belief, that Nicole suffered cardio-pulmonary arrest on the morning of March 6, 1987, and was resuscitated. This defendant further admits that Nicole Panousos died on March 7, 1987. The remaining allegations of Paragraph 16 are denied.

16. The allegations of Paragraphs 17, 18, 19, 20, 21, 22 and 23 are denied and strict proof is demanded for all injuries and damages alleged.

17. This defendant affirmatively asserts that any alleged injury or damages sustained by Nicole Panousos individually, or by plaintiffs, were solely and proximately caused by the medical condition and/or illness that prompted her hospitalization and not by any act or omission of this defendant.

WHEREFORE, Defendant Robert Allen, M.D., respectfully moves this Court for dismissal of the Motion for Judgment and for an award of costs expended on its behalf.

ROBERT ALLEN, M.D.
By Counsel

GODARD, WEST & ADELMAN, P.C.

By George M. Andrews
Gary A. Godard #014712
George A. McAndrews #023618
3975 University Drive
Suite 220
Fairfax, Virginia 22030-1287
(703) 273-4800
Attorneys for Defendant
Robert Allen, M.D.

LAW OFFICES
GODARD, WEST
& ADELMAN, P.C.
MONROE STREET
SUITE 310
FALLS CHURCH, MARYLAND 20850
O1) 340-1140

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing was mailed, postage prepaid, and transmitted via fax transmission, this 26th day of November, 1990, to:

John D. Quinn, Esquire
Fehrenbacher, Sale, Quinn & Deese, P.C.
910 16th Street, N.W.
Fifth Floor
Washington, D.C.

20006

George M. Andrews
George A. McAndrews

V I R G I N I A:

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

NIKOLAOS AND SANDRA PANOUSOS, :
Administrator and :
Administratrix of the Estate of: :
NICOLE PANOUSOS, :
: :
: :

Plaintiffs : :
: :
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: :

AT LAW NO. 98695

v. :
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ROBERT ALLEN, M.D. :
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Defendant :
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CLERK OF CIRCUIT COURT
FAIRFAX COUNTY VA

EXPERT IDENTIFICATION STATEMENT OF
DEFENDANT ROBERT ALLEN, M.D.

COMES NOW the defendant, Robert M. Allen, M.D., by counsel,
and states that the following may be called to testify on his
behalf as expert witnesses at trial in this civil action:

I EDWARD R. LIPSIT, M.D.
916 19th Street, N.W.
Suite 200
Washington, D.C. 20006

a) Subject matter of expected testimony:

Dr. Lipsit will testify as to the standard of care
applicable to a reasonable and prudent radiologist practicing
in the Commonwealth of Virginia in March of 1987.

b) Summary of expert's opinions:

Dr. Lipsit is expected to testify that, in all material
respects, the care rendered by this defendant to Nicole
Panousos on March 5, 1987, complied with the appropriate
standard of care. Dr. Lipsit's opinions are more fully set
out in the testimony that he rendered before the Medical
Malpractice Review Panel that has previously evaluated his
claim. Plaintiffs are referred to Dr. Lipsit's deposition

testimony of February 20, 1990, and to Dr. Lipsit's testimony before the Medical Malpractice Review Panel during the ore tenus hearing on May 22, 1990.

c) Summary of grounds for each opinion:

Dr. Lipsit bases his opinions upon his review of the hospital chart for Nicole Panousos' March 5, 1987, admission to Fairfax Hospital, his review of the sonogram films taken March 5, 1987, and his knowledge, training, and professional experience in the field of radiology.

II THOMAS A. MASSARO, M.D.
Department of Pediatrics
University of Virginia Hospital
Charlottesville, VA

a) Subject matter of expected testimony:

Dr. Massaro will testify as a medical expert regarding the post-operative care that Nicole Panousos received. He will also issue opinions on causation.

b) Summary of expert's opinions:

Dr. Massaro will testify on the lack of any causal relationship between the failure to drain Nicole Panousos' bladder prior to surgery on March 5, 1987, and her cardiac arrest on the morning of March 6, 1987. Dr. Massaro may also testify regarding the appropriateness of the monitoring that Nicole received post-operatively. He will testify consistent with the testimony that he rendered when this claim was pending before the Medical Malpractice Review Panel. Plaintiffs are referred to Dr. Massaro's testimony given at

his deposition on April 25, 1990, and his testimony before the Review Panel during its hearing on May 22, 1990.

c) Summary of grounds for each opinion:

Dr. Massaro bases his opinions upon his review of the hospital chart for Nicole Panousos' March 5, 1987, admission to Fairfax Hospital, and his knowledge, training, and professional experience in the field of pediatrics and intensive care medicine.

III BRADLEY ROGERS, M.D.
Department of Pediatric Surgery
University of Virginia Hospital
Charlottesville, VA

a) Subject matter of expected testimony:

Dr. Rogers will testify as a medical expert in the field of pediatric surgery.

b) Summary of expert's opinions:

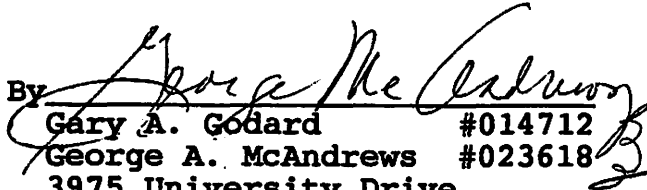
Dr. Rogers is expected to testify that Nicole Panousos was an appropriate candidate for surgery on March 5, 1987. He is further expected to testify that no causal connection exists between the surgical procedures performed on March 5 and her eventual cardiac arrest on the morning of March 6, 1987. Dr. Rogers will testify in a manner consistent with the testimony that he gave in his de bene esse deposition taken on May 7, 1990, in the course of the Medical Malpractice Review Panel proceedings. Plaintiffs are referred to that deposition testimony for a more complete statement of Dr. Rogers' opinions.

c) Summary of grounds for each opinion:

Dr. Rogers bases his testimony upon his review of the hospital chart for Nicole Panousos' admission of March 5, 1987, to Fairfax Hospital, and upon his knowledge, training, and professional experience in the field of pediatric surgery.

ROBERT M. ALLEN, M.D.
By Counsel

GODARD, WEST & ADELMAN, P.C.

By 
Gary A. Godard #014712
George A. McAndrews #023618
3975 University Drive
Fairfax, VA 22030
(703) 273-4800
Attorneys for Dr. Allen

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing was transmitted via facsimile and mailed, postage prepaid, this 19th day of September, 1991, to:

Stephen Sale, Esquire
John D. Quinn, Esquire
Fehrenbacher, Sale, Quinn & Deese, P.C.
910 16th Street, N.W.
Fifth Floor
Washington, D.C.

20006


George McAndrews

FILED

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COMMONWEALTH OF VIRGINIA
FAIRFAX COUNTY CIRCUIT COURT

- - - - -X
NIKOLAOS and SANDRA PANOUSOS, :
Administrator and Administratrix :
of the Estate of NICOLE PANOUSOS, :
Plaintiffs, :
V. : At Law No. 98695
ROBERT ALLEN, M.D., AND :
FAIRFAX RADIOLOGICAL CONSULTANTS, :
P.C., :
Defendants. :

- - - - -X
Washington, D.C.
Saturday, November 30, 1991

Video-taped deposition of RICHARD B. KARSH,
M.D., a witness herein, called for examination by counsel
for Plaintiffs in the above-entitled matter, pursuant to
notice, the witness being duly sworn by JAN WILLIAMS, a
Notary Public in and for the District of Columbia, taken
at the offices of Fehrenbacher, Sale, Quinn & Deese, P.C.,
910 16th St., N.W., Fifth Floor, Washington, D.C. 20006,

1	C O N T E N T S		
2	WITNESS	EXAMINATION BY COUNSEL FOR	
3	DR. KARSH	PLAINTIFF	DEFENDANT
4	By Mr. Sale	6	
5	By Mr. Goddard		92
6	By Mr. Sale	128	

7	E X H I B I T S		
8	PLAINTIFFS' EXHIBIT	IDENTIFIED	RECEIVED
9	NO. 2		15
10	NOS. 3 and 4	20	
11	NOS. 15 and 16	34	
12	NOS. 5, 15 and 16		36
13	NO. 9		43
14	NOS. 6 and 8		46
15	NO. 7	49	
16	NO. 12	64	
17	NO. 10	74	
18	NO. 11	76	
19	NO. 13 and 14	85	

20

21 * Exhibits 13 through 15 retained by counsel.

22



24

1 review, or was it intended to come up with a specific
2 finding?

3 A. Whatever the intent of the folks who sent the
4 records to me, my intent is to simply come up with as
5 accurate a review as possible, with no vested interest one
6 way or the other.

7 In essence, the records come to me. And I'm
8 asked to review a case. I do so and return the records.
9 I have no knowledge of what attorneys are involved. And
10 really, the only names that I have are those that appear
11 on the medical record.

12 Q. Doctor, have you testified on behalf of
13 plaintiffs and defendants in medical malpractice cases?

14 A. Yes, I have.

15 Q. What materials did you review in preparing
16 opinions on Nicole Panousos?

17 A. Primarily the hospital record and files. I had
18 occasion, over the past several years, to review a number
19 of depositions -- both written and video -- of physicians
20 involved in the case.

21 Q. When you derived your initial opinions on the
22 case, what did you review?

23

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1111 FOURTEENTH STREET, N.W.
SUITE 400
WASHINGTON, D.C. 20005
(202) 289-2260
(800) FOR DEPO

1 A. The initial opinions were based just strictly on
2 the medical record.

3 Q. What are the other opinions you have in this
4 case based upon?

5 A. They're really still based upon medical
6 records -- with perhaps one or two instances of
7 elaboration or confirmation by the obstetric medical
8 records.

9 Q. Did anything outside the records change your
10 opinions?

11 A. No, they did not.

12 Q. When you were asked to review this case, did you
13 take that responsibility seriously?

14 A. Yes, I did. And I do.

15 Q. On the basis of that review, did you form
16 opinions to a reasonable degree of medical certainty?

17 A. Yes, I did.

18 Q. Would you please tell the members of the jury
19 the opinions that you have reached in very summary form,
20 Dr. Karsh?

21 A. In essence, the opinion that I have reached is
22 that in all medical probability, that an accurate

1 diagnosis based upon ultrasound or other radiologic
2 techniques, diagnostic imaging techniques available
3 through the radiologist on 5 March 1987, could have and
4 should have been made, which would have eliminated the
5 necessity of emergency surgery on Nicole Panousos, a four-
6 and-a-half-month-old infant, and thereby the high risk
7 that she encountered, which ultimately led to her death,
8 would have been eliminated. And she would have survived
9 her surgery and post-operative course.

10 Q. Did you identify a violation of the standard of
11 care to a reasonable degree of medical certainty?

12 A. Yes, I did.

13 Q. And who was that violation by?

14 A. That was violated by Dr. Allen, the radiologist.

15 Q. And can you say, at this point in time, that Dr.
16 Allen did not meet the standard of care for a reasonably-
17 prudent physician practicing diagnostic radiology in
18 Virginia in 1987?

19 A. Yes, I can.

20 Q. Doctor, do you have any opinion, to a reasonable
21 degree of medical certainty, whether that violation of the
22 standard of care caused the death of Nicole Panousos.

1 A. Yes, I do -- in as much as it engendered the
2 emergent nature of the surgery and complications that
3 ultimately occurred, it was a cause of the patient's
4 death.

5 Q. Doctor, will you please describe for the jury
6 what you saw, in your review of the sonography done by Dr.
7 Allen?

8 A. Yes, I will.

9 But first, if I may, let me try to give the jury
10 a bit of a picture of the patient and her condition at the
11 time of the exam.

12 Nicole is an approximately four-and-one-half-
13 month-old baby who had been sick for 4 or 5 days with a
14 symptomology that was primarily to be the flu. Over the
15 24 hours or so, prior to admission, she developed more
16 abdominal pain, and a rather tense belly. She was seen in
17 the emergency room by a pediatrician, and by Dr. Hodin,
18 the pediatric surgeon and admitted to the hospital.

19 On the morning of the 5th of March, she was
20 brought to the radiology suite for an ultrasound of the
21 abdomen and pelvis.

22 I'd like to use a chart -- actually, two

1 pictures -- to give a little bit of an idea of what the
2 ultrasound would show. And what I'm trying to do is show,
3 more or less graphically, what a normal, side-view
4 ultrasound would show, in terms of the structures that
5 were important here.

6 In a normal situation, just try to orient
7 yourselves to the pubic bone. That's the bone that's way
8 down in your pelvis, anteriorly. And I'm sure everybody
9 has had times when they've had to urinate, and they feel
10 some pressure on there. So you know that the bladder,
11 when it gets big, is right behind that pubic bone.

12 If you look on the side view, the bladder is
13 kind of like a balloon full of water. And leading into
14 the bladder is a long tube called the ureter, which comes
15 from the kidney. The ureter, itself, is probably not
16 going to be visible on an ultrasound, because it's very
17 thin, and not really full of water. There may be a few
18 droplets here or there.

19 Similarly, the urethra, which is the tube that
20 leads out from the bladder to the outside -- and the blood
21 goes to the end of the penis; in a girl, it enters the
22 vagina -- also will not be visible on the ultrasound

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1 unless, for some reason, it is actually distended as if
2 there's a blockage at the end of it.

3 In Nicole's case, though, things were different.
4 In Nicole's case, there were two balloons full of water in
5 her abdomen and pelvis. One was somewhat posterior, in
6 back and low; one was forward, and extended way up into
7 her abdomen -- actually to or beyond the belly-button.

8 In addition, the collecting system, the little
9 tubes within the kidney were dilated. They were filled
10 with fluid, with urine -- mildly, to moderately
11 so -- indicating that there was some obstruction to flow,
12 down low.

13 Now, I have taken some liberties here, because
14 remember I said that the urethra -- which I am showing
15 here as connected to one of these masses -- could not be
16 seen on the ultrasound.

17 What we saw in Nicole's case was the reflection,
18 on several of the images, of a catheter which did not
19 definitively enter either one of these two, fluid-filled
20 structures. So the question was, instead of one, fluid-
21 filled structure that's obviously the bladder, there were
22 two in this baby. Both of them were pretty big. The one

1 that's anterior and high was much bigger than the other.

2 Which one, if either one, is the bladder? And
3 what could the radiologist do? Well, the radiologist
4 tried to do the right thing. He put a catheter into the
5 urethra to see if he could see where the catheter went.
6 And it went either right adjacent to, or maybe in one of
7 these two masses. But he couldn't tell for sure.

8 What else could be done? The standards of
9 diagnostic radiology and diagnostic ultrasound in 1987
10 would indicate that to make a definitive diagnosis, to be
11 sure of which one is the bladder, one of two things needed
12 to be done: either the radiologist would get a flow of
13 urine out of the catheter and be able to watch on the
14 ultrasound as the bladder got small -- just like when a
15 balloon loses air it gets smaller; or, if for some reason
16 he couldn't get the water back out -- the urine come out
17 of the catheter -- he could squirt sterile water into the
18 catheter and into the bladder and number one: watch the
19 bladder get bigger; number two, the stream of water going
20 into the bladder creates a bunch of little eddy currents,
21 like rapids of a stream and ultrasound -- which is like
22 sonar or radar -- picks it up as turbulence. And it picks

1 it up pretty much throughout the entire bladder.

2 Either way would have been accurate, and either
3 way would have been necessary to confirm which of these
4 structures was the bladder. Based upon the medical
5 record, neither one was done.

6 Q. Doctor, is that line drawn precisely as Dr.
7 Allen would have seen Nicole's anatomy on the ultrasound?

8 A. No, it's not.

9 And what I've tried to do here is give an idea
10 of what the anatomy would look like. And this, of course,
11 makes it a lot easier. If it had been like this, Dr.
12 Allen wouldn't have had any problems.

13 In reality, this mass back here was a little
14 bigger, and pressing upon the lower portion of this mass.
15 And the two of them were just -- the lower back-half of
16 the upper mass, and the upper part of the lower one, which
17 is right next to each other -- you could see where one
18 ended and the other began. But you really couldn't see
19 anything in-between them.

20 And then the catheter that he put in, kind of
21 went right to a point in-between the two, and you couldn't
22 tell for sure which one it was in, if either.

1 Q. So could you see, on ultrasound, space between
2 the urethra and the pubic bone?

3 A. Well, you really couldn't see the urethra. You
4 could only see the catheter, the reflections off the
5 catheter. But you could not see any definite space behind
6 the pubic bone or the other structures of the pelvis.

7 Q. From the location of Mass II on your drawing, is
8 that the location where you would expect to find the
9 bladder in a child?

10 A. Actually, neither location is the place where
11 you'd like to find the bladder. Because if you remember,
12 the normal place is more posterior. But it is anterior.

13 If one had to make a choice between these two,
14 it becomes difficult without the other techniques that I
15 mentioned. The bladder should be anterior in the pelvis.
16 It should be to the front. So it would be unlikely to be
17 posterior and low.

18 There's really nothing else that normally lives
19 there. And if one can imagine a balloon getting bigger
20 and bigger, for whatever reason, you know, it tends to
21 enlarge both sideways and upward, as you blow it up. And
22 that's exactly what you'd expect the bladder to do.

1 On the other hand, in a little girl, it's less
2 likely to have isolated, tremendous enlargement of the
3 bladder than it would be in a little boy. And I think
4 that may have been a confusing issue as well -- again,
5 making it that much more important to confirm which one
6 Dr. Allen thought it was by either definitely getting
7 drainage and seeing the bladder get smaller, or by
8 squirring water back in, seeing the bladder get bigger, and
9 seeing all the soundwaves.

10 Q. Doctor, your first drawing there, is that a
11 reasonable depiction of Nicole Panousos' anatomy when her
12 anatomy was totally normal?

13 A. Yes, it would be.

14 Q. Doctor, is your second drawing a reasonable
15 facsimile of Nicole Panousos' anatomy as seen by Dr.
16 Allen?

17 A. I think it's reasonable. As I said, it makes it
18 a little clearer than it was to Dr. Allen, without the
19 help of the techniques I described.

20 MR. SALE: At this point, I would like drawing
21 one marked as Plaintiff's Exhibit No. 15, and drawing two
22 marked as plaintiffs' Exhibit No. 16 for introduction into

1 evidence.

2 (The documents referred to
3 were marked Plaintiffs'
4 Exhibit Nos. 15 and 16 for
5 identification.)

6 BY MR. SALE:

7 Q. What procedure did Dr. Allen do to determine
8 that he was, in fact, inside the bladder?

9 A. As best as I can tell from the chart, he did
10 catheterize the urethra. But he did not either inject
11 fluid or contrast into the bladder, nor did he get a
12 significant fluid return -- a urine return from the
13 bladder, or document the bladder getting either larger or
14 smaller, while he was attempting such procedure.

15 Q. Doctor, I'm going to give you a document that is
16 marked as Plaintiffs' Exhibit No. 5. And I'm going to ask
17 you to tell the jury what that document purports to be?

18 A. Well, this document is labelled as a death
19 summary for Nicole Panousos. Obviously, if a patient dies
20 instead of the concluding portion of the hospital record
21 being a discharge summary, it's termed a death summary.
22 Albeit, this is a normal portion of the hospital record.

1 Q. Who prepared that? You can tell from the
2 record.

3 A. This was prepared by the pediatric surgeon,
4 Dr. Hodin.

5 Q. Is that record normally prepared in the course
6 of care for a pediatric surgery patient?

7 A. Yes, it is. It's typically prepared by the
8 attending physician.

9 Q. Is it normally maintained by the physician in
10 the hospital?

11 A. It's part of the hospital chart. So it's
12 maintained by the hospital.

13 Q. Is the physician required to prepare that report
14 in the course of his care of a surgical patient?

15 A. Yes, he is -- unless that patient has actually
16 transferred to a different service and is no longer that
17 surgeon's patient. So in other words, if another doctor
18 had taken over the primary care of the patient, then it
19 would be that doctor's responsibility.

20 Q. If the child remained in the hospital, and
21 Dr. Hodin remained as the attending surgeon, would he be
22 required to prepare that report?

1 A. Absolutely.

2 Q. Reading that report, does it appear to you that
3 Dr. Hodin prepared it? Does it show evidence of what he
4 would have found in surgery?

5 A. Yes, it does.

6 Q. What does that report tell you regarding the
7 production of urine in the course of the catheterization
8 and ultrasound?

9 A. It indicates that no urine was produced during
10 the catheterization and ultrasound.

11 MR. SALE: At this point I'd like to move into
12 evidence Plaintiffs' Exhibit No. 5. I would also like to
13 move to admit Plaintiffs' Exhibit Nos. 15 and 16, the two
14 charts.

15 (The documents previously
16 referred to as Plaintiffs'
17 Exhibit Nos. 5, 15, and 16
18 were received.)

19 MR. GODARD: I think Plaintiffs' Exhibit No. 5
20 is going to be part of the larger, overall hospital
21 record. In that sense, we'll be duplicating. I have no
22 objection to the overall record.

1 BY MR. SALE:

2 Q. Doctor, I'm going to provide Mr. Godard and you
3 with a document marked as Plaintiffs' Exhibit No. 6. And
4 I'm going to ask you what that document purports to be?

5 A. This is the operative report, again by
6 Dr. Hodin, from the actual operative procedure on Nicole.

7 Q. Would that document normally be prepared in the
8 course of surgical treatment to a patient in the hospital?

9 A. Yes, it would.

10 Q. Would it normally be maintained by the hospital.

11 A. Yes, it would.

12 Q. Does the standard of care require that that
13 document be prepared and maintained?

14 A. Yes, it does.

15 Q. And what does that document tell you, if
16 anything, regarding the production of urine from Nicole
17 Panousos in the course of catheterization in radiology?

18 A. It does not indicate that any urine was produced
19 during the catheterization and radiology. And, of
20 interest, it does indicate that in surgery, this same sort
21 of catheter was utilized to drain the bladder.

22 Q. You say the same sort of catheter. What

1 catheter was that?

2 A. It's called an 8 French Pediatric Feeding Tube,
3 which is a very thin, hollow tube.

4 Q. And what purpose was that used for in surgery?

5 A. Well, at surgery, the bladder was identified and
6 found to be very large, and very tight. And it was felt
7 necessary to drain it, to relieve pressure on the other
8 abdominal organs and the kidney.

9 Q. And what size catheter was used?

10 A. It's called an 8 French, which simply reflects
11 the diameter of the catheter in millimeters.

12 Q. Doctor, what portion of the report are you
13 referring to when you're giving me these facts?

14 A. I'm referring to the operative report.

15 Q. And what does it state?

16 A. At one point it states, "Because a pre-operative
17 sonogram had been done, which had specifically stated that
18 this was not bladder, based on insertion of the catheter
19 to what was thought to be urethra, the prep was extended
20 to include the perineum and the urethra catheter. It was
21 found that this, indeed, did communicate with the bladder.
22 And an additional 200 c.c. of urine was evacuated.

1 Q. Now you also said that an 8 French catheter was
2 used in some other point in Nicole's care? What point was
3 that?

4 A. Well, this was used both as a catheter for, an
5 attempted catheterization in the radiology suite, as well
6 as in the operating room.

7 Q. From the two documents we've reviewed, was urine
8 produced when it was used in the radiological suite?

9 A. There is no evidence in the record that urine
10 was produced in the radiology suite.

11 Q. Now, doctor, if urine was not produced in the
12 course of catheterization, what did the standard of care
13 require Dr. Allen to do to confirm that he was, in fact,
14 in the bladder?

15 A. The standard of care, as I mentioned before,
16 would then have required him to try to inject sterile
17 water into the bladder to see if the bladder would then
18 enlarge, or if one of these two masses would
19 enlarge -- or, at the very least, to see a lot of internal
20 echoes as the ultrasound, sonar, bounced off the
21 turbulence extending into the bladder. And this would
22 involved virtually the entire bladder. And it would be

1 very difficult to miss.

2 Q. Would you have to find the point of the catheter
3 ultrasound in order to see the turbulence?

4 A. No, not at all. The turbulence would involve
5 virtually the entire bladder.

6 Q. Is it a difficult procedure to visualize the
7 turbulence in the bladder in ultrasound?

8 A. No, it's not. It's routinely done by Birch-Dow
9 ultrasound-oriented physicians.

10 Q. Now, doctor, you explained that the urethra was
11 pressed against the pubic bone. Is it possible that Dr.
12 Allen, in fact, could not have gotten a catheter into the
13 bladder?

14 A. It's possible that the catheter simply didn't go
15 all the way. That's right.

16 Q. In that instance, would the injection of sterile
17 water have confirmed that Mass II was flatter?

18 A. Yes, it would have.

19 Q. How would that have occurred?

20 A. Because the back pressure from injecting water
21 through the catheter would have been enough to open up the
22 urethra, as the urethra is, after all, a soft, distensible

1 tube. And so water could flow back into the bladder.

2 One can certainly use more pressure in injecting
3 backwards, than this baby's bladder and abdomen muscles
4 would have been able to force this movement forward.

5 Q. So the use of the sterile saline would actually
6 help you in getting the catheter in the bladder?

7 A. Well, not getting the catheter in the bladder,
8 but getting identification of the bladder by the stream of
9 saline going into the bladder.

10 Q. In the anatomy of Nicole, as presented in
11 ultrasound, on March 5, 1987, is it possible that the
12 saline, itself, still would not have gone into the
13 bladder?

14 A. It's conceivable. And in that case, there would
15 be several other means of identification of which mass was
16 the bladder? One would be performing a CAT scan. The
17 other would be performing a procedure called an IVP.
18 Either one of these would be readily available in the
19 departments, and would take 25 or 30 minutes to perform.

20 Q. Now, if the salt water was injected into the
21 catheter, and it did not go into the bladder, what would
22 that tell you about whether or not your catheter was in

1 the bladder?

2 A. It would certainly tell me that the catheter was
3 not in the bladder.

4 Q. Is there any indication in the record that the
5 CT scan was performed?

6 A. No, it was not.

7 Q. Was there any indication in the record that a CT
8 scan was possibly envisioned?

9 A. Yes, there is a note by Dr. Hodin -- actually
10 prior to the ultrasound being performed -- that indicated
11 that he thought a CT scan might be necessary.

12 Q. We're going to give you Plaintiffs' Exhibit No.
13 9, and a copy to Mr. Godard as well, and ask you if that
14 was the note you were referring to?

15 A. Yes, it is. On page 3587, the Pediatric
16 Surgical Attending note, signed by Dr. Hodin -- and
17 apparently in his handwriting -- indicates -- and I'll
18 just read the last paragraph, "Will get sono," meaning
19 ultrasound. "Believe this is probably left uretero
20 peritonital mass, like a tumor, with infection." Then he
21 goes to the end -- "sono probably best, with perhaps CT to
22 follow."

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1 MR. SALE: I'm going to move into evidence
2 Plaintiffs' Exhibit No. 9.

3 (The document referred to and
4 previously marked as
5 Plaintiffs' Exhibit No. 9 for
6 identification was received.)

7 MR. GODARD: Again, it's my understanding that
8 the entire record is, or will be, in evidence.

9 BY MR. SALE:

10 Q. Doctor Karsh, from your review of the record of
11 this case, have you seen any evidence that that document
12 would be part of the chart?

13 A. Yes, it would be part of the chart.

14 Q. Have you seen any evidence in your review of
15 this case that the chart would have accompanied Nicole
16 Panousos when she went to the radiology department?

17 A. It's standard procedure that the chart
18 accompanies any patient to ultrasound. But there is no
19 definite indication in the chart that that occurred.

20 (Discussion off the record.)

21 BY MR. SALE:

22 Q. I'm going to show Mr. Godard and you, a document

1 that's been marked as Plaintiffs' Exhibit No. 8, for
2 purposes of this testimony.

3 And I'm going to ask you, what is that document?

4 A. That is the Report of Radiologic Consultation.
5 It's the report of the Dow ultrasound examination on the
6 5th of March.

7 Q. And could you tell me what the findings are in
8 that report?

9 A. The findings show the presence of two, cystic
10 masses within the abdomen and pelvis, of which the lower
11 mass is identified as the bladder. And several
12 possibilities are suggested as to the upper mass, none of
13 those possibilities being the bladder.

14 Q. Can you see any evidence that a CT scan was
15 done, from that report?

16 A. No, I cannot.

17 Q. Can you see any evidence from that report that
18 sterile water was injected into the bladder?

19 A. No, I cannot.

20 Q. Can you see any evidence from that report that
21 any other testing was done to confirm the bladder was Mass
22 II?

1 A. Well, it indicates that a catheter was inserted
2 with sterile precautions, to confirm the location of the
3 bladder. But it does not indicate, beyond that, how such
4 confirmation was made.

5 Q. Does it say that, in fact, the introduction of
6 the catheter confirmed the bladder?

7 A. Yes, it does.

8 Q. Does it indicate that any moisture, or droplets
9 were produced in catheterization?

10 A. No, it does not.

11 Q. Does it indicate that a free-flow or a steady
12 stream was produced?

13 A. No, it doesn't.

14 Q. Doctor, the opinions you've given here regarding
15 compliance with the standard of care, would those opinions
16 change if, in fact, Dr. Allen had produced several
17 droplets or drops of liquid?

18 A. No, not at all. I think everybody can
19 understand that after you urinate, there's often a couple
20 of drops of urine left. And a catheter and bladder can
21 certainly pick up -- or I should say a catheter in the
22 urethra, or even just in the vagina, could pick up a drop

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1 or two without creating a steady stream.

2 MR. SALE: I want to move into evidence
3 Plaintiffs' Exhibit No. 6 and Plaintiffs' Exhibit No. 8.

4 (The documents previously
5 referred to as Plaintiffs'
6 Exhibit Nos. 6 and 8 for
7 identification were
8 received.)

9 MR. GODARD: Again, to the extent, there are
10 duplicated, with the exhibits already in evidence, I think
11 they're unnecessary.

12 BY MR. SALE:

13 Q. Doctor, can you tell from looking at the record
14 here, whether there was any exigency that shortened the
15 time for radiology?

16 A. If by that you're asking was there adequate time
17 before the ultrasound examination and the eventual
18 operation for other examinations, such as an IVP or a CAT
19 scan to be performed, no. There was no difficulty in
20 doing one or both examinations, if necessary.

21 Q. Was there anything in the record that told the
22 radiologist that there was not enough time?

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1 A. No, nothing that I could see.

2 Q. In fact, was there time between the completion
3 of the radiology and the surgery to complete that testing?

4 A. Yes, there certainly was. There was almost 3
5 hours between the time the baby was in the radiology suite
6 and left for the operating room. And that would have been
7 more than enough time for one or both of the other
8 examinations.

9 Q. How long did you say the CAT scan would take?

10 A. With the equipment utilized in 1987,
11 approximately 25 or 30 minutes -- possibly as long as 40
12 minutes, depending upon exactly what technique would have
13 been utilized.

14 Q. And what was the other test you said could have
15 been done to confirm the bladder?

16 A. It's called an IVP. And that would usually take
17 20 to 30 minutes.

18 Q. If both tests had been completed, how long would
19 the total procedure take?

20 A. Somewhere in the neighborhood of an hour. But
21 in reality, if the CAT scan had been performed, there
22 would then be no need for an IVP whatsoever.

1 Q. Why would the CAT scan have enabled you to
2 identify the bladder better than ultrasound?

3 A. Well, it's a different type of technique in that
4 the CAT scan not only would identify the fact that there
5 were two masses within the pelvis and abdomen, two fluid-
6 filled masses, but after the patient would have been given
7 some intravenous contrasts, folks often call it dye
8 colloquially, it will show up in the kidneys and then into
9 the bladder.

10 We know the bladder was getting bigger and
11 bigger. The kidneys were still working and putting fluid
12 out even though it couldn't get out through the urethra,
13 so we know the contrast would have gone down into
14 whichever cystic mass, the bladder, and this would have
15 been confirmed by CAT scan.

16 Q. Doctor, just to make your testimony clear, is it
17 your testimony that if the catheter produced no urine upon
18 introduction into the bladder, that the injection of
19 sterile water was required?

20 A. Yes, it is.

21 Q. Doctor, I'm going to show you a document, show
22 you and Mr. Godard a document, marked as Plaintiffs'

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1 Exhibit No. 7 and ask you to tell me what is that
2 document.

3 (The document referred to was
4 marked Plaintiffs' Exhibit
5 No. 7 for identification.)

6 THE WITNESS: This apparently -- I shouldn't say
7 apparently, but this is a review of Nicole's course from
8 the time of admission through the time of her death. It
9 is not signed. I understand that this was dictated by
10 Dr. Hodin. It includes the comments of the person who
11 dictated this and apparently took care of Nicole, his
12 thoughts concerning the hospital course and the problems
13 that she encountered.

14 BY MR. SALE:

15 Q. Had Nicole survived surgery in this case, would
16 follow-up visits have been conducted by Dr. Hodin?

17 A. I believe one would have been, at least one
18 post-operative exam. Actually, given the type of surgery,
19 there would have been an additional procedure perhaps
20 6 or 8 weeks down the line because there was a small or
21 probably diverting colostomy performed which would have
22 had to have been repaired. So Dr. Hodin would have

1 followed Nicole for probably several months.

2 Q. From your review of that record does it appear
3 to you that that record was prepared in the course of
4 normal medical care provided to Nicole Panousos by
5 Dr. Hodin?

6 MR. GODARD: Well, I'm going to object to that.
7 This witness can testify.

8 THE WITNESS: I really can't tell. It would
9 appear to be reasonably contemporaneous with the hospital
10 course, but again it's not really dated or signed.

11 BY MR. SALE:

12 Q. Would it have been normal for Dr. Hodin to
13 maintain an office record?

14 MR. GODARD: Objection.

15 THE WITNESS: It would be normal for Dr. Hodin
16 to maintain an office record, but typically that record
17 would be that of the hospital chart or the portions of the
18 hospital chart that Dr. Hodin felt appropriate as well as
19 the operative note.

20 BY MR. SALE:

21 Q. In the course of surgery, what did Dr. Hodin do,
22 if you can tell from that record, once he found that the

1 large mass was, in fact, her bladder?

2 A. He drained the bladder. And then he surgically
3 removed the other mass. At the time of removing the other
4 mass, he felt that he put a small nick into the rectum and
5 that's why he did the diverting colostomy to help her
6 prevent any spill of feces into the pelvis itself.
7 Obviously, he wanted to prevent any possibility of post-
8 operative infection.

9 Q. And these facts are also shown in the operative
10 report, which I believe you've looked at?

11 A. Yes, they are.

12 Q. Did Dr. Hodin contact Dr. Allen during surgery?

13 A. According to this, he did during the course of
14 surgery. And I guess he was curious, based upon this as
15 to -- on what basis Dr. Allen made the identification of
16 the bladder when indeed what Dr. Allen had identified as
17 the bladder was not the bladder.

18 Q. And what was that basis?

19 A. The basis was based upon the catheterization.

20 Q. Was there any other procedure conducted?

21 A. Not that I can tell in either this or the
22 hospital records.

1 Q. Doctor, from your review of that record, did it
2 strike you as unusual that Dr. Hodin would have been
3 calling Dr. Allen in the middle of surgery?

4 MR. GODARD: Objection.

5 THE WITNESS: Yes, it's unusual.

6 BY MR. SALE:

7 Q. Doctor, have you ever been called in the middle
8 of surgery?

9 A. Not that I recall during the middle of surgery.
10 I've had an occasional call right after surgery
11 fortunately usually to congratulate me or one of my
12 partners on a good diagnostic call and sometimes the
13 surgeon would call and tell us that we were right about a
14 mass or something, but we didn't have the exact diagnosis
15 and it was very intriguing to him from what he found.

