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IN THE  
**Supreme Court of Virginia**

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RECORD NO. 920529

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**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.*

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**JOINT APPENDIX**  
**VOLUME II**

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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.

At Law No. 98695

CLERK  
SUPREME COURT OF VIRGINIA

RECEIVED  
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RICHMOND, VIRGINIA

Fairfax, Virginia

Thursday, December 5, 1991

The trial commenced at 10 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>	<u>RECROSS</u>
Anthony DiPaola, M.D.	287	289	302	303
Bradley Rodgers, M.D.	304	357	395	403
Edward R. Lipsit, M.D.	412	447		

EXHIBITS

<u>PLAINTIFFS'</u>	<u>FOR IDENT.</u>	<u>IN EVIDENCE</u>
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P R O C E E D I N G S

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

THE COURT: I apologize to you for keeping you waiting. I had a very important thing happen. But at any rate, I wanted to get started earlier, but we'll start now.

MR. McANDREWS: Your Honor, Dr. DiPaola went to call his office just to let them know there was a little delay. I will go get him right now.

THE COURT: Ask the jury to come in.

MR. QUINN: Your Honor, before we begin, there is an issue with Dr. DiPaola. First, Dr. DiPaola is one of those witnesses. He was the pediatrician. And again, we want to just make the Court again aware of our concern about opinion testimony from this witness.

Secondly, we subpoenaed Dr. DiPaola, and the defendants subpoenaed Dr. DiPaola. We intend or we may call him as a rebuttal witness, and we don't want him to remain here after his testimony in the event that we might use him as a rebuttal witness. Dr. DiPaola indicated he is unwilling to do that, and I'd like the matter to be addressed at this point.

1           MR. McANDREWS: Your Honor, Dr. DiPaola was told  
2 on Tuesday to be ready Tuesday to be called as a witness,  
3 and he sat in his office all day and was never called. We  
4 tried to put him on yesterday and because it ran long in  
5 the morning, we pushed it over to today. He's taken most  
6 of the patients that he was to see on Tuesday and switched  
7 them to today. He's had to rearrange one or two of those  
8 because we were not starting at 9:30. It seems unfair to  
9 make him come back. We would accept a proffer of what  
10 they want to bring out in rebuttal.

11           THE COURT: What does the rebuttal relate to?

12           MR. QUINN: Well, Your Honor, quite frankly, we  
13 are not entirely certain. It's going to depend to some  
14 extent on what the defendants' expert witness, Dr. Rogers,  
15 testifies to. A lot of his testimony has to do with the  
16 appearance of the child, the child's electrolyte hydration  
17 status.

18           THE COURT: I will deal with it if and when the  
19 issue arises. Go ahead and bring the jury in.

20           I'm sorry you had to wait this morning.

21           DR. DiPAOLA: That's all right.

22           (The jury returned to the courtroom, after which  
23 the following proceedings were held:)



1 (The witness was sworn.)

2 THE COURT: I'm sorry we didn't get started at  
3 9:30. How are you all doing this morning? Did anyone  
4 have any opportunity to read, see, hear or discuss any  
5 aspect of the case over the break?

6 Okay. There are no affirmative answers. Go  
7 ahead.

8 Whereupon,

9 ANTHONY DiPAOLA, M.D.,  
10 was called as a witness on behalf of the defendants, and  
11 after having been first duly sworn, was examined and  
12 testified as follows:

13 DIRECT EXAMINATION

14 BY MR. McANDREWS:

15 Q Would you please state your name, sir?

16 A Anthony DiPaola.

17 Q Are you a medical doctor, sir?

18 A Yes, I am.

19 Q What is your specialty?

20 A Pediatrics.

21 Q When did you go into private practice in  
22 pediatrics?

23 A 1975.

1 Q How long have you been in the private practice of  
2 pediatrics here in Northern Virginia?

3 A Since 1975.

4 Q Did there come a time when you had a patient  
5 named Nicole Panousos?

6 A Yes.

7 Q I'm going to direct your attention, sir, to March  
8 5, 1987. At that point the record, the testimony thus  
9 far, has shown that Nicole was at Fairfax Hospital, had  
10 been admitted there. Do you recall seeing Nicole Panousos  
11 at all on March 5, 1987?

12 A Yes, I do.

13 Q Do you recall when Nicole was taken to the  
14 sonography suite at Fairfax Hospital?

15 A Yes, I do.

16 Q Were you present in the sonography suite when a  
17 sonogram was taken?

18 A Yes, I was.

19 Q Let me ask you to tell the jury who was also  
20 present when that was done.

21 A Dr. Allen, the radiology technician, and Mrs.  
22 Panousos. And the baby, of course.

23 Q Do you recall Dr. Allen using a catheter in the

1 course of his study of Nicole?