16 Q. And how many times have you done a radiological
17 diagnosis as part of the surgery?

18 A. Hundreds.

19 Q. Does Plaintiffs' Exhibit No. 7 indicate that Dr.
20 Allen rejects contrast solution?

21 A. No, it does not.

22 Q. I'm going to refer you, Dr. Karsh, specifically

1 to the bottom of page 1 and the top of page 2 and ask you
2 to review those two portions.

3 (Pause.)

4 Q. Okay. On the top of page 2, which is also
5 listed as number 149, it is indicated that he put contrast
6 in it -- it's on the second line -- and thought it looked
7 exactly like bladder, but he got no urine out of it.

8 MR. GODARD: Let me just note an objection.

9 I object on the grounds that this obviously is
10 not a part of any medical record. I will object to it
11 being introduced into evidence or proffered into evidence
12 at trial. I, therefore, object to this witness reading
13 from it. It's a hearsay document, it's something prepared
14 outside of the course of his ordinary practice and for
15 whatever purpose it may have been preserved and kept by
16 Dr. Hodin other than the obvious; that is, protection of
17 his own interest in the event of anticipated litigation,
18 it is not relevant in this case and I, therefore, preserve
19 all objections to it.

20 I would ask that the video operator make a note
21 of the footage if you will so we can easily mark what time
22 he ceases to talk about it.

1 MR. SALE: I'll just respond for the record at
2 this point that Dr. Hodin maintained that record in the
3 course of his care of Nicole Panousos, was required to do
4 office follow-ups with Nicole Panousos had she survived,
5 and that office record would have been integral to the
6 follow-up care of Nicole Panousos kept in the regular
7 course of medical care.

8 MR. GODARD: Well, that's absurd. Are you
9 saying he took the body back to the office for follow-up
10 care? Nothing like that ever occurred; therefore, this
11 record has nothing at all to do with her subsequent care.

12 MR. SALE: Dr. Hodin regularly maintains these
13 office records in the course of his care and would have
14 used this record in caring for her had she survived.

15 MR. GODARD: Had she survived, this record would
16 not even exist, so proceed.

17 MR. SALE: We can go back on the video.

18 BY MR. SALE:

19 Q. Doctor, you have reviewed the stenography report
20 and you've seen the word "confirmed" in there. What is
21 the significance of the word confirmed in radiology?

22 A. In this particular case, it would indicate to

1 the referring physician, to the physician reading the
2 report, that this was a definitive rather than
3 differential diagnosis.

4 Q. And the surgeon would take that impression?

5 A. Certainly so.

6 Q. If the word confirmed were not used would Dr.
7 Hodin still be correct in relying upon the diagnosis?

8 A. It would depend upon the exact wording. He very
9 likely would or that it would be within his purview or for
10 that matter the radiologist's purview to perform
11 additional diagnostic procedures before surgery.

12 Q. Could Dr. Hodin rely upon the ultrasound without
13 reviewing it?

14 A. That would be the normal course of events.

15 Q. Do surgeons normally review ultrasound?

16 A. Not very commonly.

17 Q. And why is that?

18 A. They don't know a heck of a lot about what
19 they're looking at.

20 Q. Do you need special training to be able to
21 interpret ultrasound?

22 A. Both training and experience, yes.

1 Q. From the record, can you see an indication that
2 Dr. Hodin did order additional testing?

3 A. No, as far as I can tell from the record he did
4 not.

5 Q. Can you see from the record that he envisioned
6 any further testing prior to the sonogram?

7 A. Well, prior to the sonogram he had suggested
8 that a CAT, a CAT scan might be indicated as well.

9 Q. And that was no done?

10 A. That was not done.

11 Q. Now, you said that an 8 French catheter was used
12 surgically for draining the bladder.

13 A. That's right.

14 Q. That was also used by the radiologist?

15 A. Yes, it was.

16 Q. Was the surgeon able to get any fluid out of the
17 8 French catheter?

18 A. Yes, actually the surgeon first used a trochar
19 and got 800 cc's which is basically four-fifths of a
20 quart, got fluid out and then used the catheter to get
21 another 6 or 7 ounces, 200 cc's out.

22 Q. Doctor, how many times have you catheterized a

1 bladder?

2 A. A lot, certainly more than fingers and toes.

3 Q. And did any of those examinations involve the
4 injection of sterile contrast solution?

5 A. Yes, I have and certainly many of them involved
6 the filling of the bladder for looking at the bladder, not
7 necessary under ultrasound, some were for ultrasound, but
8 often under fluoroscopy. But it's a comparable procedure.

9 Q. So the catheter can be used either to drain or
10 to fill the bladder?

11 A. Yes, it can.

12 Q. Does this improve or detract from the certainty
13 of your diagnosis?

14 A. Well, the ability to -- in this particular case,
15 to identify a structure as being the bladder two different
16 ways to potentially improve the certainty of that
17 diagnosis.

18 Q. In your catheterization of bladder, do you ever
19 use an 8 French catheter?

20 A. Many times, it's typical.

21 Q. Have you been able to draw urine with the 8
22 French catheter?

1 A. Yes, I have.

2 Q. Have you ever been unable to draw urine with the
3 8 French catheter?

4 A. Yes, I have. There have been times that we
5 simply, for one reason or another, have not been able to
6 advance the catheter all the way into the bladder. Most
7 usually this would be in boys who actually have a
8 stricture because they're narrow in the urethra and the
9 bladder -- the catheter just bumps up against it and does
10 not empty the bladder. In those cases we have to use
11 different techniques.

12 Q. If you injected the 8 French and got no urine,
13 would you stop your examination there?

14 A. You mean if I inserted the 8 French catheter and
15 got no urine, no. Then obviously I would utilize
16 injection, either of sterile solution and ultrasound and
17 see if I could see any abnormalities of sound waves within
18 the bladder; in the case of ultrasound, just some
19 turbulence, or I could certainly take the infant from
20 ultrasound and put it under a fluoroscope and use a
21 contrast, a dye, if you will, and actually visualize the
22 dye going up the urethra or the vagina or wherever the

1 catheter happened to be and see if it flows back into the
2 bladder.

3 If you got a couple of drops when you were
4 entering the catheter and doing the ultrasound, at that
5 point you just confirmed that you got bladder and stop
6 your examination. Not only are we dealing with a cystic
7 mass that is so big that obviously whichever lead is the
8 bladder is quite full, if you're really in it you would
9 have more than a couple of drops. I mentioned before you
10 could certainly get a couple of drops either out of the
11 vagina or the urethra itself if a little tiny bit of
12 dribble had occurred.

13 Q. You said the cystic mass was so full, what
14 cystic mass were you referring to?

15 A. Actually, either one. Again, at this time Dr.
16 Allen didn't know or the diagnostic radiologist did not
17 know that he could tell that both were rather full or not
18 by looking on the ultrasound if they're full of fluid and
19 under a certain degree of tension.

20 Q. So you would suspect urine flow from either
21 mass?

22 A. Well, if either mass was the bladder, then it

1 was full of urine. And that urine would flow as the
2 catheter entered the mass. .

3 Q. Was it possible that neither of these two masses
4 were the bladder?

5 A. Extraordinarily unlikely, but I suppose anything
6 is possible.

7 Q. Could you confirm that neither of these two
8 masses was the bladder based on the cathetering done here?

9 A. No, you could not.

10 Q. Doctor, have you ever been admitted as an expert
11 witness and testified in a case tried in the Commonwealth
12 of Virginia?

13 A. Yes, I have. That was perhaps 4 or 5 years ago
14 in Alexandria.

15 Q. Would that have been in the period roughly
16 between March of 1985 and March of 1989?

17 A. Yes, it was.

18 Q. Doctor, you have testified that Dr. Allen
19 violated the standard of care regarding the radiological
20 testing. Could you summarize that opinion for purposes of
21 the jury's understanding of that opinion?

22 A. When Nicole was sent to ultrasound for

1 evaluation of an abdominal and pelvic mass, it was clear
2 there were conditions not only required, identification of
3 the fact whether or not there was indeed a pelvic mass or
4 an abdomen mass, but whether or not that mass was solid or
5 filled with fluid. But then as best as possible,
6 identification of what that mass or masses might be.

7 Given the presence of two separate masses and
8 knowing that one should be the bladder because the bladder
9 normally lives in the pelvis and lower abdomen, then the
10 standard of care made it imperative upon Dr. Allen to
11 identify which, if either, mass was indeed the bladder.

12 To do so he needed to make a definitive
13 diagnosis based upon either the range of urine from the
14 bladder, was the bladder getting smaller, that certainly
15 would identify it or increasing size of the bladder and
16 turbulence, ultrasound turbulence within the bladder from
17 injecting a sterile contrast or a sterile saline solution
18 into the bladder by way of the catheter.

19 Lacking the capability to do that, it would be
20 incumbent upon Dr. Allen to do, recommend, or perform
21 either a CAT scan or a IVP to further identify which of
22 the two structures, if either, was indeed the bladder.

1 Q. Doctor, do you see any indication in the record
2 that Nicole was going to surgery immediately regardless of
3 the outcome of radiology?

4 A. No, I don't see any definitive evidence of that.

5 Q. Is there anything in the record that would
6 indicate you would try to delay surgery here if you could
7 on the basis of radiology?

8 A. I don't recall actually if that is in the record
9 itself or in one of Dr. Hodin's notes. But there is
10 certainly an indication, I think actually in the operative
11 report that his initial intention was to wait 24 hours or
12 so, but because of the radiology report that he felt like
13 he should proceed directly to surgery.

14 Q. Were there any symptoms that indicated that
15 waiting 24 hours would be appropriate?

16 A. Not exactly symptoms as such, but certainly, on
17 the ultrasound examination there is evidence of dilatation
18 or in other words, enlargement of the collecting system
19 within the kidney. That could possibly interfere with
20 renal function. And when that obstruction is relieved,
21 there's often a period of 24 hours or so where the kidney
22 function may fluctuate fairly wildly and have an effect

1 upon the electrolytes, basically, if you will, the
2 electronic substrate of body fluids.

3 Ideally, this child would not only have had some
4 of her discomfort relieved since the bladder had been
5 emptied prior to surgery, but any possible shifts in
6 electrolytes, in the body chemistry, could probably have
7 been normalized, could have been normalized prior to the
8 surgery. She would have been a much stronger candidate
9 for her surgery.

10 Q. You have just given an explanation of what would
11 have happened had the bladder been compressed before
12 surgery. Was there anything about her physical condition
13 that would have indicated to Dr. Allen that surgery would
14 be delayed if that was possible?

15 A. I don't know. I really don't know. I think
16 that would be a judgment. My assumption would be that
17 there would be some indication with the surgeon and
18 certainly on the basis of Dr. Allen's own clinical
19 judgment and experience, it's typical that the more stable
20 a patient could be and be more contagious to acute
21 problems could be eliminated, the less need for an
22 emergency type procedure would be performed.

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1 MR. SALE: I show counsel Plaintiffs' Exhibit
2 No. 12.

3 (The document referred to was
4 marked Plaintiffs' Exhibit
5 No. 12 for identification.)

6 BY MR. SALE:

7 Q. I'm going to have Dr. Karsh review that, the
8 admission notes from Fairfax Hospital.

9 Dr. Karsh, please tell me what those admission
10 notes show about the condition of Nicole Panousos at the
11 time that she was admitted to Fairfax Hospital. First of
12 all, can you tell me from the note at what point she
13 arrived at the emergency room?

14 A. She arrived in the emergency room just prior to
15 1:00 in the morning on the 5th of March.

16 Q. What was her condition at that time as recorded
17 by Fairfax Hospital?

18 A. Other than significant abdominal pain, her
19 condition appeared to be rather stable. She had had, as I
20 mentioned before, several days of a flu-like episode. But
21 basically her body chemistries and the like were either
22 normal or very near normal and from a physiologic

1 standpoint, meaning how she seemed to feel as compared to
2 the anatomy that was ultimately discovered, there didn't
3 appear to be any definite reason for immediate conversion
4 to surgery.

5 Q. You said the electrolytes were stable at that
6 point?

7 A. Well, they were fairly normal at that point.
8 Obviously you can't say stable until you've seen more than
9 one set. But the set that was obtained in the emergency
10 room were essentially normal in terms of the important
11 aspects of electrolytes.

12 Q. Doctor, you testified that Dr. Allen's breach of
13 the standard of care caused Nicole's death. Is that
14 accurate?

15 A. It's somewhat convoluted, but it's accurate in
16 that Dr. Allen's breach of the standard of care led to the
17 emergent nature of surgery. That surgery then being
18 performed in a child whose condition was complicated by,
19 what we call post constructive diuresis, a sudden relief
20 of the pressure on the kidneys, making it more difficult
21 for the surgical and intensive care unit team to follow
22 the levels of hydration, to normalize her electrolytes,

1 and to care for her.

2 More importantly, once the child did have a
3 cardiac arrest, and interestingly at the time that the
4 most qualified personnel were in the intensive care unit,
5 that being the pediatric internist and his team, a
6 relative routine, if I could call it, successful
7 resuscitation could not be performed.

8 And I believe, in fact, I'm sure that had this
9 baby been fully stabilized for 24 hours or so prior to
10 surgery, that number one, the chance of her having a
11 cardiac pulmonary arrest would have been almost negligible
12 and number two, if it had occurred for reasons such as a
13 plug in the antrocol tube and a short term inability to
14 fill her with oxygen, it would have been a routine
15 resuscitation.

16 The resuscitation was complicated by the fact
17 that the baby was overhydrated, complicated by the fact
18 that the baby was in congestive heart failure, at least a
19 borderline congestive heart failure. It was complicated
20 by the fact that the baby's electrolytes were out of
21 kilter and in particular, CAT scan was low, which led to a
22 relative inability to get a normal heart rate and rhythm

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1 back.

2 Q. How long did the resuscitation take here to
3 restore cardiac function for Nicole Panousos?

4 A. The best I can tell, there was what we call a
5 full court press for about 30 minutes or longer. And in
6 fact, it appears that the team was about to give up and
7 finally gave some medication, adrenalin, directly into the
8 heart. And that's what finally reversed the lack of
9 ability to maintain a heart rate at all.

10 Q. What was the impact on Nicole Panousos of a
11 30-minute arrest?

12 A. Well, this resulted in severe impairment,
13 certainly to the heart and heart functions as documented a
14 day or so later by a cardiac ultrasound examination and
15 almost certainly significant damage to her brain as well.
16 Though obviously, in a 4-1/2 month old infant, under the
17 circumstances it's very difficult to assess how much of
18 that function might have come back.

19 Q. Was the arrest a factor in Nicole's death?

20 A. Yes, it was.

21 Q. And how great of a factor was the arrest?

22 A. Well, for practical purposes that was the final

1 event, that was the direct causative event of her death.

2 Q. Was the arrest the cause of her death?

3 A. Yes, it was.

4 Q. Doctor, would a reasonable, prudent radiologist
5 when conducting this exam be aware that the death of a
6 patient could result from an error in diagnosis?

7 A. That's taking things rather far. Certainly a
8 prudent radiologist understands that he's obligated to
9 provide as accurate a diagnosis as possible. And that
10 unforeseen complications, that he cannot particularly
11 specify nor give odds to could occur if, particularly a
12 surgeon encounters anatomy that he doesn't expect or if
13 the patient has to undergo surgery at a suboptimal time.

14 Q. So would a reasonably prudent radiologist have
15 known that a misdiagnosis here would cause -- could cause
16 harm to the patient?

17 MR. GODARD: Objection.

18 BY MR. SALE:

19 Q. Would a reasonable prudent radiologist know that
20 a misdiagnosis would cause harm to the patient?

21 A. He would certainly know that a misdiagnosis
22 could cause harm to the patient, but he probably would be

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1 unable to specifically identify what harm it might cause.
2 It could be anything from a larger postsurgical scar
3 obviously to death with the likelihood of death I'm sure
4 being very, very low on his list.

5 Q. Doctor, you testified that the violation of the
6 standard of care by Dr. Allen caused Nicole's death, could
7 you explain briefly how the misdiagnosis actually caused
8 the death?

9 MR. GODARD: Objection. Asked and answered. He
10 went through that 5 minutes ago.

11 THE WITNESS: Again, if you wish to summarize,
12 misdiagnosis resulted in emergent surgery. The emergent
13 surgery was then performed on the child in suboptimal
14 condition. In other words, one that was more prone to
15 complications than a condition that was more difficult to
16 follow her electrolyte status, more difficult to determine
17 her hydration status. And ultimately when the cardiac
18 arrest occurred, these abnormalities resulted in the
19 inability of the patient to be successfully resuscitated
20 with such damage that resulted in her gradual dwindling
21 and actual death a number of hours later.

22 BY MR. SALE:

1 Q. Is it your opinion that Dr. Allen's violation of
2 the standard of care caused Nicole's death within a
3 reasonable degree of medical certainty?

4 MR. GODARD: Objection, leading.

5 THE WITNESS: Based upon the scenario which I've
6 outlined, yes.

7 BY MR. SALE:

8 Q. You expressed your recent opinions here
9 regarding the causation of Nicole's death with a
10 reasonable degree of medical certainty.

11 A. Yes, I did.

12 Q. Doctor, I'm going to ask you to look at some of
13 the electrolyte values here which you have described to us
14 and please tell the jury what you mean when you indicate
15 the electrolytes were out of balance.

16 A. As the jurors probably know, cardiac action is
17 instituted basically by electronics, if you will, almost
18 like wires within the heart. And the function of the
19 electronics within the heart can be significantly affected
20 by changes in electrolytes, particularly in levels of
21 potassium within blood and intercellular fluid.

22 The normal accepted lower levels of potassium is

1 3.5 mili equivalents per liter, which we can see at 1:00
2 in the morning is exactly where Nicole's level was. But
3 both before and after that time period her potassium level
4 was low, not tremendously low, but low enough that once
5 she did indeed have a cardiac arrest, it made it very
6 difficult for her to be resuscitated. It made it
7 difficult for a normal electronic activity, if you will,
8 of the heart to be reobtained.

9 There are a number of other abnormalities within
10 the electrolytes, the sodiums, the chlorides, but these I
11 think were relatively minor and did not have a significant
12 affect upon her inability to be resuscitated.

13 Of interest, the BUN which is blood, urea,
14 nitrogen would indicate that, as it was dropping and, in
15 fact, this first measurement of it at the time of her
16 admission was 17, would indicate that there was some
17 dilution of her blood, that she was getting more and more
18 fluid during the course of her hospitalization.

19 But again, had there been 24 hours to 48 hours
20 after relief of obstruction of the bladder, these numbers
21 would have been able to have been normalized and, had the
22 very unlikely event of a cardiopulmonary arrest occurred,

1 she would have been readily resuscitated.

2 There are a number --

3 Q. Doctor, before leaving that chart, you've
4 explained which of the potassium and which of the BUNs
5 were out of order. Can you please explain which of the
6 other electrolytes are normal and tell where the
7 electrolytes are?

8 A. Well, the sodiums were a little bit high. The
9 chlorides were a little bit off. That probably reflects,
10 though, some medications that she was given, sodium
11 bicarbonate, which would be normal medication to give to a
12 child in this condition. And the departures from normal
13 are probably not significant in terms of cardiac
14 functioning, cardiac electronic function.

15 Q. Now you said that 3.5 potassium was a low
16 normal. Can you explain that answer?

17 A. Well, the normal potassium levels, you like to
18 see about 4 to 4.5 mili equivalents per liter. But
19 obviously, just as the height of a normal adult male in
20 this country is about 5 foot 10 or so, there is a range.
21 And we probably don't look at somebody 6 foot 3 or
22 5 foot 7 as being out of the ordinary. So there is a

1 range. There is similarly a range of about 3.5 to 5.,
2 that is considered within the range of normal.

3 The closer one is to the lower limit and the
4 further one is below the lower limits of normal, the more
5 likelihood there is a developing a cardiac arrhythmia or a
6 rhythm disturbance of the heart and difficulty in getting
7 it back to normal.

8 Similarly, actually the higher or a level of 5
9 or 5.5 mili equivalents per liter, there definitely, the
10 more difficulty there is in developing a normal cardiac
11 action as well. Though they tend to be different rhythm
12 disturbances depending on whether the potassium is low or
13 high.

14 Q. Doctor, please proceed to your next chart. By
15 the way, doctor, who prepared this chart you're now going
16 to look over?

17 A. Well, of course, I didn't do the charts
18 themselves, but I wrote down what needs to be on the
19 chart. So in a sense, I had prepared and then have had
20 formalized for me.

21 Q. Doctor, the chart you just put down, I'm going
22 to give you Plaintiffs' Exhibit No. 10. And I'm going to

1 ask you, the electrolytes that were reproduced in your
2 chart, were those taken from the medical records?

3 (The document referred to was
4 marked as Plaintiffs'
5 Exhibit No. 10 for
6 Identification.

7 A. Yes, they were.

8 Q. Go ahead.

9 A. I've talked a couple of times about the
10 hydration status of this baby, meaning how much fluid she
11 had on board. And the importance of that is that the more
12 fluid one gives a patient, particularly a sick patient,
13 the more of a load is put upon the heart. Because after
14 all the blood is being pumped by the heart and the more
15 blood, if you will, the more fluid that any pump has to
16 work.

17 In Nicole's particular case she entered the
18 hospital and examination was by both her pediatrician, Dr.
19 Harrison and by Dr. Hodin indicated that either she was
20 not at all dehydrated or maybe very little bit, 2 or
21 3 percent dehydrated. She weighed approximately
22 8 kilograms, that's about 17 pounds on admission. During

1 the first day of her admission, she received slightly more
2 than 700 cc's more fluid than the fluid that was excreted.
3 Now mind you, that's excluding what was already in the
4 bladder. We know that the bladder was distended, about a
5 quart, actually a little bit more than a quart of fluid.
6 But that, in essence, had already been excreted. So her
7 system was really no different than if you had weighed her
8 with a quart bottle on top of her.

9 Now that 700 or so cc's represented 10 percent
10 of her body weight. That's a very large fluid load to
11 this sick child.

12 Q. Doctor, I'm going to stop you here for a minute.
13 How was this fluid inputted into Nicole? Was it fed in
14 through her mouth?

15 A. Most of it was intravenous.

16 Q. Is that directly into --

17 A. Directly into the veins. Some of it was
18 actually was blood, was concentrated blood. Most of it
19 was other fluids. Some of it was a fluid whose
20 concentration is very similar to that of blood, a salt
21 concentration, some was what we call a bolus, a saline, a
22 very concentrated solution.

1 Q. Doctor, we're on the hydration status right now.
2 What is the normal blood volume of a child Nicole's size
3 and age?

4 A. The normal blood volume would be 550 to 600 cc's
5 total blood volume, about 8 percent of her total weight.

6 Q. And how much extra volume did you say she got
7 here?

8 A. About 700, 730 cc's.

9 Q. Okay. We're going to show Mr. Godard and you
10 Plaintiff's Exhibit No. 11. I'm going to ask you whether
11 your calculations of extra 730 cc's were based upon
12 Plaintiff's Exhibit No. 11?

13 (The document referred to was
14 marked as Plaintiffs'
15 Exhibit No. 11 for
16 Identification.

17 A. Yes, they were. And I should note that the
18 calculations were made by whoever prepared this,
19 presumably it was nurses in the intensive care unit, that
20 when they look at the output they inadvertently also
21 utilize the amount of fluid that had been removed directly
22 from the bladder at surgery. And that was really not

1 relevant because that was already in the bladder, really
2 the equivalent of being outside the patient. It just
3 hadn't been urinated yet even prior to admission.

4 Q. Is there any casual nexus between Dr. Allen's
5 violation of the standard of care and the additional
6 734 cc's administered to Nicole?

7 A. I don't think so. Other than the fact that it
8 was more difficult, as you mentioned, it was more
9 difficult for the physicians taking care of her to follow
10 her hydration because of the potential inaccuracies in
11 judging renal output after the sudden relief of the
12 obstruction in surgery.

13 Q. What was the sudden release in renal output?

14 A. Well, remember the ultrasound exam on Nicole
15 shows not only these large cystic masses in her abdomen
16 and pelvis but it showed the kidneys to be, the collecting
17 systems of the kidneys to be dilated as well, not
18 tremendously, but somewhat. You can easily see this very
19 thin branches in here that were thought to be enlarged.
20 So when the pressure causing backup of fluid, of urine
21 into the kidneys was relieved by draining the bladder,
22 then the kidneys may suddenly react either as just pouring

1 out fluid or they may constrict, we just don't know over
2 the course of a day or so exactly how they're going to
3 react.

4 So whereas, in a normal child the output of
5 urine and the specific gravity of the urine would be very
6 accurate indicators of her kidney function and good
7 secondary indicators of hydration status, in this
8 circumstances without having had that 24-hours after
9 relief of the obstruction by the bladder, it becomes much,
10 much less reliable.

11 Q. Doctor, you use the term diuresis. What is a
12 diuresis?

13 A. Well, uresis, of course, indicates production of
14 urine. So diuresis simply means increased production of
15 urine which is typically what one sees shortly after
16 release of obstruction. And again, it's as if the kidneys
17 are trying to make up for inability to produce as much
18 urine as they would like to.

19 Unfortunately, this is not a 100 percent
20 possibility. We don't know when this diuresis is going to
21 occur because there is something called antidiuretic
22 hormones which sometimes the body will produce

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1 inappropriately in a situation like this. And even though
2 the kidneys would like to open up and produce a lot of
3 urine and relieve excess fluid, it may take a while for
4 this hormone to basically die out in terms of its effect.
5 And that's why it's ideal to wait at least 24 hours after
6 relief of obstruction to really know you're in a stable
7 situation.

8 Q. And how would the 24 hours let you know you were
9 in a stable situation?

10 A. Well, then one would have that full 24 hours to
11 monitor the urine outflows, to monitor urine specific
12 gravities, and to see if there's any response, any
13 response to such things as diuretics which may be utilized
14 to counter the affect of antidiuretics.

15 In Nicole's situation, a very small dose of
16 diuretic given later on in her hospital course had time to
17 respond more than I would expect and that suggests to me
18 that there either was some antidiuretic hormone involved.
19 And again, it confirms to me that the urine outputs right
20 after surgery and urine specific gravities would be less
21 than normally reliable.

22 Q. Did Nicole have a diuresis?

1 A. Yes, she did. But not a tremendous one. Her
2 urine output subsequent to surgery was approximately what
3 one would anticipate in a normal, not overhydrated infant.
4 And I think this represented for her in her situation an
5 inadequate diuresis until the medication, Latex, was
6 actually given a number of hours later.

7 Q. Did Nicole's urine output tell the health care
8 providers after her surgery whether she was overhydrated
9 or dehydrated?

10 MR. GODARD: Object to the form of the question
11 to the extent that it suggests that Dr. Allen wasn't
12 wasn't clearly within that.

13 MR. SALE: I'll just answer that by saying that
14 nobody suggested Dr. Allen was the health care provider
15 post-operatively.

16 MR. GODARD: Well, that's why I object to the
17 form of your question, because it has no relevance to the
18 jury issues as framed as to Dr. Allen. When you frame a
19 question, certainly Dr. Allen is a health care provider.

20 BY MR. SALE:

21 Q. We'll restate, Dr. Karsh, the last question.
22 Did Nicole's urine output after surgery indicate whether

1 she was overhydrated or dehydrated?

2 A. No, it did not. And I think the problem was
3 that it was potentially serious. The indication, if this
4 was in a more normal stable situation, it would have been
5 normal hydration. And whereas, other aspects, including
6 the volume she had received which we discussed, the fact
7 that her blood pressure was persistently high, the fact
8 that a more potential measurement of fluid balance,
9 potential renal pressure had risen significantly from, I
10 think, a level of 9 centimeters of water to 19,
11 significantly elevated, were all indigenous of
12 overhydration.

13 And as I follow as best I can the rationale of
14 the folks in the intensive care unit, I think they were
15 probably somewhat confused by one set of figures looking
16 relatively normal and the other set indicating
17 overhydration. I think it would have been internally
18 consistent had the surgery not occurred until after the
19 bladder had been drained by other means.

20 Q. Did the violation of standard of care cause this
21 confusion in post op?

22 A. As I mentioned before, by resulting in the

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1 emergent surgery, this potential confusion was caused.

2 Q. In number 5 you say heart size x-rays. Can you
3 explain number 5?

4 A. Well, again as I review the chart and try to
5 determine exactly what this baby's overall condition in
6 terms of hydration and in terms of cardiac function was,
7 we look at a number of factors, a number of tests, if you
8 will, that can help us.

9 Certainly the physical examination is generally
10 primary. The numbers, such as urine output, such as blood
11 pressure, such as central venous pressure are all very
12 important. We also look at x-rays. If the heart as a
13 pump has to pump more water it increases in volume. So it
14 gets bigger.

15 Unfortunately, I do not have an x-ray taken of
16 Nicole immediately before her cardiac arrest. So the best
17 that I have to go on is an x-ray taken right after her
18 cardiac arrest and resuscitation and compare it to an
19 earlier x-ray before this extra volume load had occurred.

20 I would like to show, if I may, these two x-
21 rays.

22 Q. You only identified one x-ray, Dr. Karsh. Could

1 you identify the other x-ray for the record as well,
2 before we look at these?

3 A. Well, the x-ray that I will show, this is a
4 single sheet of x-ray film that has copies. The upper x-
5 ray will be an x-ray before the child was given all the
6 extra fluid. The bottom x-ray will be that immediately
7 after the cardiac arrest.

8 In the first x-ray we can see the kind of white
9 area in the middle of the child's chest, that represents
10 the heart. It's small. After the cardiac arrest the
11 heart fills up about half the chest or a little bit more.
12 So it has enlarged significantly. And that is entirely
13 consistent with congestive heart failure and
14 overhydration.

15 Q. Before we leave that film, can you tell me
16 whether the first film, as a pediatric cardiologist and
17 radiologist, whether that heart size is normal?

18 A. In the first film it's entirely normal. In the
19 second film it's mildly enlarged.

20 Q. And just before we leave the film again, can you
21 tell from the film what caused the enlargement in the
22 second one?

1 A. No, one cannot tell specifically what caused the
2 enlargement. One has to take that into consideration with
3 the entire clinical course. And certainly given the
4 clinical course, it's entirely consistent with excess
5 hydration resulting in a degree of congestive heart
6 failure.

7 Q. Dr. Karsh, before you take that x-ray down,
8 those two shots, can you tell me what time those were
9 taken and what date?

10 A. The first one, the upper one, was taken on the
11 5th of March at 18:55 hours, which is 6:55 p.m., whereas
12 the second one was taken on the 6th of March at
13 approximately, it looks like, 9:35 a.m.

14 Q. Okay. Now, Dr. Karsh, I would like you to look
15 at a document marked as Plaintiffs' Exhibit No. 14 for
16 identification and tell me whether looking at that x-ray
17 it either confirms or contradicts the earlier x-ray,
18 earlier meaning the one we just looked at.

19 A. Well, this particular exam on 3/6/87 is very
20 similar to the one that we saw for 9:30. This was taken
21 at approximately 10:00 a.m. and again shows the heart to
22 be somewhat enlarged.

1 Q. And that's the right frame that --

2 A. That's right. I'll just point to it right here
3 (indicating.)

4 Q. Is the enlargement more or less or the same as
5 you saw at 9:33?

6 A. Within the limitations of the technique, it's
7 the same.

8 Q. I think you can take that now, Dr. Karsh. Mr.
9 Godard, examine these x-rays and then would like to move
10 them into evidence as Plaintiffs' Exhibit Nos. 13 and 14.

11 MR. GODARD: No objection.

12 (The document referred to was
13 marked Plaintiffs' Exhibit
14 Nos. 13 and 14 for
15 identification.)

16 BY MR. SALE:

17 Q. Doctor, you have just gone over several pieces
18 of data that you put in chart form. I'm going to show you
19 Plaintiffs' Exhibit Nos. 10, 11, and 12, documents that
20 have been so marked, and ask you what those documents are
21 and what impact, if any, they had on the preparation of
22 the charts that you prepared.

1 A. Well, these are portions of the hospital record
2 which include the cumulative lab results, the inflow and
3 outflow sheets from the intensive care unit, the admission
4 sheet by way of the emergency room as well as initial
5 examination of the baby. And all of these were involved
6 in my assessment of her condition in the clinical course.

7 Q. Doctor, you have number 1 here, which we skipped
8 over rather quickly in your chart that reads "initial
9 physical exam." What's the significance of number 1?

10 A. Well, the significance, as I mentioned, is that
11 both Dr. DePaulo as well as as best I can tell the
12 emergency room physician and Dr. Hodin were not impressed
13 by a significant degree of dehydration. Neither the
14 emergency room physician or Dr. DePaulo mentions anything
15 about dehydration. And Dr. Hodin's note which is a few
16 hours later suggests perhaps minimal dehydration.

17 Q. Doctor, look again at Plaintiffs' Exhibit No.
18 20, the electrolytes. Does that indicate whether it's
19 consistent or inconsistent with overhydration?

20 A. Well, the initial electrolytes would suggest
21 normal hydration.

22 Q. Not under or over?

1 A. Neither one.

2 MR. SALE: At this point Plaintiff would like to
3 move Exhibits 10, 11, and 12 into evidence.

4 MR. GODARD: Well, again I think they're already
5 in evidence. I don't see the need for continually
6 repetitive documents. BY MR.

7 SALE: Q.Doctor, you have
8 indicated that the two charts you have prepared were taken
9 from information you derived from the chart. Was that
10 accurate? A.That's accurate.

11 MR. SALE: We would like to mark for
12 identification Plaintiff's Exhibits 17 and 18 and move
13 those into evidence as well.

14 MR. GODARD: I think I would have to object to
15 those as being not part of the medical records. I have no
16 objection to their being used for the demonstrative
17 purpose as they've been used in this video, but I think
18 they're inappropriate to go into evidence.

19 BY MR. SALE:

20 Q. Doctor, you have testified that the violations
21 of the standard of care by Dr. Allen prevented Nicole's
22 resuscitation from cardiac arrest. Is that correct?

1 A. That's correct.

2 Q. Doctor, what does this last chart relate to?

3 A. Again, this really in written form summarizes
4 the scenario that I've mentioned on several occasions,
5 that initially the physician was faced with a sick baby
6 who because of the results of ultrasound examination went
7 down to emergency surgery and was a less than ideal
8 candidate for surgery and post-operative care at that
9 time.

10 Because of difficulties in monitoring hydration
11 status and overhydration as well as abnormalities in
12 electrolytes, she developed borderline cardiac function
13 and was susceptible to an insult. At approximately 6:25
14 in the morning of the 6th we note in the hospital record
15 that the amount of oxygen in her blood, in her arterial
16 blood has decreased significantly. And this may have been
17 from a combination of factors, the respirator settings had
18 been set slightly differently, she may have developed a
19 small plug of mucous either in her trachea or bronchi or
20 perhaps in the endotracheal tube.

21 In any event, relatively shortly thereafter she
22 developed her cardiac arrest. Because of the electrolyte

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1 imbalance and the marginal cardiac function, she was
2 unable to be rapidly and successfully resuscitated. And,
3 although there was a resuscitation, by the time she had
4 cardiac function regained, a lot of damage had been done
5 to the heart and probably to her brain and perhaps other
6 organs as well, and this ultimately resulted in her death.

7 Q. Doctor, is there any indication from the records
8 of Nicole having lung problems?

9 A. No, there is not.

10 Q. Is there any indication --

11 A. Let me back that up a little bit. Certainly in
12 the pre-operative and the post-operative pre-arrest
13 course, there's no evidence of lung problems. And after
14 her cardiac arrest and probably after the ventilator
15 settings were set much higher, she developed a
16 pneumothorax, which means one of her lungs blew out like a
17 balloon and that obviously gave her significant
18 respiratory problems, significant breathing problems.

19 In addition, on the x-ray, after the 9:30 a.m.
20 x-ray after her arrest, there is some increased density in
21 the invasive left lobe, the left side of her lung. But,
22 more importantly, from physical examination and from her

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1 original x-rays, there is no evidence of any lung or
2 pulmonary problem at all.

3 Q. Did the records indicate that the lungs were
4 clear or congested prior to the arrest?

5 A. They would indicate, based upon nursing notes,
6 that they were clear.

7 Q. Does that confirm it to your satisfaction?

8 A. Well, no, it does not and that's because number
9 one, even experienced observers can miss some
10 abnormalities in small infants, and number two, because
11 she was on a respirator, this actually increases the
12 pressure within the lungs and may mask abnormalities that
13 would otherwise show up as little crack holes or
14 difficulties in breathing.

15 Q. Now, Doctor, I'm going to look at number 1 and
16 number 2. I'm going to ask you, how do they relate to one
17 another? In other words, how does a sick baby in
18 emergency surgery cause or contribute to borderline
19 cardiac function?

20 A. Well, obviously, any time one is significantly
21 ill, one's system is a little bit more prone to swings in
22 any of its parameters. You don't eat for several days,

1 you basically are going to be weaker. And any time -- the
2 heart is muscle like everything else, and if your body is
3 weak, your heart muscle will probably be somewhat weakened
4 as well.

5 More importantly, because of the emergency
6 surgery and the difficulty in maintaining appropriate
7 levels of hydration and normal electrolyte balance, she
8 developed at least border-line congestive heart failure,
9 which means that the heart was pumping along okay but it
10 was stressing itself.

11 And that when the insult of the cardiac arrest
12 occurred, and there were a number of factors that directly
13 were involved with this, electrolyte balance, the
14 increased fluid load, the change in oxygenation of the
15 blood, all came together at approximately 8:30 a.m. in the
16 morning of the 6th and caused the cardiac arrest.

17 She was then unable to be satisfactorily
18 resuscitated because she was in a less than stable and
19 less than optimal condition going into the surgery to
20 begin with.

21 Q. Doctor, can you tell me to a reasonable degree
22 of medical certainty whether Nicole could have been

1 resuscitated in the absence of the factors on that chart?

2 A. In a reasonable medical certainly, in the very
3 unlikely event that a cardiac arrest had occurred, had she
4 been more stable before the operation, she would have had
5 a so-called routine successful resuscitation.

6 Q. And when you give that opinion, do you give that
7 opinion to a reasonable degree of medical certainly?

8 A. Yes, I do.

9 MR. SALE: No further questions, Dr. Karsh.

10 MR. GODARD: Do you want to take a five-minute
11 fresh air break?

12 (Recess.)

13 EXAMINATION BY COUNSEL FOR THE DEFENDANT

14 BY MR. GODARD:

15 Q. Dr. Karsh, again, my name is Gary Godard and I'm
16 here on behalf of Dr. Robert Allen. You indicated that
17 when you received this case, you really didn't know on
18 who's behalf you were reviewing it. Who did you actually
19 get the case from?

20 A. I received the case from Medical Quality
21 Foundation.

22 Q. Do you know anything about Medical Quality

1 Foundation?

2 A. In what regard do you ask?

3 Q. Are you aware that they are a organization that
4 was formulated and that has the primary purpose of
5 providing expert witnesses in medical malpractice cases
6 around the country?

7 MR. SALE: Object. It's irrelevant.

8 THE WITNESS: Well, yes, I do. And the agreement
9 that I've had with them over the years is that any records
10 that I review for them that I do not know in advance
11 whether I'm being requested by plaintiffs or defense.

12 BY MR. GODARD:

13 Q. In other words, you've asked them to present it
14 to you in that fashion?

15 A. That's correct.

16 Q. Well, are you not aware that Medical Quality
17 Foundation never represents defendants out looking for
18 experts?

19 MR. SALE: Object again. There's no foundation
20 in the record.

21 BY MR. GODARD:

22 Q. Well, let me reform the question. Have you ever

1 been asked by Medical Quality Foundation to review the
2 case on behalf of a defendant?

3 A. Well, I don't know. And the reason being that
4 by and large, the bulk of reviews that I do for them never
5 go beyond the review and I really never get any feedback.
6 Most of the time, it's my feeling that there has not been
7 negligence.

8 But of those cases that have gone beyond there,
9 there has been only one in which I ultimately was an
10 expert witness for the defense.

11 Q. This activity that you get involved in in cases
12 like this is not exactly strictly a public service?

13 A. No, it's not.

14 Q. I mean, you get paid for your time and your
15 efforts.

16 A. Yes, I do.

17 Q. Incidentally, how much are you getting paid in
18 this case?

19 A. Going all the way back to square one or just for
20 today or --

21 Q. Well, what's your basic rate and method of
22 charges in this case?

1 A. Okay. Well, basically, if I can outline, when I
2 receive records to review from Medical Quality, they send
3 a check, usually about \$250. Subsequently, my rate is
4 approximately \$200 an hour and of course, in a situation
5 like today's, if I have to go out of town, that represents
6 a full day and in this particular case a little bit more
7 than a full day because I was in Washington yesterday as
8 well.

9 Q. So how much overall will your bill be for your
10 testimony here today?

11 A. \$102,000 or \$2400, I forget which.

12 Q. All right. Now let me ask you a few questions
13 about your professional education and background, if I
14 may. Do you consider yourself primarily a pediatric
15 cardiologist or primarily a radiologist?

16 A. Primarily a diagnostic radiologist at this time.

17 Q. And why is that? By choice, I take it.

18 A. Yes, it is.

19 Q. Might I inquire as to why, after all those years
20 of study and involvement in pediatrics and pediatric
21 cardiology, that you then decided to go on to radiology?

22 A. Yes. Actually, my wife suggested to me that

1 perhaps, if I did something else, I would feel a little
2 more free to choose practice location and not be totally
3 committed to a teaching position, which was pretty much
4 the situation previous.

5 And also, I have to admit that in the late
6 '70's, I was somewhat stressed out, that taking care of
7 very sick babies all the time in the situation I was in, I
8 really had no back-up. I needed a bit of a break. And
9 radiology appeared to dovetail with my prior interests and
10 I figured I would give it a try and I've enjoyed it.

11 Q. And indeed, taking care of very sick babies is a
12 rather stressful profession, is it not?

13 A. Yes.

14 Q. And I take it, in your present practice or the
15 practice that you've been in since making that career
16 change, you in essence, don't get involved in the hands-
17 on, clinical management of very sick pediatric patients.

18 A. Only occasionally. And the practice situation
19 in Thomasville is such that, in terms of pediatric care,
20 we do not operate as a tertiary care center, so that the
21 very sickest babies I may well see on consultation. And
22 then they would ultimately be flown to Tallahassee, where

1 there is a tertiary care nursery or to Atlanta or
2 Gainesville, Florida.

3 Q. And the consultation that you would be seen in
4 would be diagnostic related, i.e., in your case,
5 radiologically related or in that purpose.

6 A. No, not really. But more in terms of cardiac
7 consultation and helping the pediatricians in terms of
8 treatment of the child. We do, at least a half dozen
9 times a year, have children with congestive heart failure
10 which may or may not be on a basically cardiac origin.

11 For example, it may be children who are septic
12 with super infections or children with sickle cell anemia
13 in crisis. And the pediatrician will generally ask me to
14 help them in terms of medical dosages and following
15 cardiac function.

16 Q. All right. You certainly don't consider
17 yourself a pediatric intensivist.

18 A. No, not at this time. Maybe 10 years ago, but
19 not now.

20 Q. And you, as a radiologist, are now practicing
21 primarily radiology, certainly don't routinely follow and
22 manage infants in regard to their fluid management and

1 their electrolytes and so forth.

2 A. No, not routinely any more.

3 Q. Speaking of your pediatric radiology involvement
4 now, I understand from your testimony that certainly you
5 had experience with sonography, ultrasound, such as the
6 kind of study that was done in this case by Dr. Allen.
7 Could you estimate for us approximately how many
8 diagnostic ultrasound studies you have performed in an
9 infant, that is, a child less than 1 year of age, in the
10 past year?

11 A. One could quantify or qualify -- let me try to
12 be even more specific, because we do a fair number of
13 studies of pediatric brains in newborn infants.

14 Q. I'm restricting that to ultrasound.

15 A. But, let's say -- well, I'm talking about
16 ultrasound of the brain, because we do that quite a bit.

17 Q. All right.

18 A. And in addition, one could consider, and I think
19 legitimately consider the latest obstetrical ultrasound
20 that we do were largely looking at the anatomy of the
21 fetus.

22 But let's eliminate all those and let's look,

1 just really, have them in a pelvic examination, some
2 infants. And in my practice overall, we probably do 50 or
3 60 of those a year. I probably, because of my pediatric
4 background, do a larger share than would normally be the
5 case, but we're still looking at maybe 20 or 25 of these a
6 year.

7 Q. How many times have you done ultrasound
8 specifically to identify the bladder in a child less than
9 6 months of age?

10 A. Well, if you're looking at the relationship to
11 this case, of course this case wasn't done specifically to
12 identify the bladder. Any time I do an abdomen or pelvic
13 ultrasound, particularly a pelvic ultrasound in a child, I
14 identify the bladder, so that's 100 percent of the time.

15 As to how many times we've seen an abnormal mass
16 or several masses within the pelvis and abdomen and then
17 had to go ahead to identify which was the bladder, we're
18 really just talking about a handful over the past several
19 years.

20 Q. Have you, in fact -- let me modify that. When
21 is the last time that you had occasion to attempt to
22 catheterize a female infant of less than six months of

1 age?

2 A. In ultrasound or in the diagnostic radiology
3 suite or take either one?

4 Q. Ultrasound.

5 A. In ultrasound, it has probably a year. In the
6 diagnostic radiology suite, it's been within the past
7 couple of months.

8 Q. Would you consider, given all of the things that
9 you have reviewed, the medical records and the testimony,
10 this to be a highly unusual case from a physiological,
11 actual medical or anatomical problem standpoint?

12 A. Well, it's particular unusual, because the
13 teratoma, the smaller mass, usually has more solid
14 components to it. But actually, other than that, a sacro
15 or sacrococcygeal teratoma is not that uncommon.

16 Going back to 1987, it would be a little bit
17 more uncommon. There were a number of reports that came
18 out in the mid and late 1980's, in terms of the ultrasound
19 evaluation of these, particularly prenatally.

20 Q. How about the combination that existed here,
21 namely a presacral teratoma compressing the urethra or
22 and/or the neck of the bladder, so as to cause distention

1 of the bladder to the extent that we ultimately proved to
2 have here? How unusual is that?

3 A. Well, it would certainly be unusual. But, of
4 course, the unusual is what we're trained to always be
5 alerted for.

6 Q. Have you ever seen such a case?

7 A. Not that I can recall. I generally see
8 teratomas going backwards instead of forwards.

9 Q. Now, let me ask you. What is your impression or
10 your understanding as to the general setting that existed
11 in the radiology department and/or the ultrasound
12 laboratory, if you will, where Dr. Allen performed this
13 study on March the 5th?

14 And by that, I mean to ask, what was the
15 clinical manifestation and situation with the child as it
16 was there in the ultrasound department?

17 A. Since there is no actual physical exam exactly
18 at the time of the ultrasound, I can only go by the
19 physical exam at admission and several hours prior to
20 that, in which the child appeared to be stable, but with a
21 distended abdomen.

22 She does not appear to have been given any

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1 medication, say for sedation, to be down in the ultrasound
2 department. It is my understanding that the parents and
3 her pediatrician were in attendance at the time of the
4 examination, as well as Dr. Allen and the ultrasound
5 technologist.

6 It is also my understanding that a CAT scanner
7 and fluoroscopic and radiographic equipment for potential
8 IVP were also available in close proximity to the
9 ultrasound suite.

10 Q. Now why did you mention that?

11 A. Because I have mentioned in the past that those
12 would be alternative methods of investigation.

13 Q. Well, I understand it. I just wanted to know if
14 you felt that went toward answering my question?

15 A. Oh, yeah. You know, kind of --

16 Q. As to what condition the child was in?

17 A. Oh, okay. I just heard -- you had said what the
18 condition was in the radiology department. I'm sorry. Of
19 course, has nothing to do with the condition the child was
20 in.

21 Q. This was a sick child, was it not?

22 A. Oh, no question.

1 Q. The child was in pain, the child was irritable,
2 the child was crying.

3 A. Well, I don't know at that time. But one could
4 assume that certainly the child was irritable when the
5 transducer was in place, the ultrasound probe, if you
6 will. Because it was described on physical examination as
7 not being in significant distress except when we pressed
8 on her belly.

9 Q. Well, you keep saying you don't know these
10 things about the child. Did you not read the mother's
11 testimony?

12 A. The mother's testimony is not in the chart. Of
13 course --

14 Q. Did you read it?

15 A. Yes.

16 Q. Or are you discounting the other?

17 A. If you recall, way back, I said I'm trying to
18 keep as much as what I'm stating based upon the medical
19 record as far as possible.

20 Q. Why?

21 A. Because that is the most contemporaneous record
22 that I have and that's as equitable, if you will, but

1 certainly, if you are willing to accept what the mother
2 says, I will certainly accept what the mother says. And
3 based upon that, the child was irritable and crying.

4 Q. All right. Well, you certainly would agree with
5 me, would you not, Dr. Karsh, that not all the facts in
6 any case go directly into the medical record. There are
7 always additional facts to be gained from other sources
8 apart from the medical report, are there not?

9 A. Yes.

10 Q. So given the fact that this 4-1/2 month old
11 child was a very sick baby, was irritable, was in pain,
12 was fussy, tended to move about, would you say this was a
13 somewhat difficult procedure and examination, the
14 ultrasound procedure, and the catheterization involved in
15 that, to perform?

16 MR. SALE: I object. There wasn't a full
17 foundation for that question.

18 MR. GODARD: Objection noted.

19 THE WITNESS: I'm sure it was, but in the -- and
20 these are the things that we're trying to do and
21 presumably the technologist was trying to do. And the
22 reason I bring the technologist in, of course, is that I

1 don't know if Dr. Allen actually used the transducer
2 himself. Either way, it would be a legitimate way of
3 examining.

4 BY MR. GODARD:

5 Q. All right. Well, since you've mentioned the
6 transducer, let's talk about that for a moment. All that
7 you have seen in the way of documentation, if you will, of
8 the ultrasonography actually performed here that is by way
9 of actual memorialization of what was showing on the
10 screen, are a couple of films, plain, still films.

11 A. That's correct.

12 Q. Now, in reality, for the benefit of the ladies
13 and gentlemen of the jury, what happens when an ultrasound
14 study is done, an ultrasound study like this one, is that
15 the radiologist, through the use of a transducer and the
16 general fluoroscopy means available, is actually looking
17 at a continuous image on the screen while he or she
18 performs that study.

19 A. That's quite correct. And then chooses
20 particular images to --

21 Q. I'm sorry, that was my fault. I spoke when he
22 was speaking. I should not have done that.

1 What you were saying and what I mean to add the
2 emphasis to, was that at some point in performing that
3 procedure, the sonographer will call for the taking of a
4 certain number of still photographs, if you will, or films
5 of what has been shown on the screen.

6 A. That is correct. In addition, depending upon
7 the institution, there may or may not be a videotape
8 record of the entire examination.

9 Q. All right. Now, over all, that sonographer, who
10 in most instances is a radiologist, but with a
11 subspecialty or at least training that includes ultrasound
12 sonography. That sonographer will be basing his or her
13 ultimate judgments and opinions upon everything that's
14 presented to him or her during the course of that
15 examination.

16 A. That's correct.

17 Q. And those of us who come along later to look and
18 make judgements about the procedure retrospectively, are
19 lacking some of those things that the radiologist had at
20 the time, in order to make judgements about that
21 assessment, are we not?

22 A. There is no question in that. The radiologist

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1 or technologist, for that matter, since certain ultrasound
2 exams are performed independent of the radiologist,
3 generally chooses the best images, the ones that most
4 support the conclusions that allow that sonographer to
5 make the conclusions.

6 But, of course, there is some additional
7 information that we do never see.

8 Q. Which I started to say. Those still films,
9 irrespective of the acumen, if you will, of the decision
10 to take those particular still pictures, they can't
11 possibly show the entire story that has been displayed
12 over that real time or that continually visualized study
13 upon the screen.

14 A. I disagree. They can but they don't necessarily
15 do.

16 Q. Now, focusing upon the performance of the
17 procedure itself by the radiologist, the objective here is
18 to essentially make a study which based upon his
19 professional training and experience and judgments enables
20 him to with reasonable medical accuracy, which I think
21 we'll all agree is never perfect, but reasonable medical
22 accuracy, if you will, of what is being seen in that

1 child's abdomen and to identify as was the case here what
2 the predominant cystic masses most likely were.

3 A. Of course.

4 Q. Now, I presume you would agree that the practice
5 of radiology like any of the subspecialty skills in the
6 overall practice of medicine certainly doesn't require
7 perfection and absolute accuracy in every diagnostic
8 effort?

9 A. That's correct.

10 Q. The objective here for that radiologist was to
11 exercise reasonable skills and reasonable efforts to reach
12 the point where he reasonably could feel comfortable in
13 diagnosing what he was seeing on that screen?

14 A. That's correct.

15 Q. Now, let me ask you, Doctor, hypothetically, if,
16 in fact, the radiologist performing this study had, in
17 fact, successfully passed a catheter in and up through the
18 urethra and watching that catheter pass on the screen as
19 he would be watching it and seeing what he would interpret
20 as evidence that the catheter is, indeed, passing into the
21 cystic mass which he is trying to diagnose and seeing then
22 a few droplets of what he interprets to be urine come from

1 that catheter and knowing or feeling confident that the
2 catheter has been inverted into the urethra and knowing
3 from this medical training that the urethra leads into the
4 bladder, assuming all of those facts hypothetically, that
5 radiologist would be exercising reasonable medical skill and
6 judgment as a radiologist if he concluded that, in fact,
7 that particular mass was most likely the bladder, would he
8 not?

9 A. Well, as I have stated, the radiologist would
10 need to have been again, given this hypothetical
11 circumstance, would have to be terribly suspicious of why
12 there was just a drop or two of urine and in knowing the
13 very quick means that would take a minute to confirm the
14 location of the catheter by injecting saline into the
15 catheter and seeing the turbulence within the bladder, it
16 would be incumbent upon the radiologist to question, well,
17 here I've gotten a couple of drops of what looks like
18 urine, why if this catheter is in the middle of a
19 distended tense bladder, am I only getting a couple of
20 drops of urine, I feel that the standard of care makes it
21 incumbent upon him to further confirm that either by
22 attempting to get more urine out, enough to show that the

1 bladder is actually decreasing in size, or to inject
2 saline within.

3 Q. Doctor, what we're talking about here is the
4 radiologist being impressed with the fact that it's not
5 the hugely distended mass that's the bladder but that it's
6 the other smaller, less distended mass that he's
7 identifying as the bladder?

8 A. Well, that's right.

9 Q. Is that not correct?

10 A. That's correct, but that mass in and of itself
11 was still big enough and with smooth enough margins to
12 indicate enough tension to indicate a significant flow of
13 urine.

14 Q. Incidentally, since we're to the point of
15 talking about sizes, would you mind reaching behind you
16 and flipping over the drawing of the abdomen or pelvis
17 that I believe was the very top of all of your drawings.

18 A. (Witness complies.)

19 Q. Now, while I think no one is quarreling with the
20 essential anatomic relative accuracy of that diagram, in
21 reality that diagram is grossly distorting of the actual
22 physical size that we're talking about in this case, is it

1 not?

2 A. As I mentioned it underestimates the size of the
3 large mass.

4 Q. Well, and I understand not only that, but would
5 you not also agree with me that looking at that diagram,
6 that would more commonly be interpreted to be a full adult
7 pelvis and general anatomically out of these organs, would
8 it not, just going by the sizes as you've drawn them?

9 A. Well, even in an adult, if that's the bladder
10 going up to the belly button, that would be awfully big
11 for an adult.

12 Q. I guess my point is we know from the records
13 that Nicole Panousos on March 5 of 1987 was 4-1/2 months
14 old, I believe the records show that she was 28 inches
15 long and she weighed 17 pounds. Now, in short Nicole
16 Panousos' entire body would fit within area that you have
17 on that chart.

18 A. Oh, sure.

19 Q. And then some. Or, to put it another way, if
20 one were to accurately draw a picture of the organs
21 involved in this little girl, we would be looking at very
22 small gross depictions?

1 A. Well, that's right. And that's one of the
2 reasons why ultrasound equipment has the capability of, if
3 you will, zooming or magnifying what we see.

4 Q. I understand. And I understand you drew this
5 for simplification and general illustrative purposes. I'm
6 not accusing you of deliberately misleading anyone. But,
7 just for clarification, this is a blow-up that's probably,
8 what would you say, 20 times the actual anatomy that would
9 have been present?

10 A. Oh, more likely four times.

11 Q. Now, coming back to the difficulties that are
12 inherent in doing this procedure -- or before I follow
13 through with that, let me just ask one question and follow
14 up to the response you gave my previous question, namely
15 about my asking you would not the radiologist be within
16 the standard of care and acting reasonably if he did all
17 those things that I described to you and, in fact,
18 hypothetically had done them correctly, was in the
19 urethra, visualized the catheter approaching this cystic
20 mass, visualized some droplets of urine emerge from the
21 catheter and whatever other additional facts I may have
22 thrown in there, but you then indicated that, even with

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1 all of those factors, you feel the radiologist should have
2 been suspicious at least that he is obtaining a few drops
3 of urine?

4 A. That's right, as you yourself just mentioned,
5 you're talking about the catheter approaching the cystic
6 mass and not actually being within. There are times, for
7 example, when we will catheterize a patient, whether a
8 child or an adult's bladder with particularly a Foley
9 catheter that has a little balloon on it and one can see
10 on ultrasound, you can actually see this balloon expanded
11 within the cystic mass that is the patient's bladder, and,
12 of course, this is not the kind of catheter that was used.
13 And the point that I was attempting to make or bring out
14 here was that the radiologist as you understand it was not
15 actually making an attempt to fully catheterize and drain
16 the bladder here, was he?

17 A. No.

18 Q. He was simply try to locate and identify the
19 cystic mass that the urethra led up to?

20 A. Correct.

21 Q. Now, if one assumes that hypothetically the
22 radiologist had done that job, had successfully inverted

1 this catheter into the urethra and had successfully
2 followed it up that canal far enough to visualize it on
3 the screen and albeit that he was just barely into the tip
4 or the neck, if you will, of the bladder, would that first
5 of all not explain how it would be that he would only get
6 a few drops?

7 A. It could explain why he might only get a few
8 drops, and that is with extrinsic pressure upon the
9 bladder neck, it's possible that only a few drops would be
10 obtained, the location of the catheter actually being in
11 the bladder neck could and should then be confirmed by
12 squirting saline or sterile water back into the bladder.

13 Q. Why is that? I mean, if the radiologist, in
14 fact, based upon what he is visualizing and what he
15 himself is doing, if he has confidence that he is, in
16 fact, in the urethra and into the shallow neck of the
17 bladder, if you will, why would he need to go forward and
18 take that extra step?

19 A. Well, then there is no question that in his mind
20 or her mind, that he or she feels that appropriate
21 standards have been maintained.

22 Q. Well, if he has that feeling, if he is convinced

1 from what he is seeing that he has successfully identified
2 the bladder, then albeit that he may be wrong as by not
3 entering the urethra or for some other mistake nonetheless
4 he would not be expected to go forward if he felt
5 confident that he had identified the bladder?

6 MR. SALE: Beginning this line of questioning
7 counsel stated that they were hypothetical. Is counsel
8 now talking about Nicole Panousos? Or are they still
9 hypothetical?

10 BY MR. GODARD:

11 Q. Well, both, they're Nicole Panousos but with the
12 radiologist doing what we're describing.

13 A. I think it's very reasonable that, if the
14 radiologist is convinced of his or her findings, that the
15 radiologist would cease at that time. Whether the
16 examination as performed would stand up to scrutiny is a
17 question.

18 Q. I understand. Now, let's move on to the issue
19 of the terminology that the radiologist uses in describing
20 his findings. First of all, to the surgeon. Now, counsel
21 has presented to you the typed report that was ultimately
22 prepared pertaining to Dr. Allen's performance of this

1 study. And he asked you in particular about the use of
2 the word confirmed. Before I ask you a few other things
3 about this report, let me just clarify for the ladies and
4 gentlemen of the jury, this report had nothing to do with
5 what was conveyed or what was actually viewed by the
6 surgeon or received by the surgeon on March 5, 1987?

7 MR. SALE: Object, there's no foundation in the
8 record for that question.

9 BY MR. GODARD:

10 Q. Well, there will be.

11 A. May I see that.

12 Q. Surely.

13 Just to make sure my question is clear, I'll
14 rephrase it slightly. The surgeon never saw that typed
15 report before he took Nicole Panousos to surgery on March
16 5, did he?

17 A. Well, I don't know that for sure, but in most
18 hospitals he would not have. That would have been a two-
19 hour or so turnaround, and my assumption has always been
20 that, whatever was conveyed to Dr. Hodin is reflected upon
21 the report that was dictated. And I assume the report was
22 dictated contemporaneously with a verbal report given to

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1 Dr. Hodin.

2 Q. And more than likely a fair assumption, I would
3 presume. But nonetheless you as a radiologist would not
4 purport to have a discussion with a surgeon or a treating
5 physician particularly if there were a rather extended
6 discussion and then to go back and a few minutes or a
7 couple of hours later, whatever proved to be, pick up a
8 dictaphone and use the very same exact words throughout
9 your dictation as you used with that surgeon in your
10 discussions, would you?

11 A. No, I would use substantially the same.

12 Q. All right. To put it another way, however, the
13 fact that Dr. Allen, when he ultimately dictated this
14 report used the term that this was confirmed to be the
15 urinary bladder, it doesn't really tell you whether that
16 was the word he used in his discussions with Dr. Hodin or
17 not, he may have used some other word?

18 A. That's correct.

19 Q. But nonetheless it does once again in fairness
20 indicate to you, does it not, that Dr. Allen had a fair
21 degree of confidence in the study that he had just
22 performed as to it correctly identifying this particular

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1 mass as being the bladder?

2 A. Yes, it does.

3 Q. Now, you had indicated that, if the radiologist
4 was not confident or had lingering doubts about having
5 identified which of these masses was the bladder, that
6 there were these alternative procedures open to him, the
7 injection of sterile water being one, the performance of
8 contrast studies with CT scanning being another, and I
9 believe the performance of a intravenous polygram being
10 another?

11 A. That's correct.

12 Q. Now, we've already touched on the sterile water,
13 let me touch, if I may, on those other two. Those are
14 what we would call more invasive-type procedures, are they
15 not, or at least they require injecting a foreign
16 substance into this child?

17 A. That's correct.

18 Q. And you would agree I presume as a practicing
19 radiologist that any radiologist, before he injects a
20 foreign substance, be it contrast material or otherwise,
21 into someone, takes into consideration, A, the necessity
22 or the appropriateness of doing that and, B, the possible

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1 or potential effects that that might have upon that
2 patient?

3 A. That's quite correct.

4 Q. And indeed it is true, is it not, that the
5 injection of contrast can, indeed, have untoward effects?

6 A. Yes, it can.

7 Q. And the reasonable and prudent radiologist, once
8 again, would go forward to subject the patient, albeit it
9 a 4-month-old or a 40-year-old to that kind of procedure,
10 only if he or she felt that it was really appropriate and
11 necessary to confirm his diagnosis.

12 A. That's quite correct.

13 Q. And if that radiologist were confident, at dead
14 field, that he has successfully made that diagnosis, then
15 he would not want to subject the patient to that. Isn't
16 that correct?

17 A. That's correct.

18 Q. Now, what is your understanding as to the time
19 of day that all of this study took place in the ultrasound
20 department?

21 A. My understanding is that the examination took
22 place about 10:30 in the morning and that ultimately the

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1 child was sent to the operating room about 1:15 in the
2 afternoon.

3 Q. And then how long was the child in the operating
4 room?

5 A. 4 or 5 hours, I believe.

6 Q. To what degree was the child unstable at the
7 time she was taken to surgery?

8 A. That is very difficult to definitely document.
9 There's no doubt in my mind that preoperatively and during
10 the surgical procedure, she was gradually over-hydrated.
11 Her electrolytes were abnormal going into surgery. And
12 those are really the major factors of her overall
13 condition as indicated on physical exam prior to surgery.

14 Q. Surgery was completed around 6:45 that evening?

15 A. Yes.

16 Q. How did the child do in the immediate post-
17 surgical hours?

18 A. The immediate post-surgical hours she seemed to
19 be doing well.

20 Q. And how many years post-surgery was it when she
21 ultimately experienced the arrest?

22 A. The arrest was approximately 14 hours post-

1 operatively. Some of the signs that became and were about
2 11 or 12 hours post-operatively.

3 Q. You have said repeatedly throughout your
4 responding to counsel's direct questions that Dr. Allen's
5 negligence or Dr. Allen's breach of the standard of care
6 in not making the diagnosis of which mass was the bladder
7 caused and contributed to the confusion and the
8 difficulties in managing this child post-operatively, have
9 you not.

10 A. Yes, I have.

11 Q. Now, first of all, let me just clarify. This
12 child tragically, some 14 to 14-1/2 hours after surgery,
13 suffered a cardiac arrest and proved unable to be
14 immediately resuscitable from that arrest and died as a
15 result of that oxygen starvation.

16 A. That's correct.

17 Q. Now, the real -- the first issue that then
18 arises is what caused the cardiac arrest. Am I correct?

19 A. That's correct.

20 Q. And I understand it is your opinion,
21 essentially, that fluid overload and electrolyte imbalance
22 acted in combination in causing the arrest.

1 A. That's correct.

2 Q. Now, and as you have repeatedly indicated, had
3 the child not been taken to surgery immediately and had
4 that surgery been delayed by some 24 hours, then in your
5 view that problem of post-surgical fluid management would
6 have been less complicated.

7 A. That's correct.

8 Q. Notwithstanding the fact that it may have been
9 less complicated, there was certainly nothing that
10 prevented, that made it impossible to manage this child's
11 post-surgical fluids and electrolytes.

12 MR. SALE: The question of impossibility is not
13 at issue in this case. It's irrelevant.

14 BY MR. GODARD:

15 Q. Well, I use that word partly because it's been
16 used repeatedly in the direct examination of what was
17 possible and what was not. So, if impossible, the
18 negative aspect of that offense, counsel, let me turn it
19 around and say it certainly was possible for this child's
20 electrolytes and fluids to be appropriately managed, if, in
21 your view, they were not appropriately managed.

22 A. That's right. It was more difficult to see

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1 exactly where one was, but certainly possible.

2 Q. All right, sir. Now, let's back up for a moment
3 and let me ask you another hypothetical. Let's presume
4 for the moment that, in the course of performing the
5 ultrasound examination, Dr. Allen had correctly identified
6 the bladder. And that, either by him or someone else, the
7 bladder had been completely and successfully drained and
8 that Dr. Hodin had, under those circumstances, made the
9 decision not to take the child immediately to surgery.

10 Would fluid and electrolyte management have been
11 necessary at that point, even without the child having
12 been taken to surgery?

13 A. If the child -- well, yes, it certainly would be
14 necessary.

15 Q. Would the child have required IV administration
16 of fluids?

17 A. I don't know. Probably so, but there would
18 probably have been a fair amount of oral fluids as well.
19 I think the IV fluids would have been more kind of a
20 keeping a line open proposition.

21 As best I can judge from the clinical history,
22 the child was taking fluids by mouth until shortly prior

1 to admission.

2 Q. Well, you indicated earlier that the child's
3 electrolytes were not totally normal before surgery. So
4 ongoing efforts, even had the child have been taken to
5 surgery, would have been necessary to get the child's
6 electrolytes totally back to normal.

7 A. That's right.

8 Q. And would have not have, in all likelihood,
9 required some IV fluid management over the succeeding
10 hours?

11 A. Certainly some, yes.

12 Q. And thereby the requirements of ongoing
13 judgments about the laboratory that were obtained and the
14 management of the fluids going in and the management of
15 the fluids going out, certainly would have been necessary,
16 would they not?

17 A. Yes.

18 Q. And certainly under those circumstances,
19 mismanagement can occur?

20 A. Yes, it can.

21 Q. To put it another way, if it is your opinion
22 that this child's fluid management and electrolyte

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1 management was not appropriately done in this instance and
2 that that resulted in the child's ultimate cardiac arrest
3 and death, the same potential certainly existed even had
4 the child never gone to surgery.

5 A. It's much less likely, but yes.

6 Q. Now, incidentally, just so the ladies and
7 gentlemen of the jury are totally clear, the radiologist
8 plays no role whatsoever in actual management of the
9 patient's or this child's fluids and electrolytes. Isn't
10 that correct?

11 A. That is correct.

12 Q. And so your repeated references to Dr. Allen's
13 negligence being responsible for the ultimate death, those
14 certainly don't mean to imply in any sense that Dr. Allen
15 should have been up there watching over and helping to
16 manage these electrolytes and this fluid.

17 A. Not at all.

18 Q. You're simply saying that the people whose job
19 it was to manage those electrolytes and fluids would have
20 had their job made somewhat easier had the child never
21 gone to surgery.

22 A. That's right. It had been stabilized

1 beforehand.

2 Q. All right. And several times throughout your
3 testimony you indicated that Dr. Allen's negligence
4 prevented a successful resuscitation of this child. Just
5 for clarification, once again, what you're really saying
6 there, you're not saying anything about that post-surgical
7 management was Dr. Allen's responsibility.

8 You're simply saying that, as you had said
9 before, had the surgery not been performed, the job of
10 post-surgical management would have been easier and the
11 arrest would never have occurred and resuscitation, by
12 definition, would have been much more likely or possible
13 even had it occurred.

14 A. That's correct.

15 Q. All right. To put it another way, what
16 prevented this child's resuscitation, at least by your
17 view of the medical evidence here, was the fact that she
18 did suffer from having been fluid overloaded and from
19 electrolyte imbalance.

20 A. That's correct.

21 Q. In other words, the same thing that caused her
22 arrest made her arrest or resuscitation from the arrest

1 more difficult in your view.

2 A. That's right.

3 Q. And incidentally, you were asked earlier what
4 you had originally been asked to do and you indicated --
5 strike that. Let me rephrase it.

6 You were asked after your review of all of the
7 materials, had you identified any breaches of standards of
8 care or any aspects of medical negligence and you said yes
9 and then proceeded to identify Dr. Allen as being the one.

10 Well, in truth or at least in completeness, you
11 identified not just Dr. Allen as being guilty of
12 substandard care, but identified those who had managed
13 this child's post-surgical fluid management and
14 electrolytes and those who had been charged with looking
15 after the child as being guilty of breaches of standard of
16 care as well.

17 MR. SALE: Object. It's beyond the scope of the
18 direct. It's not relevant here. Parties are not involved
19 in this case.

20 MR. GODARD: You opened it up, counsel, when you
21 asked him what he had been asked to do. I'm merely
22 clarifying that you were initially asked to identify those

1 items of negligence as well.

2 THE WITNESS: At a prior time, that's correct.

3 BY MR. GODARD:

4 Q. Finally, doctor, back in May of last year, you
5 appeared before the Medical Malpractice Review Panel that
6 had been constituted for evaluation of this case and gave
7 live testimony before them, did you not?

8 A. Yes, I did.

9 Q. Before those two physicians and two lawyers that
10 constituted the panel and you were asked questions by
11 counsel for the plaintiff and by other counsel and by
12 members of the review panel themselves, were you not?

13 A. Correct.

14 Q. And is it not correct, doctor, that you gave,
15 for all intent and purposes, the same body of testimony to
16 those members of the review panel as you have given today?

17 A. That's right. My organization may be slightly
18 different, but the facts are really the same.

19 Q. The essence and the body of your opinions are
20 the same today as they were, as you expressed them, to the
21 Medical Review Panel in May of 1990.

22 A. That is correct.

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1 MR. GODARD: Thank you. That's all I have.

2 MR. SALE: We'll have a little bit on redirect.

3 FURTHER EXAMINATION BY COUNSEL FOR PLAINTIFFS

4 BY MR. SALE:

5 Q. Doctor, in your area, are there any other
6 pediatric cardiologists?

7 A. Depending by the area, there is a pediatric
8 cardiologist in Tallahassee, Florida, which is about 30
9 miles away. But in terms of board certified pediatric
10 cardiologists, we've got 100 miles in any direction.

11 Q. So to find a board certified pediatric
12 cardiologists, you'd have to go 100 miles in any
13 direction?

14 A. That's correct.

15 Q. Doctor, have you ever taught pediatric
16 cardiology?

17 A. Yes, I have.

18 Q. Where did you do that?

19 A. Both at Letterman Army Medical Center and the
20 University of California, San Francisco.

21 Q. Okay. Doctor, to the extent you're opinions
22 could be deemed to be opinions on cardiac, pediatric

1 cardiology, has the standard of care increased or
2 decreased, meaning has it gotten stronger or weaker, since
3 the time you taught pediatric cardiology?

4 MR. GODARD: Object to the form of question.

5 BY MR. SALE:

6 Q. It has gotten stronger?

7 A. Yes, it has.

8 Q. Doctor, you said you treat patients in
9 congestive heart failure?

10 A. Yes, I do.

11 Q. Do you do that routinely?

12 A. I don't know if, perhaps half a dozen times a
13 year would be considered routinely, but it's not
14 particularly out of the ordinary.

15 Q. You do treat it when it arises at Thomasville?

16 A. Yes, I do.

17 Q. You said you also prescribed drugs for that
18 condition?

19 A. Yes, I do.

20 Q. Doctor, going back to the anatomy of Nicole
21 Panousos, Plaintiff's Exhibit 16 for identification, if
22 mass no. I were the bladder, would it be more likely or

1 less likely that the bladder neck would be compressed as
2 far as ability to withdraw urine?

3 A. One of the problems that I had in looking at the
4 ultrasound themselves in trying to call mass no. I the
5 lower mass, the bladder, is that when I saw the reflection
6 of the catheter heading towards kind of a position between
7 the two masses and maybe immediately adjacent to the top
8 of mass no. I, the urethra generally inserts into the
9 bottom of the bladder.

10 And that would require quite a bit of rotation
11 of the -- or, if you will, if mass no. I were the bladder,
12 it would have to be really pushed down by the mass above
13 it. And, I really didn't see that, if that answers your
14 question.

15 Q. Would you expect the bladder anatomically, as
16 far as normal anatomy, to be in the front of the abdomen
17 or in the lower part of the abdomen in a normal child?

18 A. Of course, it's really in the pelvis and not the
19 abdomen. But it's anterior. It's in the front of the
20 pelvis in a normal child.

21 Q. Doctor, injecting saline solution, does that
22 pose a significant risk to the child?

1 A. Really, none whatsoever.

2 Q. Would you call that an invasive procedure?

3 A. Very minimally. Certainly no more so than
4 having put the catheter in the urethra to begin with.

5 Q. And does saline water pose any health risk to
6 the child?

7 A. No, not under those circumstances.

8 MR. SALE: No further questions.

9 MR. GODARD: I have nothing further.

10 MR. SALE: We will waive.

11 (Whereupon, at 12:20 p.m., the signature of the
12 witness having been waived by counsel, the witness being
13 present and consenting thereto, the taking of the instant
14 deposition ceased.)

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ORIGINAL

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VIRGINIA:

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

NIKOLAOS AND SANDRA PANOUSOS,
Administrator and Administratrix
of the Estate of NICOLE PANOUSOS,

Plaintiffs,

vs.

ROBERT M. ALLEN, M.D., and
FAIRFAX RADIOLOGICAL CONSULTANTS,
P.C.,
Defendants.

FILED
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RICHMOND, VIRGINIA

Fairfax, Virginia

Tuesday, December 3, 1991

The trial commenced at 10:20 a.m.

BEFORE:

THE HONORABLE RICHARD J. JAMBORSKY and jury.

APPEARANCES:

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I N D E X

<u>WITNESSES</u>	<u>DIRECT</u>	<u>CROSS</u>	<u>REDIRECT</u>
Sandra Panousos	54	77	
Linda Stover	81	87	89
Richard B. Karsh, M.D.	96		

EXHIBITS

<u>PLAINTIFFS'</u>	<u>FOR IDENT.</u>	<u>IN EVIDENCE</u>
No. 1 (Photo)	55	56
No. 32 (Nicole's history)		86
No. 2 (Dr. Karsh's CV)		96
Nos. 15 and 16 (Documents)		96
No. 5 (Document)		97
No. 9 (Document)		97
Nos. 6 and 8 (Documents)		98
Nos. 13 and 14 (Documents)		107
Nos. 17 and 18 (Documents)		108

* * *

1 winners and losers, but the outcome in large measure can
2 be determined on the chance of how those six men and one
3 woman choose to look at this particular case.

4 I tell you all of that because you're going to be
5 much better off if you reach a settlement. True, when you
6 reach a settlement, you don't feel totally vindicated,
7 totally justified, but it sure beats being a loser. It
8 also means that you know exactly where you stand now, that
9 it's not put off because it's appealed and goes through
10 the appellate system for a year and a half, two years.
11 You know exactly where you stand right now, and that's the
12 end of it, and you get on with your lives. So I urge that
13 you reexamine your position and your motive for being
14 here. And if you can reach a settlement, I urge you to
15 try and do it. Have you had settlement discussions?

16 MR. QUINN: We had some settlement discussions
17 early on. First of all, Your Honor, we settled with the
18 hospital. They were a defendant in a related case. We
19 settled with the hospital about a month and a half ago, I
20 think it was. We have made a very reasonable settlement
21 proposal to the defendants, which they rejected and said
22 they didn't want to settle the case. That's where it was
23 left.

* * *

* * *

1 MR. QUINN: Just the objections for me.

2 MR. GODARD: Just the objections.

3 THE COURT: It will be my understanding that
4 there will be objections, and we will want those recorded.

5 (The November 30, 1991, videotape deposition of
6 Richard B. Karsh, M.D., was played to the jury.)
7 (At page 15, line 2 of the deposition:)

8 THE COURT: I overrule the objection and receive
9 the exhibit.

10 (The curriculum vitae of Dr. Karsh previously
11 marked for identification as Plaintiffs' Exhibit
12 No. 2 for identification was received in
13 evidence.)

14 (The playing of the videotape resumed.)
15 (At page 16, lines 2 through 4 of the
16 deposition:)

17 "Q Do you meet the requirements of those
18 regulations?

19 MR. GODARD: Objection."

20 THE COURT: Overruled.

21 (The playing of the videotape resumed.)

22 (At page 36, line 15 of the deposition:)

23 THE COURT: Stop that just for a second.

1 Is there any objection to 15 and 16? Okay. I
2 receive them.

3 (The documents previously marked for
4 identification as Plaintiffs' Exhibit Nos.
5 15 and 16 were received in evidence.)

6 Is there any objection to 5?

7 MR. GODARD: No objection to 5.

8 THE COURT: I receive it.

9 (The document previously marked for
10 identification as Plaintiffs' Exhibit
11 No. 5 was received in evidence.)

12 THE COURT: Let's stand up and stretch for a few
13 minutes.

14 (A stretch break was taken.)

15 (The playing of the videotape resumed.)

16 (At page 43, line 2 of the deposition:)

17 THE COURT: I receive 9.

18 (The document previously marked for
19 identification as Plaintiff's Exhibit
20 No. 9 was received in evidence.)

21 (The playing of the videotape resumed.)

22 (At page 46, line 9 of the deposition:)

23 "MR. GODARD: Again, to the extent, there are

1 duplicated, with the exhibits already in evidence, I think
2 they're unnecessary."

3 THE COURT: All right. I receive the exhibits.

4 (The documents previously marked for
5 identification as Plaintiffs' Exhibit Nos. 6
6 and 8 were received in evidence.)

7 (The playing of the videotape resumed.)

8 (At page 50, line 7 of the deposition:)

9 "MR. GODARD: I'm going to object to that. This
10 witness can testify."

11 THE COURT: I sustain the objection. What do you
12 want to do about that?

13 MR. GODARD: Well, I think it's all right to go
14 ahead because he asked another question.

15 THE COURT: Okay. Go ahead.

16 (The playing of the videotape resumed.)

17 (At page 52, line 5 of the deposition:)

18 "MR. GODARD: Objection."

19 THE COURT: Sustained.

20 MR. GODARD: We can skip over it. It's only a
21 three-word answer.

22 (The playing of the videotape resumed.)

23 THE COURT: We're going to take a 15-minute

1 break. You can go downstairs for refreshment, and we'll
2 start again in 15 minutes.

3 (A short recess was taken.)

4 (The following proceedings were held out of the
5 presence of the jury.)

6 THE COURT: Did you want me to read the next
7 question and answer?

8 MR. SALE: Your Honor, we have first a
9 preliminary to that, to which counsel indicates they have
10 no objection.

11 THE COURT: What page is it?

12 MR. SALE: Okay. First, we remain on page 52.

13 THE COURT: All right.

14 MR. SALE: The answer by the witness there that
15 was objected to was already edited out by the operator,
16 unbeknownst to all of us here.

17 THE COURT: It's a smart operator.

18 MR. SALE: Well, I won't comment on that, Your
19 Honor. But unfortunately, the edit also went into the
20 next question. And we would ask leave before we start the
21 tape to be able to read that question since it's
22 unobjected to.

23 THE COURT: Which one is it?

1 MR. SALE: Okay. "Doctor, have you ever been
2 called in the middle of surgery?"

3 MR. GODARD: Line 7.

4 THE COURT: Is there any objection to that?

5 MR. GODARD: I don't have any objection. Then
6 going on to the next page, as long as we're doing this, I
7 think just to save time, the Court will note at line 8 on
8 page 53, I note an objection. And that's to the witness
9 being asked to read from this document that they had a
10 page before marked and identified as Exhibit 7.

11 What that is, Your Honor, and my objection stands
12 to that, it's a hearsay, self-serving document that was
13 prepared by Dr. Hodin after the fact. It's not part of
14 the medical record. It's just a narrative summary in his
15 own words and in no way is part of the medical record or
16 is admissible for any purpose. That's the basis of my
17 objection. I object to the witness reading from it, and
18 he actually read about four lines there that I would like
19 deleted.

20 THE COURT: Does it have an exhibit number?

21 MR. SALE: Yes. It's Exhibit 7, Your Honor. I
22 believe it would be appended to the original.

23 THE COURT: Have you moved it in? Have I ruled

1 on that?

2 MR. GODARD: No.

3 MR. SALE: Your Honor, I don't believe that's
4 been ruled on.

5 Your Honor, if I might just respond briefly
6 before your ruling.

7 THE COURT: Go ahead.

8 MR. SALE: Your Honor, this is part of Dr.
9 Hodin's office record. It was relied on by Dr. Karsh. He
10 indicated he would customarily prepare such a record,
11 would customarily rely on it. He thinks it's an exception
12 to the hearsay rule, which is the medical records of a
13 treating physician.

14 MR. GODARD: Well, I take issue with that
15 statement. I don't think Dr. Karsh said that at all.
16 This document -- the Court has the document before you --
17 you can see is clearly in no way a medical record. This
18 patient died in the hospital. Dr. Hodin never saw the
19 patient in his office, certainly never had any occasion to
20 see the patient after March the 6th. This is simply Dr.
21 Hodin's in-anticipation-of-litigation document, if Your
22 Honor please.

23 THE COURT: Excuse me for a minute. The way it

1 comes out is does Plaintiffs' Exhibit No. 7 indicate that
2 Dr. Allen rejects contrast solution. So, obviously, the
3 reason that you want that in is for the truth of the
4 matter asserted. How is that tied up to how Dr. Karsh
5 forms an opinion?

6 MR. SALE: Well, Your Honor, it's a medical
7 record, and it's yet further corroboration from a medical
8 record what procedures were done by Dr. Allen.

9 THE COURT: Okay. Let me see --

10 MR. SALE: Dr. Hodin will be here tomorrow, Your
11 Honor.

12 THE COURT: On the next question, are you still
13 talking about Exhibit No. 7?

14 MR. GODARD: The one at line 19 on page 54?

15 THE COURT: Yes.

16 MR. GODARD: No. He's moved on to another
17 document. He's moved on to the actual radiology report.

18 THE COURT: I overrule the objection. What else
19 do I need to rule on?

20 MR. GODARD: I believe the only one that you
21 really need to rule on, Your Honor, is on page 69 at line
22 5 -- or excuse me. The objection is made at line 9. And
23 my objection simply goes to the fact that earlier on page

1 27, line 1, he had answered the same question.

2 MR. SALE: Your Honor, I would respond that 50
3 pages of intervening review of records has occurred here,
4 and that I'm simply asking whether those records have
5 changed the opinion, whether the opinion is the same, et
6 cetera. So I think it's fair to summarize for the jury
7 something that happened 50 pages ago.

8 THE COURT: I sustain the objection. I don't
9 think that we have internal summaries with respect to
10 that. Plus, you are asking the standard question and
11 asked him in effect how he arrived at it. And he went
12 through each record. But throughout, if there's any way
13 that I can eliminate unnecessary questioning, I will, so
14 there are not going to be internal summaries from anybody.

15 Is there anything else?

16 MR. GODARD: I believe that's the only one that's
17 important enough to call any attention to. Might we just
18 suggest to the bailiff when we reach that point, can we
19 just turn the sound off and go through that, do you think,
20 or is the machine not capable of doing it?

21 MR. QUINN: Is there a pause button?

22 MR. GODARD: Well, we will alert the Court when
23 we get close to it.

1 THE COURT: All right.

2 (The following proceedings were held in the
3 presence of the jury.)

4 MR. SALE: Your Honor, may I proceed?

5 THE COURT: Yes, sir.

6 MR. SALE: In connection with the starting and
7 stopping of the videotape to reflect Mr. Godard's
8 objection, my next question and the beginning of the next
9 answer was also omitted by the video operator
10 inadvertently, I'm sure.

11 The question was: "Doctor, have you ever been
12 called in the middle of surgery?" The answer, at least
13 the part that's not there, and I'll read the whole answer
14 for the sake of fullness and correctness, "Not that I
15 recall during the middle of surgery. I've had an
16 occasional call right after surgery fortunately usually to
17 congratulate me or one of my partners on a good diagnostic
18 call and sometimes a surgeon would call and tell us we
19 were right about a mass or something, but we didn't have
20 the exact diagnosis and it was very intriguing to him from
21 what he found."

22 Let the operator start.

23 (The playing of the videotape resumed.)

1 THE COURT: Well, let me back up for a moment.
2 Let me ask this question again. At the top of page 53,
3 line 4, that's not referring to the document that's marked
4 7, is it?

5 MR. SALE: Yes, it is, Your Honor.

6 THE COURT: It is referring to the same document.

7 MR. SALE: Yes, it is.

8 THE COURT: I thought that was referring to a
9 radiological report when I asked that earlier. I
10 therefore revise my ruling and sustain the objection to
11 that whole line of questioning. So disregard these
12 questions that were just asked about what a radiological
13 diagnosis may have been or, I'm sorry, about the contrast
14 solution.

15 (The playing of the videotape resumed.)

16 THE COURT: So I think we're going to start now
17 on --

18 (The playing of the videotape resumed.)

19 THE COURT: I sustain the objection.

20 MR. QUINN: There's no objection on the record,
21 Your Honor.

22 THE COURT: Well, at any rate, the Court is not
23 going to permit summaries by any witness. Let's move on

1 to new material.

2 MR. GODARD: Can we go to the top of page 62, if
3 we could find it on the video, line 1?

4 (The playing of the videotape resumed.)

5 THE COURT: "Question: Doctor, do you see any
6 indication in the record that Nicole was going to surgery
7 immediately regardless of the outcome of radiology?

8 Answer: No, I don't see any definitive evidence of that."

9 Okay. We'll start.

10 (The playing of the videotape resumed.)

11 THE COURT: "Is there anything in the record that
12 would indicate you would try to delay surgery?"

13 (The playing of the videotape resumed.)

14 MR. SALE: Your Honor, could we stop the tape?
15 In connection with that last objection, there was another
16 question that was deleted that was not objected to.

17 THE COURT: Okay. The question: "Would a
18 reasonable, prudent radiologist know that a misdiagnosis
19 would cause harm to the patient? Answer: He would
20 certainly know that a misdiagnosis could cause harm to the
21 patient, but he probably would be unable to specifically
22 identify what harm it might cause. It could be anything
23 from a larger postsurgical scar obviously to death with

1 the likelihood of death I'm sure being very, very low on
2 his list."

3 MR. GODARD: And it's at that point that there is
4 the previously sustained objection, again, to the next
5 question, so we need to skip through the tape.

6 THE COURT: All right. I sustain the objection.
7 You can go to the top of page 70. "Is it your opinion?"

8 The question is: "Is it your opinion that Dr.
9 Allen's violation of the standard of care caused Nicole's
10 death within a reasonable degree of medical certainty."

11 (The playing of the videotape resumed.)

12 (At page 80, line 10 of the deposition:)

13 "MR. GODARD: Object to the form of the question
14 to the extent it suggests that Dr. Allen wasn't clearly
15 within that."

16 THE COURT: Overruled.

17 (The playing of the videotape resumed.)

18 "MR. GODARD: No objection."

19 THE COURT: I receive it.

20 (The documents previously marked for
21 identification as Plaintiffs' Exhibit
22 Nos. 13 and 14 were received in evidence.)

23 (The playing of the videotape resumed.)

1 (At page 85, line 11 of the deposition:)

2 THE COURT: "At this point the plaintiff would
3 like to move Exhibits 10, 11 and 12 into evidence."

4 MR. GODARD: "Well, again I think they're already
5 in evidence. I don't see the need for continually
6 repetitive documents."

7 THE COURT: At some point we will go through the
8 evidence to make sure that we don't have duplicates.

9 (The playing of the videotape resumed.)

10 MR. QUINN: Okay. We would like to mark for
11 identification Plaintiff's Exhibit 17 and 18 and move
12 those in as well.

13 MR. GODARD: I think I would have to object to
14 those as not being part of the medical records. I have no
15 objection to their being used for the demonstrative
16 purpose that they have been used in this video, but I
17 think they're inappropriate to go into evidence.

18 THE COURT: Once they have been shown to the
19 jury, I conclude that they have appropriately come in, and
20 I receive them.

21 (The documents previously marked for
22 identification as Plaintiffs' Exhibit
23 Nos. 17 and 18 were received in evidence.)

1 (The playing of the videotape resumed.)

2 THE COURT: At this point Mr. Godard asked if he
3 wanted to take a five-minute fresh-air break. Instead of
4 taking a five-minute fresh air break, we can go home and
5 start again tomorrow. I have to start at 10 tomorrow
6 because I have another activity at 9:30 here. But we'll
7 start at 10 and start with Mr. Godard's cross-examination.
8 Thank you for your attention. Please don't discuss the
9 case or draw any conclusions. I think we'll be in
10 Courtroom 5A.

11 Do counsel need to see me before we adjourn?

12 MR. GODARD: I think not.

13 (At 4:50 p.m. the trial was recessed to reconvene
14 at 10 a.m., Wednesday, December 4, 1991.)
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ORIGINAL

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FILED

DEC 10 1991

VIRGINIA:

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

NIKOLAOS AND SANDRA PANOUSOS,
Administrator and Administratrix
of the Estate of NICOLE PANOUSOS,

Plaintiffs,

vs.

ROBERT M. ALLEN, M.D., and
FAIRFAX RADIOLOGICAL CONSULTANTS,
P.C.,

Defendants.

At Clerk No. 98695
SUPREME COURT OF VIRGINIA
RECEIVED
APR 01 1992
RICHMOND, VIRGINIA

Fairfax, Virginia

Wednesday, December 4, 1991

The trial commenced at 10 a.m.

BEFORE:

THE HONORABLE RICHARD J. JAMBORSKY and jury.

APPEARANCES:

JOHN R. QUINN, ESQ., and STEPHEN SALE, ESQ.,
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GARY A. GODARD, ESQ., and GEORGE A. McANDREWS,
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Fairfax, Virginia 22030, counsel for the
defendants.

I N D E X

<u>WITNESSES</u>	<u>DIRECT</u>	<u>CROSS</u>	<u>REDIRECT</u>
Richard B. Karsh, M.D.	114	115	121
Earl Hodin, M.D.	126	133	141
Arthur Maron, M.D.	143	168	191
Robert M. Allen, M.D.	203	247	

EXHIBITS

<u>PLAINTIFFS'</u>	<u>FOR IDENT.</u>	<u>IN EVIDENCE</u>
No. 33 (Dr. Maron's chart)		193
No. 34 (Radiological Report)		266

DEFENDANTS'

No. 2 (Hospital Chart)	270	270
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* * *

1 consider is that information which is presented in the
2 courtroom as evidence.

3 Sometimes in accident cases jurors will want to
4 go to the scene of the accident and look at it firsthand.
5 We tell them no, you can't do that. One time I tried an
6 obscenity case where the jurors wanted to rush home and
7 use Webster's dictionary for every one of those terms, and
8 we couldn't let them do that. The same is true in this
9 kind of a case, that you may not do individual research,
10 as logical as that may appear.

11 The information that you're confined to is the
12 evidence and testimony presented at trial and the
13 arguments which counsel will make to you with their
14 explanation or attempt to help you understand that
15 evidence or testimony. So please don't discuss the case.
16 Please don't do any independent reading or research on any
17 of the issues, and try when you're not here to keep your
18 minds blank.

19 Has anyone over the break had occasion to read,
20 hear, see or discuss any issue relating to this case?
21 Okay. There are no affirmative answers.

22 (The playing of the November 30, 1991, videotape
23 deposition of Richard B. Karsh, M.D., resumed.)

1 (Examination By Counsel For The Defendant)

2 (At page 93, line 7 of the deposition:)

3 "MR. QUINN: Object. It's irrelevant."

4 THE COURT: Overruled.

5 (The playing of the videotape resumed.)

6 (The playing of the videotape stopped while the
7 second videotape was inserted.)

8 MR. QUINN: Would you like to read that portion?

9 MR. GODARD: The question is: "Now, focusing
10 upon the performance of the procedure itself by the
11 radiologist, the objective here is to essentially make a
12 study which based upon his professional training and
13 experience and judgments enables him to with reasonable
14 medical accuracy, which I think we'll all agree is never
15 perfect, but reasonable medical accuracy, if you will, of
16 what is being seen in that child's abdomen and to identify
17 as was the case here what the predominant cystic masses
18 most likely were."

19 I think the tape actually picks it up about in
20 the middle of that question.

21 (The playing of the videotape resumed with
22 difficulty.)

23 THE COURT: All right. Let's stop right there.

1 MR. GODARD: I'm just wondering if this
2 continues, this problem, or if it's localized.

3 THE COURT: All right. Put it back on and let's
4 see where it goes for, say, another minute.

5 MR. QUINN: I don't know. We did this deposition
6 on Saturday and with the preparation -- I didn't have an
7 opportunity to look --

8 THE COURT: That's all right. We're not fussing.
9 Let's just see if it continues, and then we'll know
10 whether we need to have Mr. Godard to read it.

11 (The playing of the videotape resumed.)

12 THE COURT: All right. Let's stop it there
13 before the answer starts. And then let's let Mr. Godard
14 read that question without interruption, and then we'll
15 turn the set back on to hear what the doctor's answer is.

16 MR. GODARD: And if I may, I think the last
17 several questions were a little distorted. May I back up
18 and just read the last several questions and answers?

19 THE COURT: Yes.

20 MR. GODARD: Well, the question that I read just
21 a moment ago, the witness answered:

22 "Of course."

23 And then the next question was:

1 "Now, I presume you would agree that
2 the practice of radiology like any of the
3 subspecialty skills in the overall practice of
4 medicine certainly doesn't require perfection and
5 absolute accuracy in every diagnostic effort?

6 "Answer: That's correct.

7 "Question: The objective here for that
8 radiologist was to exercise reasonable skills and
9 reasonable efforts to reach the point where he
10 reasonably could feel comfortable in diagnosing what
11 he was seeing on that screen?

12 "Answer: That's correct.

13 "Question: Now, let me ask you, Doctor,
14 hypothetically, if, in fact, the radiologist
15 performing this study had, in fact, successfully
16 passed a catheter in and up through the urethra and
17 watching that catheter pass on the screen as he would
18 be watching it and seeing what he would interpret as
19 evidence that the catheter is, indeed, passing into
20 the cystic mass which he is trying to diagnose and
21 seeing then a few droplets of what he interprets to be
22 urine come from that catheter and knowing or feeling
23 confident that the catheter has been inserted into the

1 urethra and knowing from this medical training that
2 the urethra leads into the bladder, assuming all of
3 those facts hypothetically, that radiologist would be
4 exercising reasonable medical skill and judgment as a
5 radiologist if he concluded that, in fact, that
6 particular mass was most likely the bladder, would he
7 not?"

8 MR. QUINN: Can I read the answer to that
9 question?

10 MR. GODARD: Well, I think that's where it picks
11 up.

12 THE COURT: I think that the tape has his answer.
13 (The playing of the videotape resumed.)

14 MR. QUINN: Is counsel now talking about Nicole
15 Panousos or are they still a hypothetical?

16 MR. GODARD: Well, both.

17 THE COURT: All right. Let's stop it and let him
18 read the question.

19 (At page 122, line 8 of the deposition:)

20 MR. GODARD: The question is: "Notwithstanding
21 the fact that it may have been less complicated, there was
22 certainly nothing that prevented, that made it impossible
23 to manage this child's post-surgical fluids and

1 electrolytes."

2 THE COURT: Why don't you also read the answer.

3 MR. GODARD: Well, there's an objection, and then
4 I reform the question. Do you want me to read the
5 reformed question first?

6 THE COURT: Would you, please.

7 MR. GODARD: Well, Mr. Sale objects and says:
8 "The question of impossibility is not at issue in this
9 case. It's irrelevant."

10 And I respond: "Well, I use that word partly
11 because it's been used repeatedly in the direct
12 examination of what was possible and what was not. So, if
13 impossible, the negative aspect of that offense, counsel,
14 let me turn it around and say it certainly was possible
15 for this child's electrolytes and fluids to be
16 appropriately managed, if, in your view, they were not
17 appropriately managed.

18 "Answer: That's right. It was more difficult to
19 see exactly where one was, but certainly possible."

20 THE COURT: Go ahead.

21 (The playing of the videotape resumed.)

22 MR. QUINN: "Object. It's beyond the scope of
23 direct. It's not relevant here. Parties are not involved

1 in this case.

2 MR. GODARD: You opened it up."

3 (The electricity goes off in the courtroom.)

4 THE COURT: I would offer you the opportunity to
5 go downstairs for refreshment, but the elevators won't be
6 working. So please don't discuss the case, and why don't
7 you take a stretch break out there. And I ask counsel and
8 the parties to please remain aloof from the jurors and not
9 infringe on their space. And you all can be out there in
10 the light while we wait.

11 (A recess was taken.)

12 THE COURT: Okay.

13 MR. SALE: Your Honor. There is an objection
14 pending.

15 THE COURT: Give me the page number, please.

16 MR. SALE: Page 127.

17 THE COURT: I overrule the objection.

18 (The playing of the videotape resumed.)

19 MR. GODARD: If Your Honor please, could I ask
20 that that be backed up to the question?

21 THE COURT: Yes. Run that back a little bit,
22 please.

23 (The playing of the videotape resumed.)

1 (Further Examination By Counsel For Plaintiffs)

2 (At page 130, line 4 of the deposition:)

3 "MR. GODARD: Object to the form of the
4 question."

5 THE COURT: Overruled.

6 (The playing of the videotape deposition of Dr.
7 Karsh ended.)

8 THE COURT: Okay. Who is the next witness?

9 MR. QUINN: Your Honor, before we call a witness,
10 we have a matter we'd like to discuss with you.

11 THE COURT: All right.

12 (Counsel approached the bench and the following
13 proceedings were held:)

14 MR. QUINN: Your Honor, first we have a
15 stipulation on authenticity of medical records and also a
16 stipulation that Dr. Allen was an employee of Fairfax
17 Radiological working within the scope of his employment.

18 THE COURT: Okay.

19 MR. QUINN: Secondly, we would ask for an
20 instruction at this time. As you will recall, the court
21 excluded Dr. Tabackman yesterday and we expected Dr.
22 Tabackman to testify to mental anguish and suffering and
23 so forth.



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1 instruction on that right this minute. But I generally
2 would be favorably disposed toward letting the jury
3 consider that, particularly in view of my ruling, which I
4 think was correct, in denying Dr. Tabackman.

5 MR. QUINN: Okay. If there's no instruction, can
6 we at least argue it to the jury?

7 THE COURT: Yes. But I would like for you to
8 submit the instruction.

9 MR. QUINN: Okay. The second point is we also
10 asked Dr. -- we were going to have Dr. Tabackman get the
11 statutory mortality tables into evidence.

12 THE COURT: I will receive that as an
13 instruction.

14 MR. QUINN: Okay. Fine. Thank you.

15 The final point is we were about to call Dr.
16 Hodin, who is the surgeon who did the surgery here. He is
17 a longstanding associate of Dr. Allen's, first of all. We
18 expect he is going to be adverse. We know that Mr. Godard
19 spent some time Monday afternoon with him, again this
20 morning with him. We have a few simple questions we want
21 to ask him.

22 We bring to your attention again the argument we
23 made about the opinion evidence coming in from the

1 treating physician. We want to make the point here that
2 we ask the Court to be cautious about this, ask Mr. Godard
3 to be cautious about this. And secondly, we'd like to be
4 able to treat Dr. Hodin as adverse.

5 THE COURT: Well, I think to treat him as adverse
6 means that he will be the same as Dr. Allen as a party;
7 right? But if his testimony becomes hostile, then you may
8 cross-examine. So at any point that you choose to ask he
9 be treated as a hostile witness, do that.

10 MR. SALE: Your Honor, can we get an instruction
11 that he may not give opinions especially on causation?

12 MR. GODARD: May I say one thing? The only
13 question that I am presently contemplating that is
14 extremely relevant, and that I certainly would propose to
15 ask Dr. Hodin on cross-examination, is the one that goes
16 to the very heart of the whole causation issues in this
17 case.

18 I would propose to ask Dr. Hodin that based upon
19 his surgical findings and his examination of this child's
20 abdomen and the bladder at the time of his surgical
21 procedure, did he reach a finding or conclusion as to
22 whether or not the bladder could have been decompressed,
23 i.e., drained with a catheter without necessity of the

1 surgery. I proffer to the Court that his answer will be
2 in all likelihood it could not have been. And that by
3 puncturing the bladder from the top with the pressure that
4 was inside the abdomen and draining it as he did, that
5 that bladder had been decompressed.

6 THE COURT: Do you object to that?

7 MR. QUINN: Yes, I do. It's an opinion. It's
8 certainly outside the course of the medical treatment.

9 THE COURT: I overrule the objection. You may
10 ask that question on your cross-examination.

11 MR. GODARD: Thank you.

12 THE COURT: When you start out your examination,
13 you should treat him as you would any witness that you
14 call. If his answers prove to be hostile, then you can
15 either in the presence of the jury ask that he be treated
16 as a hostile witness or approach the bench and I will give
17 you the opportunity to cross-examine.

18 MR. QUINN: Okay. That is correct. Can I have
19 just a minute to confer with my cocouncil about these
20 rulings?

21 THE COURT: You may.

22 MR. QUINN: Thank you.

23 (The bench conference was concluded.)

1 MR. QUINN: I call Dr. Hodin, Your Honor.

2 Whereupon,

3 EARL HODIN, M.D.,

4 was called as a witness on behalf of the plaintiffs, and
5 after having been first duly sworn, was examined and
6 testified as follows:

7 DIRECT EXAMINATION

8 BY MR. QUINN:

9 Q Please state your name for the record.

10 A Earl Hodin.

11 Q And you are Dr. Earl Hodin; is that correct?

12 A Yes.

13 Q Doctor, where do you practice medicine?

14 A Fairfax County.

15 Q In what specialty?

16 A Pediatric surgery.

17 Q And how long have you practiced in this area?

18 A 16 years.

19 Q And has all that time been at Fairfax Hospital?

20 A Well, I practice at several hospitals, but
21 Fairfax is the main one, yes.

22 Q Are you an associate at Fairfax Hospital of Dr.
23 Allen's?

1 A I am.

2 Q You are. How long have you been an associate of
3 Dr. Allen's?

4 A I think as long as I've been in practice.

5 Q You're here today under subpoena; is that
6 correct, Doctor?

7 A That's correct.

8 Q Can you describe for the Court what the condition
9 of Nicole's abdomen was at the time you first saw her on
10 March 5th?

11 A Her abdomen was distended and tense and tender,
12 seemed to contain a large mass.

13 Q What did you decide to do at that point?

14 A In terms of treatment or diagnosis or both?

15 Q Diagnosis.

16 A I ordered a sonogram be performed.

17 Q And you waited for the diagnosis to decide what
18 the treatment was going to be; is that correct?

19 A Yes, that's correct.

20 Q And Nicole had a sonogram; correct?

21 A Yes.

22 Q Did you receive a report of that sonogram after
23 the fact from Dr. Allen?

1 A Yes, I did.

2 Q When was that?

3 A This is the late morning hours of March 5, 1987.

4 Q Where did you receive that report?

5 A I don't recall. I either went to the sonogram
6 suite and spoke to him in person or I spoke to him over
7 the phone from the operating room suite. I'm not sure.

8 Q What was the diagnosis?

9 A Well, he described having seen one, possibly two
10 masses or possibly one mass with a loculation; that is one
11 mass divided into two compartments. He said that he had
12 catheterized the bladder and that he was satisfied that
13 the mass was not bladder.

14 Q He told you the large mass was not the bladder;
15 is that correct?

16 A We didn't talk about a large mass or a small mass
17 because it wasn't clear whether there were two masses,
18 which is what it turned out to be, or whether there was
19 one large mass with two compartments. But in any case,
20 neither mass nor neither compartment was the bladder.

21 Q Did you presume, Doctor, on the basis of the
22 diagnosis that the lower mass was the bladder, the mass he
23 said he catheterized?

1 A No. As a matter of fact, I presumed the
2 opposite. I presumed that the mass -- or neither mass, if
3 there were two, was the bladder.

4 Q You presumed that neither of the two masses were
5 the bladder?

6 A Correct.

7 Q What did you think Dr. Allen had catheterized
8 then?

9 A I thought he catheterized the bladder.

10 Q I see. Okay. So you thought that it was one
11 septated mass, in other words, the large mass?

12 A Well, either one septated mass or two masses.
13 That wasn't exactly clear. But what I presumed was that
14 he had catheterized the bladder. The bladder was separate
15 from this mass.

16 Q So you presumed that the large mass was not the
17 bladder.

18 A Among other things, yes.

19 Q Did Dr. Allen mention anything to you about
20 getting any urine in the catheterization?

21 A We didn't discuss that aspect.

22 Q Did he mention anything about injecting any
23 contrast solution or sterile water to confirm his

1 diagnosis at that time?

2 A I believe he did.

3 Q What did he say?

4 A I believe he said he catheterized the bladder and
5 injected contrast to confirm that it was bladder and that
6 the mass was not bladder.

7 Q Now, before you got Dr. Allen's diagnosis, what
8 was your plan as far as doing surgery on Nicole? Did you
9 intend to wait 24 hours?

10 A I hadn't made up my mind exactly what to do. But
11 I had thought about both the delay and immediate surgical
12 operation. The basic plan, however, for the most part,
13 with some slight hesitation on my part, as I mentioned in
14 the notes, was to proceed with surgery unless he told me
15 something that would -- that would surprise me and that
16 would turn the situation around.

17 Q If the bladder had been properly identified in
18 the catheterization, would you have waited 24 hours to
19 conduct surgery?

20 MR. GODARD: Well, objection, if Your Honor
21 please. That doesn't address the question of whether
22 anything could have been done with the bladder.

23 THE COURT: Overruled. You may answer the

1 question.

2 A I'm sorry. Would you repeat it?

3 BY MR. QUINN:

4 Q Would you have waited 24 hours to do the surgery,
5 at least 24 hours, if you had known that the larger mass
6 was in fact the bladder?

7 A Well, it presumes a lot of things. If we knew
8 that the mass, the larger mass was bladder, presumably we
9 would have either had the bladder drained by that same
10 catheterization that established it as bladder or another
11 catheterization that I would have performed, and then you
12 have to tell me what the situation would have been after
13 we drained the bladder before I can make up my mind about
14 whether we could delay surgery.

15 Q Assuming the bladder had been drained, would you
16 have waited 24 hours based on what you know about Nicole's
17 condition, 24 to 48 hours to do surgery?

18 A The reason for going to surgery was that the
19 patient had a large, tender abdomen, what we refer to as
20 an acute abdomen. And what I would need to know is having
21 drained the bladder, would that have relieved the acute
22 abdomen. So without that knowledge, I can't tell you
23 exactly what I would have done.

1 Q Doctor, you were Nicole's treating physician on
2 the 5th of March; is that correct?

3 A Yes.

4 Q Did you maintain notes on Nicole's condition at
5 that time?

6 A I did.

7 Q Are those notes that you -- let me show you the
8 notes. I direct your attention to Exhibit 7.

9 A These are my notes. I have the originals in
10 front of me.

11 Q Okay. Now, is Exhibit 7 a note that you
12 maintained in the ordinary course of your practice?

13 A Yes.

14 MR. QUINN: Your Honor, I move for admission of
15 Exhibit 7.

16 MR. GODARD: Well, I object. I'd like to
17 cross-examine the witness about those notes.

18 THE COURT: Well, for right now I sustain the
19 objection and I don't receive the exhibit for two reasons:
20 one, because I'm not sure what the purpose of it is; two,
21 because there's a live witness here that can testify to
22 whatever is in the notes and be cross-examined. Are the
23 notes simply a memorialization of what his testimony is

1 going to be today? I'm not sure.

2 MR. QUINN: It's a medical record.

3 THE COURT: I understand that. Let's assume that
4 we have a live witness here. Is every medical record
5 coming in when the witness is here to be cross-examined?

6 MR. QUINN: I understand, Your Honor. I will ask
7 him some questions about it.

8 BY MR. QUINN:

9 Q Doctor, I want to direct your attention to page 1
10 of your March 5 note. And in the second to last paragraph
11 I'd like you to read the last sentence, if you could.

12 A "My first impulse was to operate on her in 24
13 hours, but because of her tenderness I elected to take her
14 directly to the operating room."

15 MR. QUINN: Thank you. I have no further
16 questions.

17 CROSS-EXAMINATION

18 BY MR. GODARD:

19 Q Good afternoon, Dr. Hodin. Let me ask you about:
20 You indicated in response to counsel's question that the
21 basic plan was to proceed to surgery unless you received
22 some information from the ultrasound study that caused you
23 to change your mind.

1 A That's correct.

2 Q Ultimately, based upon what you found at surgery,
3 did you find what was causing this bladder to be
4 distended?

5 A I did.

6 Q And what was that?

7 A A tumor of her pelvis which turned out to be a
8 teratoma ultimately and which was pressing on the neck of
9 the bladder.

10 Q Can you describe for us then exactly how that had
11 caused the bladder to become so grossly distended and so
12 large?

13 A Well, presumably as the tumor enlarged, it
14 compressed the structures in the baby's pelvis which is,
15 as you can imagine in a six-month old baby, extremely
16 narrow, and pushed the -- presumably pushed the bladder
17 neck forward against the pubic bone and pinched off the
18 exit to the bladder so that the urine couldn't come out.

19 Q And that would be the urethra?

20 A That's correct.

21 Q Now, during the course of that surgical
22 procedure, you drained the bladder, did you not?

23 A Yes.

1 Q How did you do that?

2 A I did that by placing a trocar, a large, hollow
3 drainage tube, into the bladder from above.

4 Q In other words, after you had made the abdominal
5 incision, you then inserted this trocar through the
6 incision that you made into the abdomen and directly into
7 the bladder.

8 A That's correct.

9 Q Were you able to obtain urine from the bladder in
10 that fashion?

11 A Yes, I was.

12 Q Did that have a decompressing effect, if you
13 will, upon the bladder?

14 A Yes, it did.

15 Q All right. What did you next do as respects the
16 bladder?

17 A Well, it was so huge that I still wasn't a
18 hundred percent sure it was the bladder, so I wanted to
19 make sure that what I was draining was in fact the one and
20 only bladder. There are some rare instances of
21 duplication of the bladder, for example. So we passed a
22 catheter into the bladder from below, outside of the
23 operative field, up into the bladder, and it confirmed

1 that everything communicated and that this was in fact the
2 bladder.

3 Q And that was after you had first decompressed the
4 bladder by some 800 cc.'s with a trocar.

5 A Exactly.

6 Q Dr. Hodin, based upon those findings that you
7 have just described at surgery, would you or anyone to
8 your opinion and based upon your findings have been able
9 to necessarily drain the bladder from below with a
10 catheter before the bladder was decompressed with your
11 trocar?

12 MR. QUINN: Objection to the question, Your
13 Honor.

14 THE COURT: Is this the reason stated?

15 MR. QUINN: No. It's for a different reason.

16 THE COURT: Come on up.

17 (Counsel approached the bench and the following
18 proceedings were held:)

19 MR. QUINN: He asked whether this witness or
20 anyone could drain the bladder. I think that goes way
21 beyond, first of all, what this witness is really able to
22 testify to. And it goes beyond your ruling, I believe.

23 THE COURT: I sustain the objection. You may

1 rephrase your question.

2 (The bench conference was concluded.)

3 BY MR. GODARD:

4 Q Dr. Hodin, let me rephrase the question. Based
5 upon your findings at surgery and your findings concerning
6 the compression and the degree to which the bladder was
7 distended at the time you opened up the abdomen, are you
8 able to tell us within reasonable medical certainty as to
9 whether or not a catheter could have been passed up
10 through the urethra and into the bladder so as to
11 successfully drain the bladder prior to the surgery or
12 without the benefit of that previous drainage by the
13 trocar?

14 A My opinion is it would have been very difficult,
15 but I can't tell you with certainty whether it could have
16 been accomplished.

17 Q What effect did the placing of the trocar have
18 upon the ability to pass the catheter?

19 A Well, whatever was obstructing the bladder I
20 think was made doubly more obstructing by the presence of
21 a large distended bladder, so that by decompressing it,
22 one factor in it being pinched off was relieved.

23 Q Coming back to your evaluations of the child's

1 situation before surgery, if in fact it had not been
2 possible to pass a catheter into the bladder, would
3 surgery have been necessary?

4 A Well, surgery would have been necessary in any
5 case.

6 Q All right. Let me rephrase that. Would you have
7 gone forward with your plan for immediate surgery if in
8 fact the bladder had been identified and if in fact it had
9 not been possible to pass a catheter into the bladder to
10 drain it?

11 A Well, that's very hypothetical because --

12 MR. QUINN: Objection, Your Honor.

13 THE COURT: What's the basis for your objection?

14 MR. QUINN: Opinion.

15 THE COURT: What?

16 MR. QUINN: Opinion.

17 THE COURT: Overruled.

18 A It's very difficult to say because you're
19 presenting a hypothetical circumstance in which we know
20 it's bladder and yet we can't catheterize it; and I'm not
21 sure that would ever be the case, because if you can't
22 catheterize, you can never be a hundred percent sure it's
23 the bladder, I mean no matter what you did to investigate

1 it.

2 Q I understand. Let me rephrase the question in
3 this fashion then. Based upon your findings at surgery,
4 did the bladder need to be drained?

5 A Oh, yes.

6 Q And if without surgery you were not able to drain
7 the bladder, would surgery have been necessary?

8 A You mean immediately.

9 Q Yes.

10 A It's quite likely that we would have proceeded to
11 surgery immediately anyway. There are other options. We
12 could have, for example, done another emergency study such
13 as a CT scan. We could have called a urological
14 consultation to see if perhaps we understood why we were
15 unable to catheterize the bladder. But I think even in
16 both of those circumstances, we would have ultimately
17 proceeded to the operating room unless we could drain the
18 bladder.

19 Q All right. And you're not able to tell us with
20 reasonable medical certainty as to whether or not it ever
21 would have been possible to drain the bladder with the
22 catheter without going to surgery.

23 A That's correct.

1 Q You indicated in response to Mr. Quinn's question
2 that even if the bladder had been identified and even if
3 it had been drained before surgery, that whether or not
4 you then would have proceeded to surgery would have
5 depended upon what your findings then proved to be; is
6 that correct?

7 A That's correct.

8 Q In other words, whether or not the abdomen still
9 felt tender or whether you still felt it to be a surgical
10 abdomen, even though the bladder had been drained; is that
11 correct?

12 A That's correct, and whether I still felt a mass.

13 Q And if I understood your answer to Mr. Quinn's
14 question then properly, you're not able to tell us, based
15 upon that hypothetical, whether or not surgery would have
16 been indicated even had the bladder been drained?

17 A Surgery would have been indicated.

18 Q Excuse me. Immediate surgery.

19 A I'm not able to tell you that with certainty.

20 Q All right. What was the condition of Nicole at
21 the time that you completed the surgery? How did you
22 evaluate her condition at that time?

23 A I thought she was quite stable. She --

1 MR. QUINN: Objection, Your Honor.

2 THE COURT: What's the grounds?

3 MR. QUINN: Beyond the scope of the direct
4 examination.

5 THE COURT: Sustained.

6 MR. GODARD: Very well. I will stop there.
7 Thank you, Doctor.

8 THE COURT: Is there any redirect?

9 REDIRECT EXAMINATION

10 BY MR. QUINN:

11 Q Doctor, you said -- I want to get you back to the
12 hypothetical where the bladder had been identified but not
13 drained before surgery. Okay? You said you couldn't say
14 with certainty that you would have drained the bladder.
15 Is that your testimony? You would have been able to drain
16 the bladder. You would have been able to get a catheter
17 in and drain the bladder.

18 A That is correct.

19 Q But you probably could have done it; is that
20 correct?

21 A I really can't answer that. All I can say is
22 that it's -- it's possible I could have drained the
23 bladder, but it is also quite likely that it would have

1 been a difficult procedure.

2 Q You would have tried, wouldn't you?

3 A Yes, I would have.

4 Q Would you have tried with a different type of
5 catheter?

6 A I'm not sure what type of catheter was used. I
7 don't remember.

8 Q 8 French.

9 A That would probably be my first choice.

10 Q Well, there would be a second choice, though,
11 wouldn't there?

12 A There would be other choices.

13 Q There are other catheters that would be more
14 prone to penetrate the bladder; is that correct?

15 A I hope you don't really mean penetrate the
16 bladder.

17 Q Enter the bladder.

18 A Enter the bladder. Yes. Quite possibly.

19 Q And if you couldn't do all this, you would have
20 called the urologist to come in and do it, wouldn't you?

21 A Possibly.

22 Q Now, if the bladder had been drained before
23 surgery, do you see any reason why Nicole would have still

1 continued to experience tenderness?

2 A I think it likely that her tenderness would have
3 been relieved.

4 MR. QUINN: Thank you.

5 THE COURT: May this witness be excused?

6 MR. QUINN: Yes, Your Honor.

7 MR. GODARD: Yes, sir.

8 THE COURT: You're excused. Thank you for
9 coming. Watch your step.

10 (Witness excused.)

11 Do you have any further testimony?

12 MR. SALE: Your Honor, at this time we'd like to
13 call Dr. Arthur Maron to the stand.

14 Whereupon,

15 ARTHUR MARON, M.D.,

16 was called as a witness on behalf of the plaintiffs, and
17 after having been first duly sworn, was examined and
18 testified as follows:

19 THE COURT: If you would like to move to see the
20 witness, don't hesitate to move.

21 MR. QUINN: We would like to move this. Perhaps
22 the witness would want to come up a bit closer so the jury
23 can see precisely what he's pointing to.

1 THE COURT: When you start your examination with
2 that easel, he may step down.

3 MR. SALE: We may approach the jury and move it
4 closer.

5 THE COURT: Yes.

6 DIRECT EXAMINATION

7 BY MR. SALE:

8 Q Dr. Maron, would you please state your full name
9 for the record, please?

10 A Arthur Maron.

11 Q What is your profession?

12 A I am a pediatrician.

13 Q How long have you been a pediatrician?

14 A 30 years.

15 Q What is your professional training, sir?

16 A I attended Albany Medical College in Albany, New
17 York, between 1954 and 1958. Then following service in
18 the Public Health Service, I took pediatric residency
19 training at Babies Hospital in Newark, New Jersey.

20 Q After that residency training, what has your
21 experience been, Dr. Maron?

22 A I've been a pediatric practitioner for that time
23 and have further involvement with the American Academy of

1 **Pediatrics in various positions.**

2 **Q What is that involvement with the Academy of**
3 **Pediatrics?**

4 **A Well, I was active both locally and a national**
5 **office in the Academy. I represented the Middle Atlantic**
6 **States of the U.S. on the executive board of the Academy.**
7 **And I was nominated to be president of the Academy on two**
8 **separate occasions.**

9 **Q Doctor, do you have any award you received or a**
10 **special standing you received in pediatrics as a result of**
11 **your experience?**

12 **A Well, I am a certified pediatrician. I am a**
13 **member of the American Academy by having board**
14 **certification in that respect. I have had presidential**
15 **citations from the president of the Academy, but that was**
16 **merely on the basis of my service to the Academy.**

17 **Q Have you received any fellowships or diplomate**
18 **status in any profession?**

19 **A I am a diplomate of the American Board of**
20 **Pediatrics, having taken the specialty boards in that**
21 **specialty.**

22 **Q At this current time, do you have anything to do**
23 **in your practice in New Jersey with the medical education**

1 of residents in a hospital?

2 A Yes. Aside from my private practice, I do have a
3 position at St. Barnabas Medical Center in Livingston, New
4 Jersey, where I am director of medical education. In that
5 role I am responsible for the education and training of
6 125 residents in various specialties, 9 different
7 specialties of medicine.

8 Q Do those specialties include pediatrics?

9 A Yes, they do.

10 Q Do they include intensive care?

11 A In medicine, yes. Not pediatric intensive care
12 per se at that hospital.

13 Q Doctor, do you have any national role in the
14 certification of pediatricians and residents?

15 A Yes. I've been named to the Residency Review
16 Committee, a committee of nine individuals in the country
17 that establish policy and review quality of pediatric
18 education in the various pediatric training programs.

19 Q Doctor, do you recall when you were first asked
20 to review the case of Nicole Panousos?

21 A It was about two years ago. I don't know the --
22 I don't remember the exact time.

23 Q At that point in time did you know if you were

1 reviewing it for a plaintiff or a defendant or a claimant
2 or for a doctor?

3 A No, I did not.

4 Q Was your initial opinion without knowledge of
5 whether you were reviewing it for a plaintiff or a
6 defendant?

7 A Yes.

8 Q Doctor, in your preparation to give an opinion,
9 how did you prepare yourself?

10 A I read the hospital record and analyzed what I
11 felt were the pertinent parts of it.

12 Q Is your opinion based on the records?

13 A Yes.

14 Q Have you developed further opinions since your
15 initial review?

16 A I've had additional information on the basis of
17 the depositions and testimonies of other individuals
18 involved in the case, so I have more information now than
19 I had when I first reviewed the hospital record, medical
20 record only.

21 Q Has that information changed your opinion based
22 on the record?

23 A It has modified my opinion slightly, but it has

1 not changed it dramatically.

2 Q Doctor, you've been practicing pediatrics for how
3 long?

4 A 30 years.

5 Q Have you ever appeared before as an expert
6 witness?

7 A No.

8 Q Well, I don't mean just in court. I mean in
9 court or depositions.

10 A Oh, pardon me. Depositions?

11 Q Yes.

12 A Two other times besides this.

13 Q You've never appeared at trial before.

14 A No.

15 Q In 30 years.

16 A That's correct.

17 MR. SALE: Your Honor, at this time I would move
18 Dr. Maron as an expert in pediatrics for causation.

19 THE COURT: Is there any voir dire?

20 MR. McANDREWS: Just a bit, Your Honor.

21 VOIR DIRE EXAMINATION

22 BY MR. McANDREWS:

23 Q Doctor, you've indicated that you are the

1 director of medical education at St. Barnabas Hospital?

2 A That's correct.

3 Q Is that primarily an administrative role?

4 A No. Would you explain what you mean by that?

5 Q Am I correct that as a director of medical
6 education, your primary responsibility is to see to it
7 that the residents in those various areas are trained by
8 other physicians who work more closely with them in those
9 different areas?

10 A Yes. In every field except pediatrics, I am
11 coordinating and responsible for their performance in
12 those fields. In pediatrics, however, I take part in the
13 teaching directly.

14 Q And when you say pediatrics, do you mean primary
15 care of pediatrics?

16 A General pediatrics, that's correct.

17 Q You have never worked in a pediatric intensive
18 care unit yourself, have you?

19 A No, sir.

20 Q When you have patients of yours in a pediatric
21 intensive care unit, are you usually monitoring them in
22 conjunction with the pediatric intensivist?

23 A I would if that were the case. It so happens at

1 my hospital we don't have a pediatric intensive care unit,
2 so that would not be responsive. But if that were the
3 case, I would work in cooperation with the intensivist.

4 MR. McANDREWS: That's all the questions I have.

5 THE COURT: Do you want to be heard on his
6 qualifications as to whether we accept him as an expert?

7 MR. McANDREWS: On causation as that relates to
8 pediatrics solely, we have no objection.

9 THE COURT: I receive the testimony and the jury
10 may receive the testimony of this witness as an expert.

11 Would you like for the witness to step down now?

12 MR. SALE: In one minute. Thank you, Your Honor.

13 DIRECT EXAMINATION (Resumed)

14 BY MR. SALE:

15 Q Dr. Maron, how extensive was your review of the
16 record in this case?

17 A The record was quite extensive, and my review I
18 hope was fairly intensive.

19 Q Was it as intense as you would review a record
20 from one of your own patients?

21 A Yes.

22 Q Dr. Maron, have you developed opinions regarding
23 causation as to the cardiac arrest of Nicole Panousos?

1 A Yes.

2 Q Doctor, have you developed opinions as to the
3 cause of the death of Nicole Panousos?

4 A In summary, yes. I mean I have an opinion as to
5 a specific cause, but I have an opinion as to a summation
6 of causes.

7 Q Are all of your opinions stated to a reasonable
8 degree of medical certainty?

9 A Yes.

10 Q Doctor, I think you have informed me you would
11 like to graphically demonstrate your opinions on
12 causation; is that correct?

13 MR. McANDREWS: Your Honor, at this point I would
14 propose an objection.

15 (Counsel approached the bench and the following
16 proceedings were held:)

17 MR. McANDREWS: Your Honor, he is proffered as an
18 expert in the field of primary care pediatrics. He's
19 indicated that he has never worked in an intensive care
20 unit, a pediatric intensive care unit, that the residents
21 that he oversees only train in an adult or a nonpediatric
22 intensive care unit.

23 The opinions that he has given previously in this

1 action at the review panel and in his deposition were
2 directed primarily at the pediatric intensive care unit
3 staff at Fairfax Hospital and at the residents of Fairfax
4 Hospital. He had no criticism of Dr. Allen on the
5 standard of care questions and as far as causation, he
6 found that postsurgical management to be a primary
7 contributing factor to the cardiac arrest.

8 The opinions I believe he's going to give relate
9 solely to pediatric intensive care, to issues that are
10 clearly beyond the expertise and experience of a primary
11 care pediatrician. We feel he hasn't been qualified
12 properly to give those sorts of opinions. I would object
13 to any of those coming in.

14 MR. SALE: Your Honor, he is a 30-year
15 pediatrician at the very top of his profession and
16 directing 125 residents. He's responsible for diagnosis,
17 care and causes of problems and medical disabilities in
18 children including death. I can't imagine a witness more
19 qualified than this to speak to causation in the death of
20 a child.

21 THE COURT: I overrule the objection. You may
22 make that argument to the jury in closing, but I think
23 it's a question of the weight that they choose to give to

1 his opinion, not to whether or not he may testify. I
2 conclude he may testify.

3 MR. McANDREWS: Okay.

4 (The bench conference was concluded.)

5 BY MR. SALE:

6 Q Where were we when we approached the bench? Dr.
7 Maron, have you indicated you would prefer to graphically
8 depict causation in the case of the cardiac arrest and
9 death of Nicole Panousos?

10 A Causation can best be understood if one takes a
11 sequence of events, so that I thought it might be helpful
12 if I approached it from that standpoint.

13 MR. SALE: Okay. You may step down, Dr. Maron.

14 (The witness left the stand and went in front of
15 the jury box.)

16 BY MR. SALE:

17 Q You may now proceed to do that depiction which
18 you thought may be helpful to the jury.

19 A Well, in reviewing the situation and the child's
20 status, I think we could safely start at the top with a
21 child who had been ill for about five days with flu
22 symptoms, with some diarrhea, some vomiting, some fever,
23 irritability, and just a child who is somewhat ill. The

1 pediatrician had been called. There had been several
2 phone calls, and there was a number of days of illness but
3 not a very acute or very dramatic illness until the next
4 step, at which time the mother noted rather rapidly a very
5 large, distended abdomen, much more acute illness. And
6 she was so concerned that she arrived at the emergency
7 room at some early hour of the -- sometime after midnight
8 of that morning. So there we come from a case of a child
9 who is somewhat ill to a child who suddenly becomes
10 acutely ill and then goes to an emergency room where there
11 is obviously some critical attention paid to the child.

12 Following that acute abdominal appearance, tests
13 are done. And following that, we come to what could have
14 happened and what did happen.

15 And what happened was a test was done, which is
16 an ultrasound of the bladder, which showed mistakenly that
17 the mass was not bladder but was another very acutely
18 growing mass which could be anything from hemorrhage,
19 abscess, some obstruction, some very dramatic and serious
20 process. That diagnosis was related to the attending
21 doctors and the attending pediatric surgeon, and therefore
22 the road then led to an emergency surgical procedure, a
23 procedure which took four hours and approximately 45

1 minutes with very intensive work and and good deal of work
2 on the part of the pediatric surgeon.

3 Following that, we had a number of events that
4 occurred following the emergency surgery. There were
5 dramatic shifts in the child's fluid balance secondary to
6 surgery and secondary to the drainage from the bladder.
7 There were electrolyte disturbances which means that the
8 ability of the child to compensate for deficiencies and
9 surpluses of various salts and electrolytes in the
10 bloodstream were affected. There was a problem with
11 hydration or fluid maintenance on the part of the child,
12 because it was very difficult to tell whether the
13 urination was secondary to having had an obstruction
14 previously or whether not getting enough fluids.
15 Therefore, fluids were given that might have been
16 excessive in error because of the fact that we're not
17 aware of the true hydration state of the child.

18 These number of things cumulatively resulted, I
19 believe, in congestive heart failure, a weakening of the
20 heart muscle and eventually cardiac arrest which occurred
21 in the early morning of the 6th.

22 The cardiac arrest was of such a nature and
23 electrolytes were of such a disturbance that the cardiac

1 arrest was irreversible in spite of the heroic measures
2 taken to restore the child's cardiac status. And
3 therefore, at that point when we went down the road, we
4 had gone down the road so far that it really was
5 impossible to go back.

6 The other alternative would have been up here at
7 the emergency procedure, in that if we had learned that
8 the large mass was really an accumulation of urine, and
9 that's all it was, it was bladder, it would take a small
10 catheter inserted into the bladder to drain the bladder,
11 literally at our convenience. The child would have been
12 appreciably better within several hours.

13 The next step down here would have been to feed
14 the baby, breast-feed the baby, have her return to better
15 health, better protein nutrition. At this point she had
16 not been fed in over two days except for water or
17 electrolytes. Do further tests over here that would find
18 out exactly what was the reason for the large bladder.
19 And really, we know now it was a mass pressing on the
20 urethra behind the bladder. Do specific tests to find out
21 what the mass would be and what the mass was. Take
22 certain steps to remove it or to treat it. It was, after
23 all, evidently benign and relatively harmless except for

1 its location. Remove it and the child would be cured.

2 So this is the road that would have been a good
3 road to take. But it was not taken. And the reason for
4 the fork in the road was the mistaken diagnosis of what
5 was or was not bladder. And therefore, it's my opinion
6 that we took the wrong road here because of the erroneous
7 diagnosis made in the ultrasound examination.

8 Q Okay, Dr. Maron. Before you leave your chart,
9 I'd like you to go through some of those things that have
10 been identified and tell me how each of them, one, would
11 have contributed to the arrest, and two, would have made
12 more difficult resuscitation.

13 A Certainly the lack of proper hydration would
14 always be a problem. Electrolyte disturbances with a
15 potassium level as low as 2.8 or 2.9 could have caused
16 significant cardiac cellular damage to make it much more
17 difficult to resuscitate the child when resuscitation was
18 necessary. The congestive heart failure certainly was a
19 succeeding factor beyond that and made it very difficult
20 to get the child's vascular tree pumping with good force.
21 And so all of those I think in accumulation not just
22 precipitated the cardiac arrest but made it irreversible.

23 Q Would the fluid and electrolyte shifts have

1 occurred anyway if the bladder had been decompressed and
2 the child not sent immediately to surgery?

3 A You mean on this road?

4 Q No. I'm talking -- I'm merely moving some of the
5 emergency item into isolation. If the bladder had been
6 decompressed prior to surgery, would the fluid and
7 electrolyte shifts have occurred in that event?

8 A And no surgery?

9 Q Without surgery, correct.

10 A Without surgery?

11 Q Yes.

12 A Not as much because four to five hours of surgery
13 would be a stressful event for any child. So some shift
14 would have occurred because of the compression being
15 released. However, having had the release occur in a very
16 quiet and easy fashion would be less traumatic than the
17 abrupt decompression that occurred in this emergency
18 situation.

19 Q Doctor, how specifically do you relate each of
20 those items to the misdiagnosis in radiology?

21 A Well, as I said before, I believe that elective
22 planned surgery would have avoided, for the most part, in
23 my opinion, virtually all of this.

1 Q So those symptoms of fluid shifts and electrolyte
2 shifts would have happened before surgery?

3 A They would have happened subsequent to
4 decompression but would have happened much less
5 dramatically and much less acutely and could have been
6 dealt with with the child being fed routinely, as most of
7 them are fed, and being cared for without the trauma of a
8 five-hour surgery.

9 Q Doctor, you indicated that one of the causes of
10 Nicole's death that resulted from the radiology
11 misdiagnosis was the potassium imbalance; is that correct?

12 A That's correct.

13 Q You indicated that this would have a disruptive
14 effect on the heart. Could you explain how that would
15 work?

16 A Well, potassium is one of the electrolytes that's
17 required for a normal cellular metabolism, and with very
18 high or low potassium, the metabolism can be affected.
19 And if it's extremely low, 2.8, 2.9 is significantly
20 depressed, even for a short time it can cause cellular
21 damage and can be correctable, but sometimes the damage is
22 a problem. It depends upon how many cells have been
23 damaged as to how major the effect is. But cellular

1 damage can occur and can affect the cardiac musculature.

2 Q Doctor, have you experienced cardiac arrest from
3 low potassium in your practice?

4 A Yes, on one occasion.

5 Q Have you experienced the difficulty to
6 resuscitate a patient who had low potassium?

7 A Well, the patient I have in mind did expire.

8 Q Now, you said those factors together caused
9 Nicole's cardiac arrest; is that correct?

10 A Right. Her general -- her debility; her protein
11 lack from her previous illness were -- made her
12 susceptible to further problems. The emergency surgery
13 and the major surgery that she underwent, the electrolyte
14 and the fluid shifts that occurred postoperatively I
15 believe were the factors involved in the cardiac arrest.

16 Q Now, you stated that the top box, which I don't
17 believe you filled in, did that relate to Nicole's flu
18 symptoms?

19 A Yes. I said that was when she was ill but not to
20 any emergency status. She was having -- apparently was
21 diagnosed as viremia with irritability, low-grade fever,
22 diarrhea, sort of vomiting. So those things occur, of
23 course, in any children.

1 Q Doctor, in this case as you've seen it in the
2 records, was emergency surgery required?

3 A No.

4 MR. McANDREWS: I object to the form of the
5 question, Your Honor.

6 THE COURT: Would you rephrase the question,
7 please?

8 BY MR. SALE:

9 Q Yes. As you have reviewed the records here, do
10 you have an opinion stated to a reasonable degree of
11 medical certainty that if the bladder had been
12 decompressed prior to surgery, emergency surgery would
13 have been required?

14 A I believe if the bladder had been decompressed,
15 then emergency surgery would not have been required and
16 could have been done on an elective basis.

17 Q Doctor, in your practice of pediatrics, do you
18 schedule elective surgery?

19 A I participate with surgeons in deciding when to
20 operate, yes.

21 Q Do you schedule emergency surgery?

22 A I certainly do.

23 Q Would you have put Nicole Panousos into elective

1 surgery based on these symptoms?

2 MR. McANDREWS: Your Honor, let me just object.
3 Once again --

4 THE COURT: Sustained. You may rephrase your
5 question.

6 MR. SALE: Thank you, Your Honor.

7 BY MR. SALE:

8 Q Do you have an opinion based upon a reasonable
9 degree of medical certainty whether Nicole Panousos should
10 have been placed into elective surgery with these
11 symptoms?

12 MR. McANDREWS: Once again, Your Honor, I am
13 going to object to the form of the question. I think that
14 is beyond the scope of what he's been proffered for.

15 THE COURT: Overruled.

16 A Would you repeat the question?

17 BY MR. SALE:

18 Q Yes. Do you have an opinion stated to a
19 reasonable degree of medical certainty whether Nicole
20 Panousos was an appropriate candidate for elective surgery
21 with these symptoms?

22 A For elective surgery?

23 Q Yes.

1 A Yes. Under good hydration and good physical
2 condition, she would be a candidate for elective surgery.

3 Q Was she a good candidate for elective surgery
4 under the left path or the right path of your drawing
5 there?

6 A Given the circumstances that were known to the
7 doctors at this time, she was a candidate for emergency
8 surgery there. On this path she was a candidate for
9 elective surgery.

10 Q So if the bladder had been diagnosed prior to
11 surgery, she would have been a candidate for elective
12 surgery?

13 A That's correct.

14 Q Okay. I'm going to go back to the previous
15 diagram, Dr. Maron. This diagram was prepared by another
16 one of the experts in the case. Can you tell from your
17 review of Nicole's medical records what represents mass
18 two in that picture?

19 A What is mass two?

20 Q Yes.

21 A The bladder.

22 Q From your review of the records, could you tell
23 how that mass was drained?

1 A From the records? Yes. It was drained with a
2 trocar, which is an insertion of a fairly large bore
3 instrument into the bladder, into the mass which turned
4 out to be bladder here. Then it was drained subsequently
5 with a catheter placed into the bladder here.

6 Q Was mass number one in that figure still in place
7 at the time the catheter was inserted?

8 A Yes, sir.

9 Q Do you have an opinion whether the insertion of
10 the catheter would have been any more difficult after the
11 trocar was used to drain the first part of the urine?

12 MR. McANDREWS: Once again, Your Honor, I object.
13 That's well beyond the scope.

14 THE COURT: Would you like to respond to that
15 objection?

16 MR. SALE: Yes, I would, Your Honor. I think he
17 is a pediatrician who is engaged in regular pediatrics.
18 He's an expert in anatomy and treating childhood
19 disorders. I would be happy to lay an expert foundation
20 for this, but I was trying to save the Court some time.

21 MR. McANDREWS: Your Honor, once again, he's not
22 a surgeon. He hasn't been proffered as an expert. He has
23 no experience as a surgeon. I don't see how he can make

1 that sort of conclusion based upon the previous testimony
2 I've heard this morning without surgical expertise.

3 THE COURT: I overrule your objection. Go ahead.

4 BY MR. SALE:

5 Q Do you have an opinion, Dr. Maron, whether the
6 child would have been more difficult or less difficult to
7 catheterize after a trocar was used to drain some urine
8 from the bladder?

9 A I think the anatomy -- the anatomy in this area
10 here was not appreciably changed by the trocar being
11 placed here. The bladder was certainly diminished in
12 size. But the urethra here and the pressure of the
13 teratoma on the urethra was unchanged by the drainage from
14 the bladder. So I believe it would have been just as easy
15 if one had entered the external urethra meatus at any time
16 that the catheter could have been inserted into the
17 bladder both prior to surgery, during surgery and after
18 surgery.

19 Q Would the urethra have been distended by the size
20 of the bladder?

21 A No, the urethra would not have been distended by
22 the size of the bladder. There was pressure. The mass
23 was pressing on the stomach, on the kidneys, liver,

1 everything else up in here. The urethra is a fixed
2 structure and is in the pelvis of the child and I don't
3 believe would have been affected by the other pressures up
4 above.

5 Q Doctor, do you treat children for pelvic and
6 abdominal disorders?

7 A I certainly do.

8 Q Do those disorders that you treat children for
9 include fluid-filled masses?

10 A I have treated children with fluid-filled masses
11 which turned out to be ovarian cysts. So my experience is
12 not very large because most pediatricians don't see that
13 many cases of this nature. But I have seen some cases of
14 ovarian cysts and other things like appendix or
15 appendicitis, abscesses that occur around the appendix.
16 Those are the most common things that I have seen.

17 Q Have you treated patients for fluid-filled masses
18 in the pelvis?

19 A Not that I recall.

20 Q Doctor, have you treated children with bladder
21 problems?

22 A I certainly have.

23 Q Doctor, does the urethra go upwards or downwards

1 to the bladder in normal anatomy?

2 A By upwards you mean towards --

3 Q From the vagina?

4 A Right. It goes up the bladder from the vaginal
5 area.

6 Q Doctor, if I told you that a catheter is placed
7 in here through the urethra, and it appeared on ultrasound
8 to be between the two masses or in the middle of the
9 septated mass, could you tell me whether at that point the
10 urethra would be going up to the vagina or down to the
11 vagina?

12 A Well, it goes both up and down. I can't -- I
13 can't respond to your question.

14 Q Okay. Stated otherwise, if a catheter was
15 inserted here, where would it go into in the first
16 instance? What would it enter, what part of the body?

17 A The urethra. If the catheter were inserted at
18 the external urethra meatus, it would have no alternative
19 but to go into the urethra and subsequently into the
20 bladder.

21 Q Okay. Now, if you visualized the catheter here,
22 if this were the bladder, would the urethra be at the top
23 or bottom of the bladder?

1 A The top.

2 Q In your 30 years of experience, have you ever
3 seen a urethra at the top of the bladder?

4 MR. McANDREWS: Objection, Your Honor. I don't
5 think there's been any foundation laid for his experience
6 with catheterization of bladders, et cetera.

7 THE COURT: Overruled.

8 A I really can't respond to that because I don't
9 have that much experience in that particular field.

10 BY MR. SALE:

11 Q But would that be unusual in the anatomy for the
12 urethra to be coming out of the top of the bladder?

13 A It would certainly be unusual.

14 MR. SALE: No further questions, Doctor. Thank
15 you.

16 THE COURT: Would you like to cross-examine here
17 or at the witness stand?

18 MR. McANDREWS: At the witness stand, Your Honor.

19 (The witness resumed the stand.)

20 CROSS-EXAMINATION

21 BY MR. McANDREWS:

22 Q Good afternoon, Dr. Maron.

23 A Good afternoon.

1 Q I just want to go over a few background questions
2 first. How many times in your 30 years of professional
3 experience have you actually catheterized a bladder in an
4 infant?

5 A I'd say about 12.

6 Q How many times in an infant under, say, six
7 months of age?

8 A I would say about the majority, nine times,
9 because I don't do it very often, frankly, in older
10 children or teenagers.

11 Q Would you agree with the -- did you review the
12 pathology report in this chart?

13 A Yes, I did.

14 Q Did you note that that pathology report indicated
15 that this mass, as it was subsequently found, was a
16 presacral teratoma?

17 A Yes.

18 Q Do you have any reason to disagree with that?

19 A No, I don't.

20 Q Would you agree with the proposition that
21 presacral teratomas are rare in young infants?

22 A Yes.

23 Q Are you aware of the Journal of Pediatric

1 Surgery?

2 A I'm aware of it, but I don't read it.

3 Q Do you feel it's an authoritative journal in your
4 field of pediatrics?

5 A I'm told that it is. I don't have any personal
6 information.

7 Q Are you aware of a survey done by the American
8 Academy of Pediatrics back in 1973 on sacrococcygeal
9 teratomas?

10 MR. SALE: I object, Your Honor. He said he has
11 no knowledge of the publication.

12 THE COURT: I overrule the objection. Let's see
13 what his answer is to this question.

14 You may answer the question.

15 A No, I don't know the article or the review.

16 BY MR. McANDREWS:

17 Q You're not an intensivist as that term is
18 understood in the field of pediatrics, are you?

19 A No, I'm not.

20 Q I believe you indicated before that when patients
21 of yours are hospitalized in a pediatric intensive care
22 unit, you would manage them along with the assistance of
23 an intensivist as a consultant?

1 A Invariably.

2 Q You yourself don't routinely manage fluid levels
3 in patients of yours who are hospitalized in an intensive
4 care unit, a pediatric intensive care unit; right?

5 A No, I do not.

6 Q Have you ever seen a patient in your 30 years of
7 practice that had a presacral teratoma like Nicole
8 Panousos had?

9 A No.

10 Q Have you ever seen a patient in your 30 years
11 that had, a four-and-a-half-month-old patient -- let's
12 limit it to that or thereabouts -- that had a bladder that
13 was filled with practically a liter of fluid?

14 A No.

15 Q That would cause a fair degree of rearrangement,
16 if you will, of the internal organs of a four-and-a-half-
17 month-old child, wouldn't it?

18 A Yes, it would.

19 Q Would there be further distortion because of the
20 presence of a separate mass that we now know was a
21 teratoma?

22 A I believe the distortion would come from the
23 bladder. The bladder's filling was a result we now know

1 of the pressure of the teratoma. The teratoma itself I
2 don't believe would have caused a great deal of pressure.
3 It was not that large.

4 Q I am talking now about the appearance or the
5 general layout of the organs within the abdomen. This is
6 presurgically. Wouldn't one expect based upon a bladder
7 filled with a liter of fluid and the presence of a
8 teratoma, that there would be some disorientation as far
9 as placement of organs inside?

10 A In my opinion the distortion, and I agree there
11 would be distortion, would be caused by the distended
12 bladder. The teratoma wasn't in the abdomen. It was in
13 the pelvis.

14 Q You've indicated you have performed
15 catheterizations in approximately nine instances over your
16 30 years of young children, Doctor, bladder
17 catheterizations. Did any of those children have some
18 sort of a teratoma or other mass obstructing the bladder
19 outlet or the urethra?

20 A No.

21 Q Did you ever perform any of those
22 catheterizations under general anesthesia?

23 A No.

1 Q You indicated that you many times have made a
2 decision as to whether a child should or is a fit
3 candidate for surgery. I think your words were you have
4 scheduled surgery before. Is that a fair recollection of
5 your testimony?

6 A I have scheduled surgery in cooperation with a
7 pediatric surgeon and consulted with him in deciding which
8 cases are elective, emergency, critical, et cetera.

9 Q Now, in that process, the final decision as to
10 whether surgery is going to go forward is the pediatric
11 surgeon's; correct?

12 A It would depend on -- I could not say that with
13 certainty. There are cases where we have an animated
14 discussion. It's debatable as to who might prevail.

15 Q Is it fair to say that your input as the
16 primary-care treating pediatrician is to satisfy yourself
17 as to the medical or the pediatric side of the care, and
18 the decision as to whether to operate would necessarily
19 have your blessing as a pediatrician, but that final
20 decision as to whether surgically the child is appropriate
21 for surgery is the pediatric surgeon's?

22 A Absolutely not. It's my decision. It's my
23 patient. I consult with the surgeon. He's my consultant.

1 I respect his opinions. But I -- if I felt strongly
2 negatively about some of his opinions, I would overrule
3 them because it's my patient.

4 Q Now, you indicated there were several factors
5 contributing to the cardiac arrest that Nicole Panousos
6 experienced early in the morning of March 6, 1987. As I
7 understood your testimony, those factors included fluid
8 shifts, electrolyte imbalance, her hydration status, and
9 then her poor nutrition or her protein depletion. Is that
10 accurate?

11 A Yes.

12 Q You don't have an opinion to a reasonable degree
13 of medical certainty as to whether any one of those
14 factors caused the arrest, do you?

15 A No. It's all a cumulative situation in my
16 opinion.

17 Q Can you give the jury any approximation as to
18 which were more or less likely as contributing factors,
19 more or less significant as contributing factors?

20 A Well, with your permission, I might want to draw
21 a little pattern on the easel there which may help to
22 explain the situation.

23 Q Just in the interests of time, not to draw it

1 out, I'd rather you just give your best summary.

2 A Okay. Fine. I feel that I cannot attribute more
3 weight to one factor than the other, but I believe that
4 cumulatively when they're all added to the scale of
5 importance, I think they all together represent the
6 ultimate cause of her cardiac arrest.

7 Q Let me just analyze a few of them individually so
8 that I understand what your opinion is. When you talk
9 about the electrolytes, you're talking about in essence
10 her potassium levels, her sodium levels and her chloride
11 levels; correct?

12 A Yes.

13 Q Those are the electrolytes that in essence would
14 affect cardiac function in a patient like Nicole.

15 A Among others, yes.

16 Q Let's look first at the potassium level. I
17 believe you testified that her potassium level was low and
18 you feel that was a contributing factor to the cardiac
19 arrest; correct?

20 A Yes. At about 10 p.m. on the night prior to her
21 arrest, it was below 3. 2.8 I believe was the reported
22 figure. Then after some correction, it was hovering into
23 3.2 to 3.5 areas later that night or early the next

1 morning. All of those are low. But certainly the 2.8 is
2 dramatically low.

3 Q Okay. Now, in the lab reports that you derived
4 those figures from, do you recall what the range of normal
5 values for potassium was?

6 A On the laboratory report?

7 Q Right.

8 A I don't have it. You must have it there.

9 Q It said low normal was 3.5 and high normal was
10 5.3. Would that sound reasonable to you?

11 A Yes, it would.

12 Q Does that comport with your understanding of the
13 normal range?

14 A Some labs say 3.6 to 4.6.

15 Q That can vary from lab to lab?

16 A Perfectly understandable, and that's correct.

17 Q The first value you pointed out was roughly the
18 10 o'clock one which was 2.9, which we agree was below
19 those normal values. The next value you mentioned was
20 3.5. That was at 1 a.m., according to the chart. Now,
21 that is essentially low normal; correct? Obviously, her
22 potassium had improved by then. At 1 o'clock in the
23 morning are you aware of any cardiac problems Nicole

1 experienced or were reported in the chart?

2 A No.

3 Q Going back earlier to the 10 o'clock potassium
4 level, the 2.9, it clearly was below normal. Do you have
5 any recollection of any reports of cardiac irregularities
6 or cardiac problems at the time of that obviously low
7 potassium level?

8 A No.

9 Q In fact, her heart rate was regular, was about
10 what it was through most of the night. It was in the
11 180s, was it not?

12 A That's correct. You're trying to establish,
13 though, an instantaneous, spontaneous response to a
14 laboratory report. As I pointed out before, I'm referring
15 to a cumulative effect of cellular damage having been
16 caused the night before. So it might not have shown up
17 until the next morning.

18 Q And that damage probably was reduced, if not
19 eliminated, by the time, just a few three hours later when
20 that potassium level at least went back up to the low
21 range of normal.

22 A The clinical course of the child showed the
23 damage was irreversible, as a matter of fact.

1 Q Are you simply saying because she arrested? Is
2 that the basis for that opinion?

3 A No, because she arrested and the arrest was very
4 intractable and difficult to reverse.

5 Q How does one manage or how would one correct a
6 low potassium level or low electrolyte level?

7 A Depending on the electrolyte, I would like -- if
8 it were potassium, I would administer potassium in the
9 intravenous fluids or feed orally, if that was possible,
10 things like orange juice, other oral feedings.

11 Q That is something that is done by the pediatric
12 intensive care unit staff?

13 A When the child is in the intensive care unit,
14 yes.

15 Q That's right. Would the same thing go on if the
16 chloride levels were elevated?

17 A Yes. All the corrections would be the
18 responsibility of the people in charge of the child's
19 care.

20 Q Going back briefly to those 10 o'clock blood test
21 results that we are referring to where the potassium was
22 2.9, that same blood test showed that her chloride level
23 was 115 which you would consider to be elevated; correct?

1 A Yes.

2 Q It also showed that Nicole's sodium level was
3 138. Now, that's a relatively normal, is it not?

4 A Yes.

5 Q And we're not aware of any cardiac irregularities
6 that Nicole began to experience until much later. And in
7 that interim time, her potassium had improved, her
8 chloride had changed just slightly and was in fact coming
9 back down again shortly before the arrest. Correct?

10 A Yes. I believe the potassium then went down
11 again subsequently.

12 Q After the arrest, the potassium was 3.2 at 5
13 o'clock and remained that essentially until noon the next
14 day, well after the arrest.

15 A (Witness moves head up and down.)

16 Q Have you seen children arrest -- well, let me ask
17 you first. You mentioned you had one patient that had
18 arrested because of potassium, low potassium levels? Do
19 you recall the levels in that child?

20 A Not specifically. I believe it was 3.2.

21 Q Was that over a long period of time that she had
22 a decreased potassium level?

23 A No. That was acute. It was a postoperative

1 tonsillectomy case.

2 Q And that's the only one in 30 some odd years of
3 practice you've ever experienced?

4 A That's correct.

5 Q You weren't present, obviously, during Nicole's
6 surgery; correct?

7 A Correct.

8 Q You don't have any information other than the
9 chart or the testimony of those who were present as to,
10 for example, the degree of compression that teratoma
11 inflicted upon the bladder outlet, the urethra.

12 A No.

13 Q Would you defer to what the pediatric surgeon who
14 actually operated on her, what his opinions were and his
15 observations were as far as the degree of compression in
16 the placement of the organs when he did his surgery on
17 Nicole?

18 A I couldn't comment on his opinions.

19 Q Am I correct that although you feel overhydration
20 was a contributing factor to Nicole's arrest, that it is a
21 factor that could have been managed postoperatively?

22 A Yes.

23 Q You have previously testified about other health

1 care providers who cared for Nicole during this period.
2 These are health care providers in the Fairfax Hospital
3 pediatric intensive care unit; correct?

4 A Yes.

5 Q And you had opined as to those health care
6 providers that their management of her hydration status
7 was inappropriate postoperatively; correct?

8 MR. SALE: Your Honor, I object for the record.
9 It calls upon opinions that are irrelevant. It's outside
10 the scope of direct, and it involves parties not in this
11 case.

12 THE COURT: Overruled.

13 BY MR. McANDREWS:

14 Q One of the specific criticisms you had of them
15 was the way they managed her electrolyte status; correct?

16 A My basic concern was the -- what I considered to
17 be lack of hands-on attendance during the critical five to
18 six hours prior to the arrest, which included phone calls
19 to modify the I.V. fluids and other orders that I felt
20 could have been better given after direct examination.

21 Q Those people should have been there observing the
22 child and factoring in the results that they were getting
23 in order to more what, appropriately or more quickly, how?

1 A No, I think to more appropriately order. I would
2 have felt more comfortable if the people in charge had
3 been physically present.

4 Q You also indicated that the resident erred in
5 giving Nicole a bolus of saline early in the morning
6 shortly before the arrest. Do you recall when that bolus
7 of saline was administered?

8 A There seems to be some discrepancy in the medical
9 record. But I would say in the vicinity of 7:30 to 8 in
10 the morning.

11 Q Could you explain to the jury, number one, what
12 we mean when we talk of a bolus of saline and your
13 understanding of why it was given to Nicole?

14 A A bolus of saline is a rapid injection of a
15 specific amount of fluid. In this case it was saline,
16 which is salt water. It was not clear from the record
17 exactly why it was given because no one ever stated why it
18 was given, but there was some allusion to the fact that it
19 was to correct her hydration status.

20 Q Do you feel that it did?

21 A No.

22 Q Did it have any effect on her hydration status?

23 A It may have had some, but she had a cardiac

1 arrest shortly after that.

2 Q Did it have any effect on her electrolyte status?

3 A I'm sure it did, although it was not measurable
4 on the tests we have. But a bolus of saline would
5 normally have some effect on the sodium and chloride in
6 the blood.

7 Q If those were elevated in the early morning
8 hours, would it have worsened that elevation?

9 A It would have increased the elevation, yes.

10 Q You had indicated, I believe, that a lot of these
11 problems could have been eliminated if the bladder had
12 simply been identified; correct? You're not offering any
13 opinions on the performance of the sonogram or Dr. Allen's
14 interpretation of what he saw; correct?

15 A I'm not second-guessing any of the written
16 reports. I've only said that the procedure was
17 apparently --

18 Q I'm sorry. The results were reported incorrectly
19 and that resulted in that progression you outlined on the
20 board over there.

21 A That's correct.

22 Q That's a fairly big if, isn't it?

23 A What is a big if?

1 Q If the bladder was identified correctly.

2 A I think it's a very big if.

3 THE COURT: How much longer are you going to be?

4 MR. McANDREWS: I would say about five or ten
5 minutes, Your Honor.

6 THE COURT: Please don't discuss the case or draw
7 conclusions. We're going to take a break. And we'll
8 start again at 2:10. Thank you.

9 (At 1:10 p.m. the trial was recessed to reconvene
10 at 2:10 p.m.)
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1 AFTERNOON SESSION (2:12 p.m.)

2 (The proceedings resumed in the presence of the
3 jury.)

4 Whereupon,

5 ARTHUR MARON, M.D.,

6 resumed the witness stand, and having been previously
7 sworn, was further examined and testified as follows:

8 CROSS-EXAMINATION (resumed)

9 BY MR. MCANDREWS:

10 Q Dr. Maron, just to summarize the area that we
11 were talking about when we broke before, am I correct that
12 it's your opinion that while the fact that Nicole
13 underwent surgery or was undergoing surgery at the time
14 that her bladder was drained, that while that complicated
15 or made more difficult management of her fluid status,
16 management of her electrolyte balance, did it by no means
17 make it impossible?

18 A I'm sorry. I didn't get your question.

19 Q Okay. Am I correct that your testimony has been
20 that the fact that Nicole underwent surgery and that she
21 was in essence a postop. patient as she experienced
22 post-obstructive diuresis, the fluid shifts that you had
23 talked about and the electrolyte imbalance, the fact that

1 she was a postop. patient made management of her
2 electrolyte balance more difficult. Correct?

3 A Yes, sir.

4 Q It made management of her hydration status more
5 difficult; correct?

6 A Definitely.

7 Q Now, taking that one step further, is it your
8 opinion that it made it impossible, or conversely, could
9 those still have been managed in the pediatric intensive
10 care unit?

11 A They could have been managed in the intensive
12 care unit, but it made it significantly more difficult to
13 manage them because it was a much more delicate and
14 sensitive process in a child of Nicole's status.

15 Q So it's not only a matter of degree; is that a
16 fair characterization?

17 A I would not include the word only because I think
18 that the degree was intense, but it was a matter of
19 degree.

20 Q Let me just go back to this question of the mass
21 that we now know is a teratoma, the fluid-filled bladder
22 with roughly one liter of fluid. You testified that some
23 degree of organ displacement would have resulted from the

1 fact that the bladder was so markedly enlarged; correct?

2 A Yes.

3 Q And you feel that's the primary source of any
4 organ displacement or rearrangement, if you want to call
5 it that, within Nicole's abdomen. You said less likely
6 was that the teratoma had any significant impact on her
7 organs.

8 A The teratoma would have an impact on the
9 immediate area surrounding the teratoma by a few
10 centimeters, but the profound changes in her abdomen were
11 the result of the grotesquely enlarged bladder.

12 Q Would it be a reasonable assumption anatomically
13 to assume that that bladder being so large may have in
14 essence resulted in some sort of kinking of the urethra?

15 A I don't think so.

16 Q Can you say to a reasonable degree of medical
17 certainty that it could not have happened in any scenario?

18 A I don't understand that the anatomy could cause
19 that. So in my opinion, I don't understand how that could
20 happen. The ureter, which goes from the kidney to the
21 bladder, certainly could have been kinked or blocked or
22 obstructed. But the urethra, which is not usually a
23 free-standing or a tubular structure but it's embedded

1 within the tissue, I just personally don't understand how
2 that could have been blocked by the bladder itself.

3 Q Couldn't the bladder's movement of other organs
4 or perhaps movement of other organs impacting on that
5 teratoma which Dr. Karsh said was pressing right up
6 against the urethra, might not that have resulted in some
7 sort of possibly kinking of the urethra?

8 A Well, I think certainly the teratoma, my
9 understanding of the pictures, was compressing the
10 urethra, so that I would think the urethra could be
11 compressed by any number of factors. A kink to me is a
12 kink in a tube, and it's usually a free-standing tube,
13 such as a tube which can be bent. And I believe that all
14 I could imagine in the urethra in a female would be
15 compression from external sources, not a kinking in my
16 understanding of it.

17 Q So you feel that perhaps a teratoma could have
18 pressed that urethra up against the pubic bone and in
19 essence obstructed it?

20 A Yes. Pardon me. That's my opinion.

21 Q Of what actually happened?

22 A Exactly, yes.

23 Q And is it not reasonable to assume that if that

1 teratoma was pressing that urethra up against the pubic
2 bone sufficient to, in essence, prohibit any urine from
3 draining from the bladder, is it not a reasonable
4 assumption that it would have made catheterization
5 impossible without surgery?

6 A That would be an assumption to make. That would
7 be an incorrect assumption because during surgery,
8 catheterization was successfully performed by I believe
9 the pediatric surgeon, proving that catheterization was
10 possible if the tip of the catheter were inserted into the
11 external urethral meatus.

12 Q So we're talking about the same subject, the
13 catheterization you're talking about that was done by the
14 pediatric surgeon was done after he had opened her
15 abdomen, after he had drained almost 800 cc.'s of fluid
16 from her bladder; correct?

17 A Correct.

18 Q That is a considerably different scenario than a
19 preoperative patient whose abdomen has not been opened,
20 whose bladder still has a thousand cc.s or more of fluid
21 in it and has a teratoma pushing up against the urethra
22 and you feel compressing it against the pubic bone.
23 Correct?

1 A The teratoma that was compressing the urethra was
2 not changed by evacuating the bladder of its urine. The
3 same anatomy that existed before surgery -- the
4 relationships anatomically between the teratoma and the
5 urethra were not changed by putting a trocar in the
6 bladder. And if the surgeon was able to catheterize
7 through the urethra, the teratoma is still there at
8 surgery. It would seem to me it would have been possible
9 to do the same thing prior to surgery.

10 Q So opening the abdomen and draining more than
11 half of that fluid would have had no impact on the amount
12 of pressure that teratoma was asserting on the urethra?

13 A Not in my opinion.

14 Q Okay. Doctor, is it correct that you were
15 initially contacted to review this case by the Medical
16 Quality Foundation?

17 A Yes.

18 Q Have they sent you other cases --

19 A Yes.

20 Q -- in the past?

21 That's all the questions I have, sir.

22 THE COURT: All right. Is there any redirect?
23

REDIRECT EXAMINATION

BY MR. SALE:

Q Doctor, it's been asked of you whether you have catheterized urinary bladders in infants in the past.

Could you restate your answer?

A Yes, I have.

Q For what purpose did you catheterize bladders in infants?

A Usually to obtain urine for a culture in a small child -- small infant when we needed a sterile specimen for specific culturing.

Q How would you determine if the catheterization was successful?

A Well, once having put the tip of the catheter -- actually, I use the feeding tube, not a catheter, although it performs the same function. I think it's a little less traumatic. I use a small 5 or number 8 feeding tip. I insert the tip into the external urethral opening. And there's usually a little resistance as you advance the tip of the feeding tube through the urethra. Then after that, when it hits the bladder or reaches the bladder, generally there's a little less resistance, and that's when the urine is seen. And usually we get, depending on the size

1 of the infant, anywhere from 10 to 15, 20 cc.'s of urine
2 for culture, and that's the purpose of my catheterization.
3 So when the urine appears, of course I am convinced that
4 I'm in the bladder.

5 Q How would you confirm it if there was no urine?

6 A If I felt I was in the bladder? Well, I would
7 probably -- if I wanted to confirm that for sure, I would
8 inject some sterile water or sterile saline in and be sure
9 I had a good flow back and forth.

10 Q Have you done this in your practice?

11 A I did that only on one occasion when I wasn't
12 sure. That's when the bladder was not -- there was not
13 any urine in the bladder.

14 MR. SALE: No further questions, Doctor.

15 THE COURT: May the witness be excused? You are
16 excused. Thank you for coming.

17 (Witness excused.)

18 MR. SALE: Your Honor, at this point I would like
19 to have marked for identification and moved into evidence
20 as Plaintiffs' -- I would like to have marked for
21 identification and moved into evidence as Plaintiffs' 33
22 the chart drawn by Dr. Hodin.

23 THE COURT: Is there any objection?

1 MR. McANDREWS: Dr. Maron?

2 MR. SALE: Dr. Maron, I'm sorry.

3 THE COURT: I receive it.

4 (Dr. Maron's chart previously marked for
5 identification as Plaintiffs' Exhibit No. 33 was
6 received in evidence.)

7 MR. SALE: Thank you.

8 MR. QUINN: Your Honor, plaintiffs rest their
9 case.

10 THE COURT: Okay.

11 MR. GODARD: May we approach?

12 THE COURT: Yes, sir.

13 (Counsel approached the bench and the following
14 proceedings were held:)

15 MR. GODARD: Your Honor, at this time I do have a
16 motion to strike. I have considerable that I want to
17 argue and place on the record in that regard, and I would
18 ask perhaps if you could excuse the jury.

19 (The bench conference was concluded.)

20 THE COURT: Would you all excuse us, please. We
21 will be with you very shortly.

22 (The jury left the courtroom, after which a short
23 recess was taken:)

1 MR. GODARD: If Your Honor please, with the
2 plaintiffs' evidence now completed, they having rested, I
3 would respectively move to strike the plaintiffs' evidence
4 and to enter summary judgment on Dr. Allen's behalf and
5 FRC or Fairfax Radiologic Consultants' behalf on the
6 grounds of their failing to make a prima facie case as
7 respects causation.

8 As I am sure is now clear to the Court, the
9 entire plaintiffs' case in theory is focused upon the
10 alleged negligence of Dr. Allen in not identifying and in
11 essence in not draining the bladder; and coupled to that,
12 the theory advanced by Dr. Karsh and to some degree by Dr.
13 Maron that this complicated the medical management picture
14 that confronted the other health care providers charged
15 with that duty thereafter and contributed to the
16 difficulties and led to the cardiac arrest.

17 I submit that that is insufficient proof of
18 causation on several grounds. First of all, the Court has
19 now heard the testimony of the surgeon in the case, Dr.
20 Hodin, whose testimony is crucial and entirely critical to
21 this point in that Dr. Hodin has confirmed, first of all,
22 that even if the bladder had been identified and even if
23 it had been drained, that he could not say with reasonable

1 medical certainty that he would not still have taken
2 Nicole Panousos to surgery.

3 The obvious important and critical point to be
4 derived from that is if this patient were going to be
5 taken to surgery either way, then there certainly is no
6 causation as to Dr. Allen. There's no allegation
7 obviously in this case that Dr. Allen had any direct
8 responsibilities, obligations or even opportunity to have
9 anything to do with a postsurgical fluid or electrolyte
10 management; and indeed, the only allegation is that by
11 indirectly causing her to be taken to surgery, that that
12 resulted in a situation that made it more difficult for
13 the others who were managing her.

14 While I submit to the Court that it is the
15 plaintiffs' burden of proof to show with reasonable
16 medical certainty or probability that that is what would
17 have happened or that but for Dr. Allen's negligence that
18 she would not have gone to surgery and that course of
19 events, that other path, as Dr. Maron described it, would
20 indeed have been avoided.

21 In that respect I also submit that since it is
22 Dr. Hodin who had to make that decision in this case, that
23 it becomes totally irrelevant and immaterial whether Dr.

1 Maron's opinion is that she should have gone to surgery or
2 not or whether it be Dr. Karsh's opinion. That Dr. Hodin
3 was the surgeon; and if Dr. Hodin could not to a
4 reasonable medical certainty say that she would have gone
5 to surgery or she would not have gone to surgery had the
6 bladder been drained, I submit is fatal to the plaintiffs'
7 case.

8 The other aspect is, I submit, that by Dr.
9 Hodin's testimony, it cannot even be said that the bladder
10 could have been drained. And Dr. Hodin, I submit to the
11 Court, very obviously, is the only person qualified to say
12 that because Dr. Hodin is the only person that looked
13 inside of Nicole Panousos's abdomen and witnessed and
14 observed exactly what pressures were being exerted upon
15 the urethra and what pressures and what anatomical
16 malformations and malarrangements were in fact causing
17 this obstruction.

18 And if Dr. Hodin in his surgical judgment from
19 those observations cannot say to a reasonable medical
20 certainty that the bladder could even have been drained,
21 then that constitutes yet another failure and lack of
22 causative effect in this whole chain of events.

23 In short, certainly if the bladder were not able

1 to be drained other than going to surgery, then Dr. Allen
2 cannot be faulted for anything that occurred in not
3 draining the bladder as plaintiffs' theory alleges.

4 Now, finally, even if the Court should disregard
5 those two highly dispositive factors, if the Court please,
6 I would further submit that even assuming that the
7 evidence were sufficient to support the jury's
8 consideration of Nicole not having gone to surgery were it
9 not for the negligence of Dr. Allen and her thereby having
10 avoided these extra difficulties of fluid management, I
11 submit that under the law of direct causation and the but
12 for standards to be applied and under the standards of
13 foreseeability, that still is not sufficient.

14 To put it another way, to ascribe to Dr. Allen
15 the obligation, the duty, the standard to be able to
16 foresee that which occurred in this case, or to hold him
17 accountable from a foreseeable standpoint, a standpoint of
18 foreseeability, is simply not reasonable.

19 All of the testimony in this case from
20 plaintiffs' own experts has been that the actual cardiac
21 arrest was caused by fluid and electrolyte mismanagement,
22 and that that mismanagement was occasioned as more
23 difficult because of the alleged negligence, but that it

1 was not impossible. And indeed, as we've heard, both Dr.
2 Karsh and Dr. Maron both opined that Nicole could have
3 been managed properly and could have survived and this
4 arrest need not have occurred even given the more
5 difficult job as they have described it because of the
6 preceding alleged negligence.

7 I submit to the Court that this circumstance is
8 really no different than that which would exist if a
9 mechanic of a bus were alleged to be negligent in
10 diagnosing and repairing the brakes on a bus so as to
11 delay the bus's departure for a number of hours. And then
12 because of that delay, the bus driver found himself
13 driving in a rainstorm that he would not otherwise have
14 encountered, so as to make his job more difficult. But
15 yet he, in driving in that rainstorm, is negligent and
16 allows the bus to crash.

17 And I submit that under the laws of
18 foreseeability and proximate cause, the negligence
19 preceding that event by that mechanic simply could not be
20 causally related to the ultimate accident and event.

21 That's what we have here. Even notwithstanding
22 all the other factors that we pointed out, which I submit
23 make the plaintiffs' case deficient, even if the Court

1 doesn't focus on that, it simply stretches the whole
2 foreseeability issue and the proximate cause issue too far
3 to hold Dr. Allen responsible for the ultimate arrest
4 which could and by the plaintiffs' evidence and theories
5 should have been prevented by proper care of those
6 assigned to managing her postoperative electrolytes and
7 fluids.

8 For all of those reasons, I submit the
9 plaintiffs' case is deficient, does not constitute a prima
10 facie case, presents nothing to be considered by this
11 jury, and should be stricken and summary judgment entered.

12 THE COURT: All right.

13 MR. QUINN: Your Honor, I would first like to
14 point out that both of the causation witnesses that
15 they're going to bring on tomorrow, both of them testified
16 that the hospital did absolutely nothing wrong in the care
17 of this baby. I know that's not part of the case now, but
18 I thought the Court should know that.

19 First of all, Mr. Godard proposed a but for test
20 for foreseeability. I think both Dr. Maron and Dr. Karsh
21 testified that Nicole Panousos would not have died but for
22 Dr. Allen's negligence. That's number one.

23 Number two is the proper test in Virginia is that

1 some harm is foreseeable. It doesn't mean that the
2 radiologist has to foresee the exact harm that came about.
3 There is a case from the Supreme Court of a couple years
4 ago. It's England is one of the names of the case. I
5 believe I even have it here with me. But certainly it was
6 foreseeable by the radiologist, and there was testimony
7 directly on this point. It's foreseeable that some harm
8 would come about as a result of his misdiagnosis. And
9 that's all that's required by law. We do not have to
10 prove that the exact chain of events would have occurred;
11 only some harm.

12 Secondly, as to the drainage of the bladder, our
13 expert witnesses testified that it could have been drained
14 and should have been drained. Dr. Hodin I don't believe
15 said it could not be drained. He said he couldn't testify
16 to a certainty that it could be drained. That's all he
17 said. But that's his opinion.

18 We have an expert witness who testified directly
19 on this point just a few minutes ago who said that it
20 could have been drained and it should have been drained.

21 Further, Dr. Maron testified that Nicole Panousos
22 was not an adequate candidate for elective surgery, which
23 of course would have been the case if the bladder had been

1 drained.

2 Finally, all Dr. Hodin said about putting her
3 into surgery in his testimony was that he would have
4 looked at tenderness as a criteria. If he had drained the
5 bladder and she was still tender, then he might have put
6 her into surgery. However, he said, on cross-examination,
7 that she probably wouldn't be tender after the bladder was
8 drained.

9 So I think the elements of the case are there.
10 And I submit that a motion to strike at this point is not
11 appropriate.

12 MR. GODARD: May I just respond briefly to that.
13 May I additionally point out to the Court, and I think it
14 likewise is very important, that we're not talking about a
15 case where under the plaintiffs' theory Nicole Panousos
16 went to surgery and because of her instability and the
17 additional stresses placed upon her during that surgery,
18 she failed to survive the surgery.

19 The undisputed evidence is that she did survive
20 the surgery. Not only did she survive it, she came out of
21 the surgery being very stable, by plaintiffs' own witness,
22 Dr. Hodin, and remaining very stable over those succeeding
23 14 and a half hours or at least, at the very least, 12

1 hours by Dr. Karsh's own testimony.

2 In short, that's too remote in time, and the
3 connection with Dr. Allen, if any, ended at the time the
4 surgery, which they allege he caused, at the time that
5 surgery ended, and Nicole was stable, in good condition,
6 and being well managed.

7 For the next 12 hours she is under the care of
8 totally different health care providers, providing their
9 expert care and addressing those issues which by
10 plaintiffs' own evidence were the sole factors and the
11 sole matters which led to her cardiac arrest 14 and a half
12 hours after that surgery. That's superseding negligence,
13 if it's nothing else. And it's certainly not a causative
14 link to the negligence that occurred 18 hours earlier as
15 alleged by Dr. Allen.

16 THE COURT: I deny your motion to strike.

17 MR. MCANDREWS: Your Honor, our first witness
18 will be Dr. Allen.

19 THE COURT: Okay. Let's ask the jury to come in.

20 (The jury returned to the courtroom, after which
21 the following proceedings were held:)
22
23

1 Whereupon,

2 ROBERT M. ALLEN, M.D.,
3 defendant, was called as a witness by and in his own
4 behalf, and after having been first duly sworn, was
5 examined and testified as follows:

6 BY MR. McANDREWS:

7 Q Would you please state your name?

8 A Robert M. Allen.

9 Q What is your business address, sir?

10 A Fairfax Hospital Radiology Department.

11 Q Fairfax Hospital is in Annandale, Virginia?

12 A Annandale.

13 Q Would you please give the jury a brief summary of
14 your medical training?

15 A Yes. After graduation from Pennsylvania State
16 University in 1950, I attended Jefferson Medical College
17 from 1950 to 1954 and graduated with an M.D. degree. The
18 following year I interned at the Lankenau Hospital, which
19 is a teaching hospital in Philadelphia. Then I took a
20 surgical residency for a little over a year where I was
21 chief resident of a hospital in St. Luke's Children's
22 Medical Center in Philadelphia.

23 While awaiting to go into the service under the

1 doctors draft law, I spent two years in Philadelphia Naval
2 Hospital in the Fourth Naval District in charge of a
3 mobile X-ray unit to serve civilian and naval personnel
4 for tuberculosis. That occupied about a third of my time.
5 The other two-thirds of my time I was an officer in the
6 medical clinic.

7 I then took a radiology residency from 1958 to
8 1961 at the Philadelphia Naval Hospital, and this
9 residency was affiliated with the University of
10 Pennsylvania and Jefferson Medical College for additional
11 training as well as the Children's Hospital of
12 Philadelphia.

13 I was board certified -- I was then on the staff
14 of the Naval Hospital there in Philadelphia until 1962 and
15 was board certified, American Board of Radiology. The
16 following three years I was in San Diego Naval Hospital in
17 charge of children's independent radiology.

18 In 1964 I left the Navy and came to Fairfax
19 Hospital here in Falls Church, Virginia, where I've been
20 ever since.

21 Q Okay. Let me just go back. You mentioned that
22 you were board certified.

23 A Yes, sir.

1 Q Could you explain to the jury what board
2 certification is?

3 A Board certification, the American Board of
4 Radiology is the board-certifying organization for
5 radiologists. They prescribe the course in radiology
6 training for the residency, the exact amount of time and
7 areas covered throughout the residency, and they design
8 the examination. At the end of that time they control who
9 is eligible and decide who will take the examination.
10 They give the examination. And if they deem you have
11 passed it, they certify you as a radiologist.

12 Q Is that a written examination?

13 A It's a combined examination, written and oral.

14 Q And you passed that back in 1962?

15 A Yes.

16 Q Have you been continuously certified ever since?

17 A Radiology has not had a continuing certification
18 system. Very few specialties do. I think the internal
19 medicine society does. But they do have ongoing education
20 requirements of different categories of credits. Whether
21 it's teaching others, taking courses or writing papers,
22 you have to get so many credits a year, and they keep
23 track of this. And they use this as their ongoing

1 education program. And the American Board of Radiology is
2 a -- they cosponsor these ongoing educational programs
3 with the American College of Radiology, Radiology Society
4 of North America, which is meeting this week in Chicago,
5 and the American Radiation Society.

6 Q The American College of Radiology is a separate
7 group?

8 A Yes.

9 Q Are you a member or affiliated with that group in
10 any way?

11 A Yes. I've been a member of the American College
12 of Radiology since 1962, and I am a fellow in that
13 organization.

14 Q What is a fellow? What does that imply?

15 A There are qualifications for fellowship that
16 entail either service to the organization through duties
17 of the college or special teaching, merit or they have
18 several different categories. And they have a fellowship
19 committee that meets every year. And the local chapters
20 of the American College of Radiology all over the country
21 submit one or two names each for consideration, and the
22 College committee reviews these applications and selects
23 certain people every year for a fellowship.

1 Q And when were you selected as a fellow?

2 A It was 1982.

3 Q Have you published any textbooks or articles in
4 your career, sir?

5 A Yes. I published a small chapter on
6 interventional ultrasound and a textbook on advances in
7 diagnostic imaging. This was about 1980 when the
8 conference was held. And the book was the compilation of
9 the courses that were -- papers that were submitted over a
10 two-week period. Interventional ultrasound then was new.
11 It was an idea of inserting needles or catheters or for
12 abscess drainage or very -- previously considered surgical
13 procedures but doing them under ultrasound and local
14 anesthesia.

15 Q Are you the member of any local medical society,
16 state or local medical society?

17 A Yes. I am a member of the American Medical
18 Association, Virginia State Medical Association, the
19 Fairfax County Medical Association, and the --

20 Q Do you hold any positions within any of those
21 groups?

22 A Yes. I am the president elect. I will be
23 installed next week as president of the Fairfax County

1 Medical Society. And I'm a delegate and have been for 10
2 or 12 years to the State Medical Society.

3 Q What is the American Registry of Diagnostic
4 Medical Sonographers?

5 A That is the organization that is established to
6 give examinations and certify ultrasound technicians,
7 which are now called diagnostic sonographers. Linda
8 Edwards is one of these people. And the examination and
9 certification she referred to is given by that
10 organization. They are the only nationally recognized
11 organization to perform this function.

12 Q Linda Edwards, you meant Linda Stover?

13 A Yes. Well, her name was Edwards before her
14 marriage.

15 Q Let me direct your attention now to giving the
16 jury a little bit of information about your private
17 practice since 1962. How long have you been performing
18 ultrasound examinations yourself?

19 THE COURT: Before we get into that, let's all
20 stand and have a stretch break. Okay?

21 (A stretch break was taken.)

22 BY MR. McANDREWS:

23 Q Okay, Doctor. How long have you been performing

1 ultrasound examinations?

2 A Since the late 1960s, we did our first ultrasound
3 examination. The machine was a new modality at that time.

4 Q Have you been doing it ever since that time?

5 A Yes, sir.

6 Q Back in 1987, what percent of your professional
7 practice was devoted to sonography?

8 A It varied greatly from week to week. On a yearly
9 basis I would suppose it was at least 30 percent. But
10 some weeks it would be a hundred percent. Last week I did
11 nothing but ultrasound the entire week.

12 Q Have those percentages, even though they varied,
13 remained roughly constant for the last five years or so?

14 A Yes.

15 Q Can you give the jury some idea of what
16 diagnostic ultrasound is, what its purpose is?

17 A Yes. Ultrasound is the use of sound waves to
18 make pictures. It's a sophisticated form of picture
19 making that -- you might consider the police radar is
20 maybe the most basic type which just causes a blip on the
21 screen and they can read it out as a speed.

22 But this is a system where the transducer, which
23 we hold, emits sound waves of a frequency which respond

1 best to the frequency of tissues in the body. And it's
2 adjusted for that particular frequency range. These sound
3 waves are sent out, and they bounce back, like the police
4 radar bounces back, only they bounce back at different
5 rates depending on the resistance of the tissues that they
6 strike. The ultrasound machine takes these echoes back
7 and puts it through a basic type computer and makes a
8 picture out of what would otherwise be just frequency
9 echoes. And that's basically how it works.

10 Q You mentioned that it makes a picture. What does
11 that picture show up on?

12 A There's a television screen, CRT tube, television
13 screen on the ultrasound machine.

14 Q How are hard films or hard pictures made off of
15 that process?

16 A Well, either electronically or through mirrors,
17 depending on the machine, the image is split and sent in
18 to a camera. And we use a film type exposure, not paper,
19 but see-through film.

20 Q Okay. Now, when you're talking about this I will
21 imagine that you see on a TV screen, we know that it has
22 length and width. As far as the depth, what depth are you
23 seeing of the objects that you're scanning with that

1 transducer?

2 A Well, it's a 2-D image. It's not 3-D. The
3 transducer is like a fan of sound waves going out in one
4 plane. To get other planes, you must move the transducer
5 into different areas. There's just one plane. So it has
6 a straightforward depth, and it has both sides of the
7 transducer, two dimensions. But it has no width.

8 Q So when you're looking at a structure within a
9 patient's abdomen, for example, is it essentially like
10 you're getting cross-sectional pictures?

11 A Exactly. It used to be called tomography,
12 ultrasound tomography, for that reason.

13 Q And in order to scan an abdomen, do you simply
14 vary the depths so that you look at different levels in
15 sequence?

16 A Yes. Through the -- electronically you're able
17 to adjust the focus of the sound waves so that you can
18 best see them at different depths.

19 Q So an object or a structure that's not within
20 that cross-sectional plane wouldn't even show up when
21 you're scanning it.

22 A No, sir. It's not there.

23 Q Tell the jury a little bit about your experience

1 in catheterizing the urinary bladder in the course of an
2 ultrasound examination. How often does that occur in your
3 practice?

4 A It doesn't happen very often anymore, but it used
5 to happen more often, because of the way medical practice
6 has changed. But I was trained in pediatric radiography
7 at Philadelphia Children's Hospital. Most of the places I
8 went in the Navy; and when I came to Fairfax, I had more
9 training in that area than other people, so I ended up by
10 doing the pediatric radiology. And every time a cystogram
11 or anything related to the pelvis or bladder had to be
12 done, I usually had to do the catheterization on the
13 infants.

14 More recently, in more recent years the nurses in
15 the intensive care units have gotten very good at doing
16 this. But when they have trouble, I still help them out.
17 In our X-ray Department now we have nurses that are
18 assigned to the X-ray Department, and they're getting
19 pretty good at doing this, so I do less of it. But again,
20 when they have trouble, they call me. So I'm doing a
21 little less of it these days, but I've done a great deal
22 of it over the past 35 years.

23 Q Back in 1987 was the frequency with which you did

1 it about the same as it is today?

2 A Yes. Yes.

3 Q When you see a patient like Nicole Panousos, what
4 is your role in evaluating the patient?

5 A Well, my role is always as a consultant trying to
6 answer the question that the referring physician has
7 asked. The referring physician asked for a study of a
8 certain area, in this case an ultrasound examination of
9 the abdomen. And he tells us he's looking for -- he has a
10 certain problem that he informed us about. So my role is
11 to do that examination and try and evaluate that problem
12 as best I can strictly as a consultant and strictly at his
13 order.

14 Q If you feel additional tests are warranted, what
15 happens?

16 A If I feel -- I would have to discuss that with
17 the referring physician.

18 Q Looking at Nicole Panousos's case for a minute,
19 who was the referring physician in her case?

20 A My understanding, it was Dr. Hodin.

21 Q Is he the one who ordered the sonogram?

22 A That was my understanding at the time.

23 Q Why don't we talk a little bit about the

1 procedure at Fairfax Hospital in 1987 for ordering
2 sonographic studies. What were the mechanics of that
3 process?

4 A We have a computer system. And the usual process
5 is that the physician orders the study by writing on the
6 chart or telling the nurse directly or over the phone
7 initially and then subsequently writing on the chart that
8 he wants a sonogram of a certain area for a certain
9 reason. And that order is then typed into the computer,
10 and the request for that is transmitted and prints out in
11 the ultrasound department. And frequently that's all we
12 need. But that's not always the case by any means.

13 Q When a patient actually arrives in the sonogram
14 suite, what parts, if any, of the chart accompany the
15 patient?

16 A Usually the whole chart. But on occasions we
17 don't get any chart. It's whatever -- whatever happens.

18 Q That will vary from patient to patient?

19 A Oh, yes. If it -- if it's the emergency room,
20 you might not get any chart at all. From the floor they
21 might be using the chart. We usually get the chart, but
22 we don't always get it.

23 Q Dr. Hodin ordered an abdominal sonogram of Nicole

1 Panousos?

2 A Yes.

3 Q Okay. Tell the jury essentially what is done
4 once a patient like Nicole arrives in the suite, the
5 mechanics of how that study is completed generally back in
6 1987 once again.

7 A Well, we do it the same way today. We are
8 usually not satisfied with the completeness of the request
9 as far as the indication for the study, and we're not
10 always certain that the requested study has been properly
11 put in the computer by the secretary. And for those two
12 reasons, we had the technician first look at the chart and
13 find the order and confirm that indeed that is the order
14 of the physician. And it sometimes happens that it isn't.
15 So we confirm that.

16 Next she goes through the chart and confirms why
17 the study was ordered. It may be clear on the order sheet
18 or it may not be clear. It may not be there at all, or it
19 may not be adequate, in which case she looks at the
20 physician's progress notes, sometimes the nurse's notes,
21 whatever notes are necessary to get more information. If
22 that still is not satisfactory, she'll call the floor and
23 talk to the nurse. If that still is not satisfactory,

1 then I have to get ahold of the physician himself and ask
2 him on the phone what we're doing.

3 Q Is that information recorded on the clinical
4 history record?

5 A Yes.

6 Q With the Court's permission, I want to show a
7 document that Mrs. Stover identified yesterday when she
8 testified that is a part of the chart and I believe has
9 been admitted as an exhibit, although I don't have the
10 exhibit number exactly. I will ask you questions about
11 it. (Handing to witness.) On that clinical history form,
12 does it indicate why this sonogram had been ordered?

13 A It does and in an indirect way. But there is a
14 list of medical problems here. And the last one on the
15 list says probable left abdominal mass. And that would
16 probably be the indication. For more completeness, it
17 lists other symptoms and medical problems here --

18 Q Okay.

19 A -- which I think were read previously.

20 Q That's right. The sonographer, in this case Mrs.
21 Stover or Miss Edwards as she was known back then, they
22 take some initial films?

23 A Yes. After it's confirmed what we're to do, the

1 patient is then taken into the ultrasound examination
2 room, and the ultrasound technician performs a routine
3 examination or whatever appropriate examination we have
4 deemed would be for that area and this problem. She
5 obtains the images and then presents them to the
6 radiologist to evaluate. And that's where my role usually
7 begins.

8 Q Okay. Do you recall the sonogram that was done
9 on Nicole Panousos on March 5, 1987?

10 A Yes, I do.

11 Q When did you first become involved in this whole
12 process?

13 A After she presented the images to me and told me
14 that she was ready for me.

15 Q There's been testimony previously that Nicole
16 arrived sometime around 10:30 a.m. Does that comport with
17 your recollection?

18 A I knew it was in the morning. As I remember,
19 these films all have a -- all the machines -- all
20 ultrasound machines have a clock on them, so we can always
21 look at the film and know exactly when it was taken. And
22 I know it's about that time.

23 Q Why don't you tell the jury briefly what you did

1 once you became involved in the care, and then we can go
2 over in detail some of what you did. Just give them an
3 overview of what happened.

4 A Well, after viewing the images, which revealed
5 some large cystic masses, I went into the ultrasound room
6 to try to make some more sense out of this process. And
7 naturally, the baby was intermittently fussy and moving
8 around, as ill babies do. The abdomen was apparently
9 tender, which increased this whole business because we
10 have to touch the anterior abdominal wall. Their body
11 must have contact with that ultrasound transducer. It
12 cannot be held away from the body wall. We have to be in
13 contact with it. And we use a contact fluid to conduct
14 the sound.

15 But anyway, the baby was fussy, as we frequently
16 have with sick babies. And I was trying -- I tried to
17 confirm the images that I had already seen and see if I
18 could make more sense out of what these masses represented
19 and what they didn't represent.

20 The initial problem, of course, was there were
21 some large cystic masses which were contiguous. And this
22 could be a large solitary cyst with septa or it could be
23 adjacent cystic masses that were contiguous to each other

1 because of pressure and flattening against each other.

2 MR. McANDREWS: Dr. Allen, let me interrupt you
3 at this point.

4 With the Court's permission I would like to set
5 up a view box, and perhaps it would speed things up to let
6 Dr. Allen show the jury what he was looking at.

7 THE COURT: All right.

8 MR. McANDREWS: May Dr. Allen come down and
9 approach the jury?

10 THE COURT: Yes.

11 (The witness left the stand and went in front of
12 the jury box to the view box.)

13 BY MR. McANDREWS:

14 Q Why don't you first show the jury the CAT films
15 that were taken by the sonographer prior to your becoming
16 involved?

17 A These are copies of the films from -- by the way,
18 these are labeled Exhibit 9A?

19 Q This is Defense Exhibit 9A.

20 A All right. The film size is here, and it's just
21 copied onto this larger film. We get six images on this
22 camera. And these are these thin slices through different
23 parts of the abdomen. And Linda Edwards' name is up here,

1 who is now Linda Stover, who took the films and the date.
2 The time here, by the way, is 10:38, 10:37, 10:39, 30
3 seconds. It's a very accurate clock.

4 This is in the upper abdomen, and this is through
5 the liver, and we see right below the liver it's black,
6 echo-free mass which we know is fluid.

7 Q All black masses like that would indicate fluid?

8 A Yes. Sound travels best in water and is not
9 reflected back, so that it comes out black. The only
10 thing we -- the only thing that makes an echo on here is
11 what is reflected back. And I know you all have been
12 familiar -- I mentioned before or mentioned other times if
13 you put your head under the water and you make a noise,
14 you really hear it much louder than you do in the air
15 because the sound is so well conducted in the water
16 compared to air.

17 So this would have to be fluid. And these other
18 structures are various solid densities which are --
19 somewhat are more echogenic than others. And this is
20 about normal for a liver or a spleen. This happens to be
21 the liver. And the fat beyond the liver is very
22 echogenic.

23 So these are upper abdominal scans, mostly

1 through the liver. And this one happens to hit these two,
2 hit the right kidney, and we can see there's some black
3 areas in the right kidney. And they represent
4 fluid-filled, dilated, renal collecting systems. They
5 should not be dilated. They should be collapsed and we
6 should not see them. So this indicates some degree of
7 obstruction.

8 Q What's the next film in sequence that you have
9 there?

10 A Then this --

11 Q Before you go on, when you're talking about the
12 spleen, where anatomically would that be?

13 A The liver is on the right side and the spleen is
14 way over here. So you have to move the transducer to
15 whatever angle or direction or plane.

16 This is now labeled -- this is the right kidney,
17 to show that area better, throughout the liver and we can
18 see all the black, dilated areas which represent a fair
19 amount of distention of the collecting system and
20 obstruction.

21 Here are some more liver views and more liver
22 views. The liver is quite a large organ, and it takes a
23 fair number of sample sections to adequately say you have

1 a record of what's there and what isn't there. And these
2 are all normal. The only abnormality here is the
3 obstruction of the kidney.

4 Q And those are the top two squares on Exhibit 9B?

5 A Yes.

6 The next film, now we have the left kidney, which
7 looks just like the right kidney. It has all of these
8 dilated calices.

9 Q What are calices?

10 A The collecting system of the -- the kidney is a
11 complex filtering system and active excretion system,
12 actually, too. And the excreted, tiny, little tubules
13 then are collected into a few larger reservoirs. And
14 under normal pressures, these never distend. They just
15 flow through the kidney and down the ureters into the
16 bladder. The bladder is what does the distention. That's
17 the storage place. The rest of it doesn't distend because
18 it's not for storage and it's not desirable because that
19 would be -- that would back flow into the kidney and cause
20 pressure differences which would not -- have the kidney
21 not operate correctly.

22 So these areas -- there's different names for
23 different parts of this collecting system, and I shouldn't

1 use any of them here. But these are all parts of the
2 collecting system that are distended, and that's why
3 they're black within the kidney indicating an obstruction
4 on the right side.

5 And here is the adjacent spleen next to the
6 kidney, left kidney, which looked just like the liver.
7 And more of the left kidney. And then we have a new area
8 down here.

9 Q That's the lower right corner.

10 A And this is labeled sagittal mid pelvis.

11 Q What is a sagittal view?

12 A In English sagittal means right down the midline
13 of your body in a plane directed from front to back. And
14 actually, it doesn't have to be mid, so we do say in this
15 case mid to show that the front/back plane was in the
16 midline; and pelvis, which means we're down anatomically
17 below the umbilicus going into the pelvis. And if you
18 remember, the first picture had a cystic mass up against
19 the liver. And now at the bottom of that cystic mass we
20 have a septum and then another cystic mass, and we're into
21 the pelvis.

22 Q Let me stop you for one moment. What is the
23 septum?

1 A A septum is a division.

2 Q That's all that means?

3 A That's all that means.

4 Q That's the white?

5 A That's the white area. That's not fluid. That
6 is echogenic. And at this point we don't know whether
7 that is a septum within a large cyst or whether it's two
8 cysts adjacent to each other and the border flattens out
9 between them. So we don't know if they're one thing or
10 two things, just looking at these films.

11 Q Now, typed in there is the word bladder.

12 A Bladder.

13 Q Who would have done that?

14 A Linda. Linda was still taking these films.

15 And now we have the fourth film, and we're going
16 to stay down in the pelvis. And all this black area is
17 all cyst. Some of these are transverse, which means
18 across. And some of them are sagittal. We've discussed
19 that as straight front to back.

20 Q Let me just ask you. When you're doing a
21 sagittal view, where are you putting the transducer on
22 Nicole's abdomen?

23 A Well, it's still in the same place, but it's

1 turning the transducer because the transducer acts like a
2 fan, so I have to turn it this way to get a transverse,
3 this way to get a sagittal. You aim it any direction, so
4 that the anatomy is --

5 Q So on a sagittal view the waves are going in in
6 one --

7 A On a plane straight in.

8 So these are both sagittal and transverse, and we
9 have this large cystic mass in the upper pelvis and lower
10 abdomen with another cystic mass below it. And here
11 again, this is labeled BL for bladder, and this one isn't.
12 The back of the cystic mass is the echogenic fat in the
13 back of the abdomen. That's how large this was. It
14 filled the abdomen.

15 Now, up here we have mass and bladder. We have
16 the two cystic masses. And this is sort of a transverse,
17 oblique sort of thing. It's not clearly either one. And
18 we deal with the anatomy in all planes, instead of very
19 formal planes, because we try to make the best picture we
20 can. And she was trying to show that this -- the septum
21 or separation in this sagittal plane could be visualized
22 in a transverse plane, again, suggesting that maybe these
23 are two separate adjacent structures.

1 Q Maybe it will just help the jury understand if
2 you could briefly draw for us on the blackboard there
3 essentially what this would translate to if we were
4 looking at a diagram not unlike what Dr. Karsh drew.

5 A I think so.

6 We'll take this from the side. Now, we haven't
7 talked about scanning from over here, but diagrammatically
8 it will be easier to draw and to appreciate, I believe.
9 So if this is the back of the infant, this would be the
10 front of the abdomen. This is the distended abdomen,
11 which it was. And the spine comes down about here to the
12 sacrum, and then it cuts pretty superficially back here.
13 You know, we know we can all feel our sacrum back here
14 pretty easily, whereas the spine you can't feel. It has
15 things sticking back here which you can't feel, but the
16 spine itself is pretty further in.

17 Now, none of this is going to be seen on a
18 sonogram. We're using a transducer here in the front of
19 the abdomen and around the front, with this emphasis right
20 about here. And what we have is a large mass that went up
21 to the liver, to the top of the abdomen, down into the
22 pelvis (drawing), something like this. And then below
23 that, we had one filling the pelvis. And right here it

1 looked on some of them, especially when scanning live, not
2 the realtime, not taking pictures necessarily, it did look
3 like there might be a separation in here. And I could not
4 find a hole any place here to be certain that these were
5 connected. So they appear to be not connected. This is
6 judgmental. Nothing is a hundred percent. But when I was
7 finished, my best bet were these were two separate things.

8 Q Let me just ask you. That septation you referred
9 to before on one of those films is the black line between
10 the two masses?

11 A Yes, yes. And if we scanned it this way
12 transversely, we would get some of this and then the
13 septum and some of this. And that was one of the
14 transverse images, this top one here. Whereas, sagittally
15 through here, we would just go straight on through. And
16 we had -- this would be a sagittal image just straight
17 through this way, and we would see this on the oblique.

18 So Linda labeled this bladder and this mass.

19 Q Okay. This emphasis you referred to before,
20 that's the pubic bone?

21 A That's the pubic bone right here. Now, the liver
22 is pushed up here. The kidneys were pushed way back here.
23 And this -- this totally filled the pelvis, right back to

1 the sacrum. And indeed, when the pathologist, who was the
2 first one to know the truth of the situation, declared
3 this to be a teratoma a day or so after the surgery, it
4 had to arise from the sacrum, again confirming the contact
5 with the sacrum all the way back here.

6 The drawing you have been looking at, which was
7 explained to be not exactly realistic, demonstrated this
8 little mass as a little thing up here. Well, it arose
9 from back here and just filled the whole pelvis.

10 Q Let's go now to the point where you came into
11 this picture. Up until now you've been talking about the
12 films that Miss Stover took.

13 A Yes.

14 Q When you came in to the picture, did you talk to
15 Miss Stover first about what she found?

16 A Yes. I talked to her, and we went over what
17 these images were and what she thought they represented
18 and what the problem might be.

19 Q Did you look at the chart or anything?

20 A No. I don't recall looking -- I mean I don't --
21 this seemed to be enough information. The only thing I
22 knew that wasn't on there is I was told by one of the
23 technicians that this patient was on the way to surgery.

1 And the reason for that was this patient was not a
2 scheduled patient. And we have a schedule, which we try
3 to keep to. But it's -- it's not very good in the
4 hospital. We get so many interruptions, so many add-ons
5 and emergencys. But we have a schedule, and we try to get
6 things down to certain times. And then when something is
7 pushed in, they explain it, that we had to put this in.
8 This patient is on their way to surgery. So I don't know
9 which technician told me that, but somebody involved in
10 the process of bringing the patient to the department told
11 me that. So --

12 Q In your discussion with Miss Edwards, would you
13 have gotten essentially from her any history she gleaned
14 from the chart or that --

15 A Yes, yes.

16 Q Now, let's go to the study that you yourself did.
17 First, lets put on the view box Defendants' Exhibit 9E.
18 Why don't you tell us what you actually saw?

19 A Well, after I confirmed this and didn't really
20 find anything different than what I had seen on the
21 films --

22 Q Let me just stop you there. To confirm that, you
23 simply used the transducer?

1 A Yes. I scanned the patient and tried to find a
2 separation of these two masses. I could not. So it still
3 didn't mean it couldn't be, but it seemed like they were
4 separate masses. These were not one.

5 But I didn't have an absolute diagnosis. What I
6 did have, and we did have a lot of information that was
7 given to Dr. Hodin and also subsequently put in the
8 report, it was clearly not from the liver. These masses
9 were clearly not from the kidneys. They were not from the
10 pancreas. All of these are sources of large cystic masses
11 in the abdomen. It was clearly not retroperitoneal.

12 Q What does that mean?

13 A There's some reference in the chart to Dr. Hodin
14 said it might be a retroperitoneal mass. It means within
15 the abdominal -- in -- the abdominal cavity has a lining.
16 Anything inside is called intraabdominal. Anything that
17 is outside, whether it pushes in or not, is called
18 retroperitoneal if it comes from the back. And it's a
19 source of large masses in adults and children. So it
20 clearly was not retroperitoneal.

21 It was not -- not thought to be bowel. There
22 were no fluid-filled loops of bowel that were distended.
23 There were a few fluid-filled loops of bowel, but I did

1 not think this represented obstructed bowel. So I didn't
2 think it was primary in the bowel. Duplication cysts
3 arise all along the bowel and usually cause obstruction.
4 Certainly when they get large, they cause obstruction
5 because they arise from the bowel wall. And when they
6 distend, they compress the bowel. And the bowel has no
7 place to go because one of its walls is expanding. So
8 clearly it was not any one of these areas, and it seemed
9 to be arising in the pelvis. So we actually learned a
10 great deal.

11 The other thing we had learned, this was a cystic
12 mass, not a solid mass. Nobody knew that up until this
13 time. A solid retroperitoneal mass in an infant is almost
14 a hundred percent malignant. I mean it's a death warrant.
15 There's a lot of treatment and a lot of palliation, and
16 once in a while a cure. But it's a death warrant.

17 And most of the solid masses elsewhere in an
18 infant this age would fall under the same category.
19 They're usually malignant, and they're usually bad news.
20 Some of them are curable, and some of them are not. So we
21 clearly moved this into another category as cystic masses,
22 and a lot of organs -- that they weren't involved.

23 Q Let me just ask you. You heard previous

1 testimony that this was called in the pathology report a
2 teratoma.

3 A Yes.

4 Q How did teratomas ordinarily appear on sonogram?

5 A Well, teratomas are mixed masses. They can be
6 all solid or they can be solid and cystic. They're almost
7 never all cystic. So the usual thing is a mixture of a
8 lot of solid and some cyst. And their hallmark is they
9 almost all have calcification in them. And we can usually
10 see calcification because it's so dense. It just stops
11 all the sound and nothing goes beyond it. And we can
12 usually see that.

13 To have a purely cystic teratoma is just unheard
14 of almost. I couldn't find one in the literature, and I
15 looked. At surgery Dr. Hodin had no idea this was a
16 teratoma. He thought it was a duplication of bowel cyst
17 to the rectum. It was so cystic. It even fooled him when
18 he had it in his hand. So --

19 Q Let me just ask you. You've now got two
20 cystic-looking structures. You have indicated what you
21 ruled out up to this point.

22 A Yes.

23 Q What did you do next?

1 A Well, I thought it would be -- I thought one of
2 these might reasonably be the urinary bladder since we had
3 filled the pelvis, and I couldn't see anything I -- I
4 couldn't see any tissue around here that I could say oh,
5 there's a collapsed bladder. I thought, well, if we can
6 identify the bladder, we would be down to one cyst and
7 then we might say okay, it's a mesenteric omental cyst.
8 This is a fairly large cyst in the abdomen that causes
9 trouble by size and pressure, but it's very innocuous
10 otherwise.

11 So hopefully, I could find out one of these would
12 be the urinary bladder and the other would just be a cyst
13 and would further limit the diagnosis. And we're pretty
14 well down to ovarian cyst except some way-out diagnosis.
15 Pretty much down to ovarian cyst or mesenteric omental
16 cyst because we have eliminated all the other organs that
17 we might be worried about. We're no longer worried about
18 them.

19 So we've already learned a lot about what's going
20 on here and narrowed the focus for the pediatric surgeon.
21 And this is important to understand because the pediatric
22 surgeon is a highly-trained specialist. It is superfluous
23 for me to lecture him on the basics of what's where in the

1 body. He knows that. He's been dealing with it for
2 years. It would be insulting for me to tell him that.
3 All I have to tell him basically is here it is, and it's a
4 cyst or a solid, and I can't positively name it after that
5 with a hundred percent accuracy. And he can't either.

6 In fact, in this conference, this RSNA that is
7 going on right now, they have case-of-the-day kind of
8 quizzes and everything, and they publish the results in
9 the RSNA Journal which comes out simultaneously but it
10 comes out after a few days' delay. It comes out at the
11 home, so the people at the meeting in Chicago don't know
12 the answers.

13 One of the cases was a mesenteric cyst, and they
14 went all through the differentiation just like this. And
15 in the end they said despite all the modalities of imaging
16 today, you still can't be sure what it is, and you have to
17 operate on it to, A, confirm what it is and, B, to treat
18 it. And that was this brand-new journal that just came
19 out.

20 Q Okay. Let me get back to you now trying to
21 identify where the bladder was. What did you decide to
22 do?

23 A Well, I thought the easiest thing to try to do

1 would be to try to put a catheter in and see if I could
2 see the catheter in the bladder.

3 Q Now, as you're doing this, who is present with
4 you in the sonography suite?

5 A I think the same people that had been there for a
6 few minutes earlier. We did not have a pediatric catheter
7 there, feeding tube, which is the one I usually use in
8 this age group. So that someone, probably Linda, had to
9 go get it. So everything stopped, and I went in and
10 worked with another patient and then came back and we went
11 on again. And I think everybody was -- I think Dr.
12 diPaola and Mrs. Panousos, I think everybody was still
13 there that had been there just before we stopped.

14 Q Tell the jury how you used the catheter to try to
15 identify the bladder. And if you need to refer to this
16 film, you may do so.

17 A Well, I wanted to try to identify which one of
18 these was the bladder. Now, the way we traditionally do
19 that is if the structure is filled is just try to see the
20 catheter within the structure. So I got a pediatric
21 feeding tube, which is a soft, very thin, safe -- it's got
22 a rounded tip, and it shouldn't hurt anything if you don't
23 do anything strange with it -- and inserted a

1 predetermined depth, about this far, into the urethra.

2 Q Let me stop you right there. Use my pen as a
3 guide. Was it thinner than my pen or thicker?

4 A Oh, it's about 3/32nds of an inch in diameter.
5 It's very, very thin. And the hardest thing is to find
6 the urethra in an infant. Most of the time the nurses
7 have trouble doing that, and that's where I come back in
8 and do these things. But so I had to find the urethra,
9 which was difficult. And of course --

10 Q Why was that difficult?

11 A Well, it's always difficult. It's more difficult
12 than other -- some kids than others. It's always
13 difficult. But we found out later that it was even more
14 difficult because of what -- the anatomy was switched
15 around here a little bit.

16 Q Tell the jury what you mean by the anatomy being
17 switched around.

18 A Well, what we found -- this is kind of jumpy.
19 But what we found out was after I put the catheter in to a
20 predetermined depth -- and the reason I do that is from my
21 surgical training, you just never do anything that you
22 think might cause some harm with anything physical, a
23 knife, a needle or anything. You just never -- you always

1 think ahead of time what you're going to do and you do it,
2 and you don't do anything else unless you have good reason
3 to change your plan and have more knowledge about where
4 you're going. You just don't do it. So the female -- the
5 baby's urethra is only about this long. The bladder is --
6 you know, can stretch about this much, so that -- under
7 normal circumstances. So going in this far --

8 Q How far is that?

9 A Oh, two inches at most. It should be enough to
10 be in the bladder. And if it isn't, we've got to stop and
11 think the whole thing over, because you just don't want to
12 go any further. That should be enough.

13 So I insert it to about that depth. And a couple
14 of drops of fluid came out on the towel. And you know, I
15 was satisfied that's it. So I turned -- we put the lights
16 out and started scanning. And of course, the kid is
17 moving around and didn't particularly like the
18 catheterization either. And I was able to take these two
19 pictures.

20 Now, these -- they're not beautiful. But I was
21 trying to get pictures that showed the catheter in the
22 fluid collection. And as the kid is moving around, I saw
23 on the screen, I saw them, so I just snapped them. That's

1 all I wanted. And we see a catheter surrounded by some
2 fluid in both of these.

3 Q Okay. Now the catheter is this little white --

4 A This double -- closed, double white line is the
5 fine echogenic walls of the catheter. The sounds is
6 hitting the plastic catheter and bouncing back. So we see
7 part of the catheter here and part of the catheter here.

8 Now, if you remember, this is a thin slice. And
9 that catheter is crossing it some place. And we're just
10 catching -- you know, we're just catching it across.

11 There's no way to get that whole catheter on the screen
12 because the catheter is going to be in different planes
13 and we only had one plane. So I saw this and snapped the
14 pictures, and we quit. That was it. Because it seemed
15 like the catheter was in the fluid structures. I can't
16 even tell you now whether these were sagittal or

17 transverse. There were probably some kind of oblique.
18 This looks probably where that septum was and the other
19 cystic mass above. So this looks like the lower of the
20 two cystic masses right here. And, you know, it appeared
21 to be in there. And that's when the examination stopped.

22 Q Okay. Let me just ask you a few questions on
23 this. It says here bladder filled. How would that have

1 gotten on that film?

2 A Well, Linda would have typed it.

3 Q Would you have told her to type that? Is that
4 something you --

5 A Not necessarily. Not the filled. I don't know
6 what that means even now. Bladder --

7 Q And the same thing here. It's labeled bladder?

8 A Bladder, no.

9 Q That would have represented what your conclusion
10 was?

11 A Yeah. Yeah. I tell you, I was busy looking at
12 this and anything else, to try to get the pictures. And
13 these two pictures were snapped, and that's where the
14 study ended. And then going back to the initial films,
15 which were really much better than these, this seemed to
16 be the lower cyst and this the upper one.

17 Q Show them here.

18 A This seemed to be the lower one in position and
19 this other one, from the septum up, the upper one; it
20 appeared that the lower one was indeed the urinary
21 bladder. And, you know, we pulled the catheter out and
22 that was the end of the study.

23 Q Let me just ask you, this lower mass, as you

1 called it, that has the catheter near it, that you said
2 you figured was the bladder --

3 A Yes.

4 Q Given this is a four-and-a-half month old infant
5 who is approximately 26 inches long and weighed I believe
6 it was 17 pounds or so, is that either a normal size
7 bladder, a larger than normal bladder or smaller than
8 normal appearance for a bladder in an infant like that?

9 A Well, this is only a little piece of it. This is
10 off to one side. The other views are much better
11 demonstrating the size of it. These are just, you know,
12 taken --

13 Q Do you have any recollection as to whether her
14 bladder appeared on the television monitor you were
15 watching to be either larger than you would have expected
16 or smaller than you would have expected?

17 A Well, that cystic mass we did show on the other
18 film is much larger. It fills the pelvis.

19 Q Even the --

20 A Yes, it's much larger. Nobody's bladder fills
21 the pelvis normally. I couldn't even see the infant's
22 uterus, which we do routinely for other studies.
23 Everything was just flattened and gone.

1 Q Okay. Doctor, why don't you resume the stand.

2 (The witness resumed the stand.)

3 THE COURT: Why don't we use this as a place to
4 take a ten-minute break; okay?

5 We're going to take a ten-minute break. You all
6 may go downstairs. You can use that coke machine down
7 there.

8 (A short recess was taken.)

9 MR. McANDREWS: Your Honor, I expect we'll be
10 about ten more minutes on direct, and that will be it.

11 THE COURT: Okay.

12 BY MR. McANDREWS:

13 Q Dr. Allen, just a few questions to conclude here.
14 Did you feel that you had enough time to perform your
15 study on Nicole Panousos?

16 A Yes. We make enough time. That's why our people
17 wait.

18 Q You indicated you had heard from another
19 technician or someone that she was going to surgery?

20 A Yes.

21 Q Did that in any way affect the study that you
22 did?

23 A No.

1 Q As far as the amount of fluid that came out of
2 the catheter, did you feel that was a sufficient amount of
3 fluid to satisfy yourself based on what you saw on the
4 screen and what came out that you were in the bladder?

5 A Yes. It was a sufficient amount. I didn't spend
6 any time looking at it. A few drops came out. That's all
7 I wanted. The lights went out and we went on with the
8 study. So I didn't watch, you know, what came out later.
9 I don't think any great amount came out later. But I --
10 you know, this was not part of the purpose. A few drops
11 came out. I was convinced it was urine because there was
12 a white towel and it was yellowish.

13 Q Given that you had what you admit even if the
14 lower mass was what you thought was bladder, it was larger
15 than you would have expected in a child of this age and
16 size, wouldn't you have expected a gush of urine to come
17 out or a larger flow to come out?

18 A No, sir. That catheter is long and thin. And
19 there's no way fluid gushes through a long, thin catheter
20 unless you put unbelievable pressure on it like you can
21 with a small syringe. The most it would ever do is drip
22 out maybe continuously. But drip. The other thing is
23 when the urinary bladder is distended, it loses its

1 pressure. It's a muscular organ. And muscle has tone up
2 to a certain point. And stretched beyond there, it just
3 goes to flab.

4 A good example of that is if you're blowing up a
5 balloon. You know, when you first start, the balloon is
6 small, but you'd have to push pretty hard to get that
7 balloon started because that balloon is very flexible.
8 But after it starts and gets a little bigger, all of a
9 sudden it's easy to blow it up. That's because the rubber
10 loses its tone just like the urinary bladder. So it gets
11 quite large. But the pressure within it is not very much.
12 So you don't have the pressure to push it out.

13 Q Okay. Tell the jury your recollection of how you
14 reported your findings to Dr. Hodin.

15 A Well, I talked to him on the phone. And I don't
16 remember the entire conversation. The only parts I
17 remember were the parts that impressed me because of the
18 type of study. And the one thing was, of course, I
19 described the fact that there were the cystic masses that
20 I thought were two separate masses. The outside
21 possibility is one septated mass, but I thought they were
22 two separate masses.

23 The second thing is I thought I identified the

1 lower mass as the urinary bladder by inserting a catheter.
2 And this surprised me because I would have expected a mass
3 that was higher but more anterior, because that septum is
4 oblique down this way, and I would have expected the
5 other -- if one of them were the bladder, I kind of would
6 have expected the other one to be the bladder. And it
7 surprised me. But the catheter appeared to be in the
8 lower one.

9 So I expressed to him in one way or another that
10 it looked like the lower one was the bladder; although I
11 didn't understand it, that's what it looked like. And his
12 reply, I do remember, because it's his terminology and
13 I've known him for many years. And he says, "Well, we'll
14 find out." And I know that to mean we're going to
15 surgery. We're going to look in there and we're going to
16 find out.

17 Q Did you tell him that you had injected some sort
18 of contrast into the bladder?

19 A No, I did not, and I would not have. Again, from
20 surgical training, which has been very helpful in the
21 years of radiology of doing interventional things, it is a
22 cardinal rule if you have a distended area of the body,
23 you don't further distend it. If you have a distended

1 urinary bladder and you put a catheter in it, you would
2 never think of further distending it; it might rupture it.
3 It doesn't take much to rupture a distended bladder. You
4 would have to withdraw, and the usual rule is you withdraw
5 twice of what you took in. If you took out 20 cc.'s,
6 which is a third of an ounce, you could put back in 10.
7 But that's the kind of thing. There's no way I would
8 inject that bladder.

9 Q Did you ever tell Dr. Hodin at any time that you
10 got no urine out of the catheter?

11 A I don't believe so because I did get a few drops.

12 Q You have in front of you a part of the Fairfax
13 Hospital chart which is an exhibit. That is your
14 abdominal sonogram report?

15 A Yes, sir.

16 Q Do you recall when that was prepared?

17 A No. It would have been sometime after -- you
18 know, during the day. It was -- has the same date on it.
19 I don't even know when it was typed up. The date they put
20 here was the date of the study. It was dictated the same
21 day. But that doesn't mean it was typed up the same day.
22 It may have been typed up the next day.

23 Q Let me direct your attention to what appears to

1 be the last two sentences of that, of the second paragraph
2 of that report, the largest paragraph on the page. Can
3 you read that sentence that appears to the jury?

4 A Yes. "There is a separate cystic mass low in the
5 pelvis which was thought to represent the urinary bladder,
6 however, a catheter was inserted with sterile precautions
7 and this was confirmed to be the urinary bladder."

8 Q Is there a typographical error in there?

9 A Yes. I believe so. The sentence really doesn't
10 make any sense to me. It's certainly not good English.
11 And all of my English is not perfect, but I try to have it
12 make sense. I think a "not" was left out of here which
13 was in keeping with my thinking anyway. "There is a
14 separate cystic mass low in the pelvis which was not
15 thought to represent the urinary bladder, however, a
16 catheter was inserted...and this was confirmed to be the
17 urinary bladder."

18 Q Okay, Doctor. I have no further questions of
19 you.

20 Counsel will have some, so please answer their
21 questions.
22
23

CROSS-EXAMINATION

BY MR. SALE:

Q Hello, Dr. Allen. My name is Stephen Sale, counsel for the plaintiffs in this case, and I do have a few questions.

Doctor, did you use a fluoroscope at all in your examination of Nicole?

A No, I didn't. This is the ultrasound department.

Q Would a contrast normally be injected in a fluoroscope exam?

A Sometimes; sometimes not.

Q And in an ultrasound examination what would you use as the contrast in the catheter?

A In a situation with a cyst, which I assume you're referring to something near this situation, you either use air or agitated saline where you shake it up and it -- tiny microbubbles get in the saline. Even though you can't see them very well, they're there and the ultrasound sees them and then you inject that.

Q You inject it for what purpose?

A To visualize something. You rarely do it, actually.

Q In your definition of catheterization, Dr. Allen,

1 when you are catheterizing the urinary bladder, does your
2 definition include production of urine?

3 A No. The catheter is to insert a catheter. I
4 mean it doesn't matter whether it's in the renal artery or
5 the heart or the urinary bladder. It means you insert a
6 catheter. That's all it means.

7 Q Did you ever say that no urine was produced when
8 Nicole was catheterized?

9 A I don't believe so.

10 Q Dr. Allen, do you recall having a deposition
11 taken in this case?

12 A Pardon me?

13 Q Do you recall having your deposition taken in
14 this case?

15 A Yes. I don't recall the details of it, but I do
16 recall.

17 Q Dr. Allen, I'm going to proffer to you your
18 deposition, or counsel can give you one, but I think it
19 might be more effective if you looked at what I have
20 outlined here. And I would ask you to read the question
21 that's in yellow and to give me the answer to that
22 question.

23 THE COURT: Let's find out when and where the

1 deposition was taken.

2 MR. SALE: I'm very sorry, Your Honor.

3 BY MR. SALE:

4 Q Do you recall when the deposition was taken?

5 A It was several years ago.

6 Q Does the document help refresh your memory on
7 when it was taken?

8 A There's a date on it. It says July 28, 1989.

9 Q Do you recall that as being an accurate date? Do
10 you have any reason to dispute that?

11 A No, I don't. I have no idea.

12 Q What was the location of that deposition?

13 A It was in Mr. Godard's office, the offices of
14 Godard & West.

15 Q Was that in connection with the medical
16 malpractice review panel that preceded this case?

17 A Yes.

18 Q So now you do recall this deposition being taken?

19 A Oh, I recall it being taken.

20 Q This helps you recall the time frame?

21 A Yes, some of it.

22 Q And that is your deposition?

23 A It's labeled mine, yes.

1 Q And you read it at the time?

2 A Yes.

3 Q And you gave it at the time?

4 A Yes.

5 Q Okay. Could you now turn to page 34?

6 A Yes.

7 Q Could you read the question that is outlined in
8 yellow and give your answer, please.

9 A "Question: Are you saying that catheterization
10 is accomplished simply by inserting the tube in the
11 bladder and not by producing urine?

12 "Answer: That is what was done here, yes."

13 Q Do you recall ever injecting sterile water or
14 aerated water into the bladder to define the bladder?

15 A No, I did not.

16 Q Throughout the course of your practice, you don't
17 recall ever having done that.

18 A I -- no, I don't for a urinary bladder. I have
19 injected -- catheterized lots of bladders and filled lots
20 of bladders with saline and contrast and various things.
21 But injecting saline or contrast through the catheter
22 simply to identify it, I have done that when the bladder
23 is empty, not filled, to make sure that it's where it's

1 supposed to be, if there's any question, and then inject a
2 little contrast to make sure it's in the bladder and the
3 tube is in a good position. I have done that. But not
4 with a filled -- I don't recall ever with a filled urinary
5 bladder.

6 Q Dr. Allen --

7 A I might have done it, but I just don't recall it.

8 Q Okay. Have you ever used a syringe to inject
9 water into the tube and then view that on a sonogram to
10 confirm that you have in fact penetrated the bladder?

11 A I probably have. I'm trying to remember. I
12 probably have, because I have injected lots of times in
13 the bladder. But the key word here is to confirm. And
14 usually the bladder is empty when I do that.

15 Q Okay. So your answer today is you don't recall
16 ever doing that?

17 A Well, I've injected lots of things into lots of
18 bladders but not full bladders.

19 Do you understand?

20 Q Well, I understand your answer. But my question
21 did not relate to a full bladder.

22 A Well, then I've done it lots of times.

23 Q Okay. I'm going to ask you to look at your

1 deposition again on page 37 and read to the ladies and
2 gentlemen of the jury the question outlined on that page
3 and see if that changes your response.

4 A "Have you ever used a syringe to inject water
5 into the tube and then view that on a sonogram to confirm
6 that you have in fact penetrated the bladder?

7 "Answer: I don't recall ever doing that in the
8 bladder. I have done it in other circumstances, but I
9 don't recall. Go ahead."

10 I was probably thinking within the reference of
11 this case of a full bladder, which is just what I was
12 saying a minute ago.

13 Q But that's not in the question, is it?

14 A No. It might have been in my mind, though,
15 because, you know, I'm thinking of this case.

16 Q Okay. Thank you.

17 Dr. Allen, when you did the examination in this
18 case, were you able to visualize the tip of the catheter?

19 A I made no attempt to. I thought I was lucky to
20 visualize the catheter at all.

21 Q Now, you thought you were in the lower mass; is
22 that correct?

23 A It appeared on the film -- on the screen that I

1 was.

2 Q Okay. If you had attempted to visualize the tip
3 of the catheter, would that have been difficult?

4 A Very.

5 It would have meant that tiny, tiny, little tip
6 would have had to have been included on the plane of
7 the -- the thin plane of the ultrasound beam, and it just
8 would have been extremely difficult to be certain of that.

9 Q Dr. Allen, do you recall in connection with that
10 medical malpractice review panel that preceded this court
11 case being asked some interrogatories?

12 A What do you mean by interrogatories?

13 Q Some questions. Different questions which you
14 had to help answer?

15 A Yes. During the malpractice panel?

16 Q Yes.

17 A Oh, yes.

18 Q Do you remember getting those interrogatories?

19 A Yes.

20 Q Do you remember helping to answer those
21 interrogatories?

22 A Yes.

23 Q Do you remember one answer where you indicated

1 that the catheter tip appeared to be in a specific place
2 on the screen?

3 A No, I don't.

4 MR. McANDREWS: Your Honor, could I ask he be
5 shown the question and answer?

6 THE COURT: Yes.

7 MR. SALE: Be happy to do that. (Handing to
8 witness.)

9 BY MR. SALE:

10 Q Question 9 of your interrogatories?

11 A "Describe the procedure used by Defendant Allen
12 during the catheterization and review thereof of
13 Nicole Panousos on March 4, 1987.

14 "In performing the sonogram of March 5, 1987, I
15 observed what appeared to be two cystic masses in
16 Nicole's abdomen."

17 Do you want me to read this whole business?

18 Q Yes.

19 A "One could possibly have been the urinary
20 bladder. I decided to obtain a catheter and attempt
21 to insert it into Nicole's urinary bladder.

22 "I asked the sonographer, Ms. Edwards, to obtain
23 a No. 8 French catheter, and she did so. I then

1 attempted to insert this small, pliable infant feeding
2 tube into Nicole's urinary bladder while observing the
3 two cystic masses on the sonogram screen. On the
4 screen, the catheter tip appeared to be in the
5 smaller, posteriorly located cyst. A small amount of
6 fluid came out of the catheter. This fact, coupled
7 with what I observed on the sonogram screen, led me to
8 assume that I had identified Nicole's bladder."

9 Yes, I do recall thinking I had seen the tip
10 because it would have been so difficult to be certain of
11 it. But I might have thought I saw it.

12 Q Dr. Allen, go ahead and look over those answers
13 and make sure in fact those were the interrogatories given
14 to you and that those were in fact your answers.

15 A Well, I have no specific memory of what I said.
16 And so I would assume that this was what I said. I have
17 no question of that.

18 Q Okay. Now, Dr. Allen, did you look at Nicole's
19 chart yourself --

20 A No.

21 Q -- in this exam? So you wouldn't have had any
22 firsthand knowledge what was and what was not in that
23 chart.

1 A No, I don't even know if the chart was in the
2 department. I assume it was from this record. But I
3 don't know.

4 Q On your direct, you testified that you prepared a
5 radiological report in connection with this examination.
6 Is that correct?

7 A Yes, sir.

8 Q Okay. You have that in front of you. What is
9 that exhibit number as you have it?

10 A I don't think it has a number on it.

11 Q Okay. Well --

12 A It says deposition number 2, 8K or something.

13 Q Well, I'm going to hand you a document marked for
14 identification Plaintiffs' No. 34, and I will ask you to
15 tell me whether that is the same report that you have.

16 A Yes, I believe it is.

17 Q Okay. Now, that report tells you, first of all,
18 that there's fullness of the collecting system. Is that
19 correct? About midway down.

20 A Well, I was going to say it's not, first of all.
21 In the middle of the first paragraph, it says, "Both
22 kidneys are visualized with some fullness of the
23 collecting systems." Yes.

1 Q I apologize if I was unclear because that was my
2 first question. I realize that's in the middle of the
3 paragraph.

4 Okay. And your impression -- well, first of all,
5 before we get to your impression, it does say that the
6 fluid-filled mass which you thought was the urinary
7 bladder was confirmed to be the urinary bladder by the
8 injection of a catheter; is that correct?

9 A Yes. I think we just went over this. And I
10 thought there was a typo there that fit my thinking that I
11 described.

12 Q Now, when you were looking at your anatomy on
13 your self-drawn chart, if neither of those masses were in
14 fact the bladder, would the bladder have shown up on the
15 ultrasound if it was empty or relatively empty?

16 A Probably not. There might have been a little bit
17 of soft tissue in the proper place that I might assume
18 would be urinary bladder, but it would have been very
19 difficult.

20 Q Now, today you've told us that you gave Dr. Hodin
21 your report by telephone.

22 A I believe I did, yes.

23 Q Previously when you were asked that question,

1 again in your deposition, did you answer that question
2 that you had given it by telephone?

3 A That was two years ago, and I have no idea.

4 Q Okay. Well, in fairness to the witness, I'm
5 going to let him look at --

6 A I didn't memorize it. But my impression was he
7 was never in the department, so it must have been by
8 telephone.

9 Q I am going to ask you, starting with the middle
10 of page 39, whether you could read the questions and the
11 answers for the ladies and gentlemen of the jury, please.

12 A Starting with the top of the yellow.

13 Q Top of the yellow.

14 A "Was there any particular time pressure that
15 caused you not to do these things?

16 "Answer: Sure. There always is.

17 "Question: What was that time pressure?

18 "Answer: A sick child. I don't want them to get
19 sicker down in X-ray. They should be up in the room
20 where they can be taken care of.

21 "Question: You had a discussion with Dr. Hodin
22 after the sonogram was completed, didn't you?

23 "Answer: No. Not right afterward. I don't

1 recall talking to him right afterward. I recall one
2 conversation after surgery. And I may have talked to
3 him before surgery, but I don't recall it.

4 "Do you recall whether Dr. Hodin came into your
5 department to review the sonogram before surgery?

6 "He might have, but I do not recall."

7 I'm sure, you know, that they took down what I
8 said. But my memory being jogged over the time of going
9 over these things before, I don't remember seeing him in
10 the department. And I do remember the question in my mind
11 about the bladder and discussing with him, and it couldn't
12 have been after surgery, so it had to be before.

13 Q So do you recall specifically what jogged your
14 mind since this deposition was taken?

15 A Just the constant thinking of what went on and
16 trying to picture and remember, yes. It's been quite a
17 bit on my mind.

18 Q Now, you testified that someone told you that
19 Nicole was on her way to surgery; is that correct?

20 A Yes.

21 Q Who told you that?

22 A It would have had to have been one of the
23 technicians, but I don't recall which technician. And I

1 say one of the technicians because they're the ones that
2 handle this process of the person coming in the
3 department.

4 Q Dr. Allen, I'm going to ask you once again to
5 look at some of your testimony. And, I'm going to ask you
6 to review that testimony. It's from the medical
7 malpractice review panel proceeding, page 20. You can go
8 ahead and read that by the yellow.

9 A "Question: What was your impression of her
10 status as a patient, namely, did you feel that she
11 was a surgical candidate at that time?

12 "Answer: Yes, that was my understanding, that
13 she was on her way to surgery and she had an
14 abdominal mass and we were trying to determine if
15 the mass was present, of course.

16 "Question: Can you tell the panel members
17 where you got that impression from?

18 "No. I don't specifically remember. But it
19 should have been from Linda, who is the one that
20 gathers this information, and Linda is probably
21 the one who would have informed me of that.

22 "Question: Did Linda prepare a clinical
23 history form?

1 "Answer: Yes."

2 Q Before you gave that answer, had you talked to
3 Linda Edwards about whether she in fact had told you
4 whether Nicole was going to surgery?

5 A No, I did not discuss this at all with Linda.

6 Q Now, you said you didn't know who it was today,
7 but there it was your impression it was Linda Edwards.

8 A It was a guess for the same reason I said that
9 she was the one primarily involved and it was probably
10 Linda, but it really could have been one of the other
11 technicians from a phone call or some communication with
12 the front desk at the office end.

13 Q So that was only a guess when you gave that
14 testimony at the medical malpractice?

15 A Yeah. I said it was probably; just as I said, it
16 was probably Linda.

17 Q Now, when you did your ultrasound, you found that
18 the masses in Nicole's abdomen, the mass or the masses,
19 you found that, one, they were not solid; is that correct?

20 A Yes.

21 Q That indicated to you that they were not
22 malignant; is that correct?

23 A Likelihood of malignancy goes way down with that,

1 yes. It doesn't go out completely, but it goes way down.

2 Q Did you see any signs in your analysis of
3 inflammation in the abdomen?

4 A No. I don't think I would have been able to see
5 anything else. The cyst filled the abdomen.

6 Q You can't see any signs of inflammation when an
7 abdomen is inflamed?

8 A Yes, but not when all of the tissues are totally
9 distorted and compressed and displaced as these were.

10 Q Is your answer that you did or did not see any
11 signs of inflammation?

12 A My answer remains that I didn't.

13 Q Did not. Okay.

14 A And I think I said that in my report, didn't I?

15 Q Okay. Did you indicate no signs of inflammation
16 in your report?

17 A No, I don't see that. Signs of inflammation are
18 very subtle, and they're not easy to see, and this process
19 would have just totally obliterated that.

20 Q Did you see any signs of infection?

21 A No. That would be the same thing.

22 Q Now, Dr. Allen, you indicated you used an 8
23 French catheter; is that correct?

1 A Yes.

2 Q Dr. Allen, wasn't your other primary option a
3 number 5 French catheter?

4 A Yes. We didn't have either one in the
5 department. And an 8 was what I could get.

6 Q Is a 5 bigger or smaller than an 8?

7 A Smaller.

8 Q Okay. So an 8 is larger.

9 A Yes.

10 Q What does the 8 refer to?

11 A It's a measurement size. It's called 8 French.
12 It's a measurement size of catheters. It's a standard
13 measurement.

14 Q Does the number 8 mean that that is the diameter
15 of the catheter?

16 A Yes. Yes.

17 Q Okay.

18 A The 8 does not stand for any specific
19 measurement. An 8 French catheter measures about 3/32nd
20 of an inch.

21 Q So that would be 8 millimeters?

22 A No, no. I just said it does not stand for any
23 standard measurement.

1 Q Okay. So in an 8 French catheter it would not
2 have an 8 millimeter diameter that you know of.

3 A Definitely not. That's about four or five, six
4 times as large.

5 Q And the number 5 French catheter is substantially
6 smaller?

7 A No. Just slightly smaller.

8 Q Now, what would have the stronger wall? The
9 number 8 or the number 5?

10 A Well, the number 8.

11 Q Now, normally in an infant this age you would
12 have used a number 5; right?

13 A No, number 8 is fine. I always use a number 5 in
14 a newborn. But a number 8 is fine at this age.

15 Q How do you define newborn?

16 A First week or two of life.

17 Q Now, Dr. Allen, you indicated that the catheter
18 wall was thin and therefore it wouldn't stand up to the
19 pressure on insertion. Is that your testimony?

20 A No, I don't believe so. I don't even understand
21 it.

22 Q Okay.

23 A It's thin, and it's weak, and it's kind of floppy

1 when it's warm and you start using it in a body.

2 Q Could you have gotten urine out of it if you were
3 all the way into the bladder?

4 A Well, we did -- I did -- yes, you get a few --
5 you get a slow, very slow flow, a couple of drops at a
6 time.

7 Q So it wasn't totally collapsed. Some urine could
8 come through this catheter?

9 A Well, apparently some did.

10 Q And you indicated that even if you couldn't get
11 any urine out, that if the walls of the catheter were
12 collapsed, you could still be able to alleviate that
13 collapse, be able to open up the catheter again by
14 injecting pressurized water through a syringe; is that
15 correct?

16 A That could be done, but I wouldn't do it.

17 Q Dr. Allen, you primarily practice at Fairfax
18 Hospital; is that correct?

19 A Entirely at Fairfax Hospital.

20 Q Okay. And that record I gave you, Plaintiffs' I
21 believe it was 34, your radiological report?

22 A Yes.

23 Q Was that prepared at Fairfax Hospital?

1 A Yes.

2 Q And that is in fact your report?

3 A Yes.

4 MR. SALE: Your Honor, at this time I would move
5 into evidence plaintiffs' 34.

6 THE COURT: Is there any objection?

7 MR. McANDREWS: No objection.

8 THE COURT: I receive it.

9 (Dr. Allen's radiological report previously
10 marked for identification as Plaintiffs' Exhibit
11 No. 34 was received in evidence.)

12 BY MR. SALE:

13 Q Dr. Allen, I want to show you another record at
14 Fairfax Hospital, and I'd ask you to tell me what that
15 record is, if you know.

16 A It says operative report. It's not the form I
17 usually see in the chart, however.

18 Q So you have looked at operative reports before?

19 A Oh, yes.

20 There's a standard form, and this is not it.

21 Q Okay. Now, Dr. Allen, do you know who prepared
22 this report?

23 A No, I've never -- no.

1 Q Have you ever seen it before?

2 A I went through Nicole's chart originally to just
3 see what else was in there when this case was first
4 brought to my attention several years ago. I have not
5 re-reviewed the parts that had nothing to do with me since
6 then. So I -- if it was in the hospital chart, I must
7 have seen it, but I don't recall seeing it.

8 Q Okay.

9 A But it says operative report, and it's signed
10 Earl Hodin, M.D.

11 Q Dr. Allen, did you ever specifically state that
12 the large fluid-filled mass in Nicole's abdomen was not
13 bladder?

14 A Not in those terms, I know, because I was
15 surprised, but I said -- no, I didn't think it was. After
16 I was finished with the study, I said I didn't think the
17 larger upper mass was the bladder anymore because the
18 lower one seemed to contain the catheter.

19 Q Dr. Allen, could you --

20 A That was my conclusion.

21 Q Could you read for the ladies and gentlemen of
22 the jury the second paragraph of that report?

23 MR. McANDREWS: Your Honor, I object to that.

1 The document speaks for itself. The chart I believe is a
2 record in the case. I don't see what's going to be gained
3 by him reading it.

4 THE COURT: Is this in evidence?

5 MR. SALE: I don't believe it is as yet.

6 THE COURT: May I see it, please?

7 MR. SALE: Yes.

8 THE COURT: First of all, let me hear from
9 defense counsel. Is this in evidence in your opinion?

10 MR. McANDREWS: As I understand, the whole chart
11 was going to be in. That's why we signed the stipulation.

12 THE COURT: Do you agree that the chart should be
13 in evidence?

14 MR. SALE: No, we don't, Your Honor. We think
15 the chart is far too long and confusing, that the salient
16 part should be in evidence.

17 THE COURT: May I see the stipulation?

18 MR. SALE: In fact, Your Honor, could we approach
19 on this matter?

20 (The following bench conference took place.)

21 MR. SALE: We were willing to stipulate this
22 whole chart could come in having included Dr. Hodin's
23 record. Defendants refused to allow Dr. Hodin's office

1 record to come in. So basically the stipulation is that
2 the entire chart is not admitted into evidence by
3 stipulation.

4 MR. McANDREWS: I don't know what Dr. Hodin's
5 chart has to do with the hospital chart. What you're
6 looking at is part of the hospital chart. It might also
7 have a copy included of Dr. Hodin's chart.

8 THE COURT: The operative report has been relied
9 on by every expert who's testified, has it not?

10 MR. QUINN: I understood it was already in
11 evidence.

12 MR. SALE: From Dr. Karsh.

13 MR. QUINN: From Dr. Karsh. It was in evidence
14 from Dr. Karsh's deposition. It was admitted.

15 MR. GODARD: Your Honor, as I understand it, we
16 have a stipulation as to authenticity of the records.
17 We're now on our portion of the case. We would, if
18 plaintiffs' don't concede that it's already in evidence,
19 we respectfully would move the entire Fairfax Hospital
20 chart into evidence as a defendants' exhibit.

21 MR. QUINN: As long as we can have our separate
22 exhibits.

23 MR. SALE: They can have Defendants' Exhibit 18,

1 but we want the separate part because the whole thing is
2 massive and difficult for the jury to follow.

3 THE COURT: All right. I receive the hospital
4 chart as Defendants' Exhibit --

5 MR. McANDREWS: Number 2.

6 (The hospital chart was marked Defendants'
7 Exhibit No. 2 for identification and evidence.)

8 MR. QUINN: Your Honor, at this point there's
9 going to have to be some discussion between us so we know
10 which version of the hospital chart is going in, because
11 we had different copies made as far as the organization is
12 concerned and so forth.

13 THE COURT: Check it overnight.

14 Now, the next issue is whether or not you may
15 cross-examine this witness on the basis of an operative
16 report prepared by someone other than this witness. What
17 basis is there for cross-examining this witness on this
18 report?

19 MR. SALE: Pure and simple impeachment. It's a
20 medical record. It's not hearsay. It was in the
21 hospital. He indicates he's seen it before. It's a
22 hospital record. And he says he never specifically stated
23 this contradicts him.

1 THE COURT: Well, sure it does if it says in here
2 that he did --

3 MR. SALE: Right there. The yellow paragraph. I
4 asked the foundation did you ever so specifically state.
5 No, I did not. This contradicts him.

6 MR. McANDREWS: Your Honor, the question has been
7 asked several times and he's answered it. Reading from
8 that is not going to contribute anything further.

9 THE COURT: Who prepared this, this document?
10 Who has written this?

11 MR. SALE: Dr. Hodin.

12 THE COURT: All right. Dr. Hodin says that this
13 doctor did say something or did do something; right?

14 MR. SALE: Yes. Yes. That was his testimony.

15 THE COURT: He says that he doesn't recall making
16 such a statement.

17 MR. QUINN: He says he never made such a
18 statement.

19 THE COURT: Well, in your examination on the
20 stand today, didn't he say that he didn't believe that he
21 did say it?

22 MR. SALE: It's my understanding he said he would
23 never do that.

1 THE COURT: Well, I conclude that you certainly
2 may argue to the jury whatever you're going to from this
3 that's in evidence. But so far as cross-examining him
4 further on this, he has been asked about this once. He's
5 made some statement on it with respect to it. Now you
6 want him to read it.

7 MR. SALE: Yes.

8 THE COURT: To reinforce it.

9 MR. SALE: He could also refresh his memory, Your
10 Honor.

11 THE COURT: Well, if you want to let him read
12 this without reading it aloud and see if it refreshes his
13 memory and then ask him, you may do that.

14 MR. SALE: All right. That would be fine.

15 THE COURT: Rather than just reading it out loud
16 to the jury.

17 (The bench conference was concluded.)

18 BY MR. SALE:

19 Q For your convenience, the yellow lined part, I
20 would like you to read that not out loud and see if that
21 refreshes your memory here and regarding specifically
22 stating that the large mass was not the bladder.

23 A I have already expressed my opinion very

1 thoroughly about what I thought this represented and why.
2 And this may have been Dr. Hodin's way of saying the same
3 thing. But I don't think he -- he didn't put quotation
4 marks around anything, and this might have been his
5 understanding of it. And I wouldn't argue with that. But
6 I don't have to read it this is what I said because I
7 don't think it was.

8 By the way, the date on this report is 3/10/87,
9 five days afterward.

10 Q So your answer, to be specific, is that this does
11 not refresh your recollection that you had ever stated
12 that the large mass was not bladder.

13 A It doesn't refresh my recollection of specific
14 words that I used, no, because I can't remember that far.

15 Q Now, Dr. Allen, I believe you've testified when
16 you did this radiological study, this ultrasound, you were
17 under no time pressures other than those of a sick child;
18 is that correct?

19 A In general, yes.

20 Q Okay. Were you in a hurry to complete this exam?

21 A Only in that patients are waiting and we don't
22 like them to wait too long. But I was -- we take enough
23 time to do whatever we think is necessary.

1 Q Did you have four or five other patients waiting
2 at this time?

3 A Probably. There are five rooms.

4 Q During the course of the examination, do you
5 recall going out and coming back?

6 A Yes. The times on the films show a gap between
7 those final two films with the catheter and all of the
8 other films.

9 Q Now, did you ever state that you were in a hurry
10 to finish this examination?

11 A I was not in -- I was not in a hurry to finish
12 it. Anymore than when patients are waiting, you don't try
13 to waste any time. But I wasn't in a hurry to finish, and
14 I took enough time to do what I thought I had to do.

15 Q Okay.

16 A Even doing something extra that took more time
17 that we're now discussing.

18 Q Well, did you do anything to find out when Nicole
19 was going to surgery, if she was in fact going to surgery?

20 A No, I did not. I don't have time for that. We
21 have a lot of trust in the department in the hospital
22 between one physician and another, especially when people
23 are very sick. I have to take their word for things. I

1 don't -- otherwise, nothing would ever get done. When
2 someone says they're on their way to the operating room, I
3 can't stop and dispute that with anybody.

4 Q Okay. I'm going to ask you to read from your
5 deposition and ask whether -- this is at page 38, in
6 connection with -- actually beginning at page 37 in
7 connection with the hurried state of this exam. Can you
8 go down to the bottom of the page, yes, the bracketed
9 question, starting right there. Can you read that for the
10 ladies and gentlemen of the jury.

11 A "And if you were to do this kind of test, what
12 device would you use to inject a water solution?

13 "Answer: A syringe, you mean?

14 "Question: Yes. Would you use a syringe?

15 "Answer: I suppose."

16 Q You can continue, please.

17 A "Question: Is there any reason why you didn't do
18 that for the catheterization of Nicole?

19 "Answer: It didn't seem necessary. The catheter
20 was visualized on the screen and there's an endless
21 number of things you can do to just prolong things
22 which are not good for the patient necessarily, and
23 you have to reasonably stop when you're -- you can't

1 spend all day dancing around."

2 Q Is your answer still the same, that this was not
3 a hurried exam in any way?

4 A Yes. In any abnormal way.

5 Q Now, Dr. Allen, you testified today that you
6 spoke with Dr. Hodin regarding your findings by telephone.
7 Is that correct?

8 A I know he didn't come into the department. And
9 after the constant, you know, review and repetition of
10 this and knowing what happened, I had to have talked to
11 him before surgery, so I concluded it had to be by
12 telephone.

13 Q Do you recall what you said to Dr. Hodin or he
14 said to you?

15 A Only in the reference that I already testified,
16 the part that was most outstanding in my mind.

17 Q But again, in your deposition you didn't have a
18 specific recollection of even talking to him before
19 surgery, did you?

20 A At that time -- apparently I had not put the
21 whole thing together at that time. I've done a lot more
22 thinking about it in the intervening time than I ever did
23 beforehand.

1 Q Now, Dr. Allen, mention has been made, and we
2 read some of your testimony in the medical malpractice
3 review panel proceeding. Were you here for that
4 proceeding?

5 A Yes.

6 Q Do you recall whether Linda Edwards was here?

7 A Yes, she was.

8 Q She was here for that proceeding.

9 A I believe she was.

10 Q Was Dr. Hodin here?

11 A I don't remember Dr. Hodin being here.

12 MR. SALE: Your Honor, with the indulgence of the
13 Court, I only have this and maybe one more question.

14 BY MR. SALE:

15 Q Have you ever looked at the transcript of that
16 proceeding?

17 A I looked at part of the testimony before in the
18 proceeding. I did not look at it after the other one, and
19 I did not go through all of the transcript. I sat through
20 it.

21 Q You sat through it all, okay. Was Linda Edwards
22 called as -- now Mrs. Stover -- was she called as a
23 witness for you?

1 A These are a matter of records. I have no idea.
2 There must be a record there that says who was here and
3 why.

4 Q So you don't have a specific recollection of
5 that?

6 A I don't call people here. You people do. You
7 lawyers do. I don't --.

8 Q Dr. Allen, I am going to have you look at the
9 transcript from Monday. Tell me whether you have ever
10 seen that before.

11 A I haven't read it.

12 MR. McANDREWS: Your Honor, I would object at
13 this point to the line of questioning. I don't know
14 whether he is planning to impeach the doctor with someone
15 else's testimony or what, but it seems wholly
16 inappropriate. She's already testified here. He can ask
17 questions if he wants, but we are dragging it on for no
18 apparent reason.

19 THE COURT: Is this what?

20 MR. SALE: The medical malpractice review panel
21 proceeding. He's testified Linda Edwards was here. I am
22 trying to refresh his recollection.

23 THE COURT: You say she wasn't here.

1 MR. SALE: She was not here.

2 THE COURT: Do you agree?

3 MR. McANDREWS: She wasn't here.

4 THE COURT: Okay. She wasn't here.

5 MR. SALE: We will accept that stipulation, and
6 we will have no further questions of Dr. Allen.

7 THE COURT: Is there any redirect?

8 MR. McANDREWS: We have no further questions of
9 Dr. Allen.

10 May we approach?

11 (Counsel approached the bench and the following
12 proceedings were held:)

13 MR. GODARD: He has waited outside all afternoon,
14 Dr. Lipsit, our radiologic expert. As has been referred
15 to several times in the course of this trial, this
16 unfortunately happened to be the one where it's the
17 meeting of the national convention. And every radiologist
18 has this gigantic problem. Dr. Lipsit is covering for
19 practically his whole office because they're all at the
20 convention. He cannot come back tomorrow morning first
21 thing.

22 THE COURT: How long will he take?

23 MR. GODARD: Well, I don't think we're going to

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