2 A Yes, I do.

3 Q Did you observe any fluid coming out of that  
4 catheter while he was using it in the course of that  
5 study?

6 A Yes, I did.

7 Q Are you absolutely certain of that, sir?

8 A Yes, I am.

9 Q Where were you at the time in relation to Dr.  
10 Allen when he was using that catheter on Nicole?

11 A Essentially shoulder to shoulder.

12 Q Do you recall Nicole's demeanor during this whole  
13 study while you were present?

14 A She was upset, unhappy, crying, and both mother  
15 and the assistant were trying to comfort her.

16 Q Was she moving about somewhat?

17 A Yes.

18 MR. McANDREWS: That's all the questions I have  
19 of this witness, Your Honor.

20 CROSS-EXAMINATION

21 BY MR. SALE:

22 Q Good morning, Dr. DiPaola.

23 A Good morning.



1 Q Can you tell the jury a little bit what your  
2 involvement has been with this case?

3 MR. McANDREWS: Your Honor, I'm going to object.  
4 I think that exceeds the scope of direct.

5 THE COURT: Overruled.

6 A My involvement. I was the pediatrician who was  
7 on call the night she was admitted, the morning she was  
8 admitted. So I was the admitting physician. Well, Dr.  
9 Hodin technically was the admitting physician. But I was  
10 also.

11 Q Do you recall, Dr. DiPaola, there was a medical  
12 malpractice review panel proceeding in this case?

13 A Yes, I do.

14 Q Do you remember that you were initially named as  
15 a respondent health care provider?

16 A Yes.

17 Q Do you remember in that proceeding that some  
18 interrogatories were tendered to you, some questions to be  
19 answered?

20 A Before there was a deposition taken, before the  
21 panel. We were not called to panel.

22 Q Okay. So you remember the interrogatories before  
23 the deposition? Is that your answer?

1           A     I remember giving a deposition, yes, before the  
2 panel because we were not called to panel. We were  
3 released from the case.

4           Q     Okay. Well, I have some responses of Anthony  
5 DiPaola to claimants' first set of interrogatories, and I  
6 hand those to you, and just see if you recall ever seeing  
7 those before.

8           A     I guess so.

9           Q     Do those look to be your answers?

10          A     Most probably. I can't say absolutely. I  
11 remember this situation occurring. And I would assume  
12 that these are the actual copies of what transpired, yes.

13          Q     So those are the actual copies of your answers?

14          A     I hope so, yes.

15          Q     But you do remember preparing some answers with  
16 your attorneys?

17          A     I do remember preparing some answers, and I  
18 assume these are that.

19               MR. SALE: Would counsel like to review?

20          A     If you're going to ask me questions about them, I  
21 would need to see them because I can't answer your  
22 questions without them.

23          Q     I understand, Doctor. I would do that.

1           MR. McANDREWS: May we approach the bench, Your  
2 Honor?

3           (Counsel approached the bench and the following  
4 proceedings were held:)

5           MR. McANDREWS: These are interrogatory answers  
6 propounded on behalf of Dr. DiPaola in the course of the  
7 med. mal proceedings. Looking at the questions they have  
8 asked and the answers, they're either consistent with what  
9 he said or irrelevant to the issues he's been called for.  
10 They have not tendered to call him as a witness. If they  
11 want to get into extraneous issues of the care of the  
12 child prior to March 5th or anything else, they have the  
13 opportunity. I object to this being dragged out so they  
14 can raise irrelevant matters or matters --

15           THE COURT: What is it that he testified to on  
16 direct that you want to impeach? Because that's the only  
17 way this is going to come in; right?

18           MR. SALE: Yes.

19           THE COURT: Okay. Tell me the specific point  
20 you're driving at.

21           MR. SALE: The specific point, Your Honor -- and  
22 there are some tabs that I had tabbed for my reference  
23 that I had not necessarily intended to go into now, and it



1 just further demonstrates why we require him for rebuttal.  
2 I wanted to go into the matter of what he recalled from  
3 the catheterization, and there's a specific question as to  
4 that.

5 THE COURT: Show me the question that impeaches  
6 what he said.

7 MR. SALE: Okay. (Handing to the Court.) At the  
8 bottom of the page.

9 THE COURT: The witness's rebuttal or to impeach?

10 MR. SALE: When he prepared these  
11 interrogatories, he had no understanding, not aware of the  
12 method and practice, procedure used for the  
13 catheterization. But now he recalls he got some drops.

14 MR. McANDREWS: I am proffering to the Court on  
15 August 1989 he testified to exactly what he said this  
16 morning on deposition which I believe was subsequent to  
17 these.

18 MR. SALE: That would be my next point of  
19 questioning, Your Honor. But this was prior to the  
20 deposition.

21 THE COURT: What question other than that?

22 MR. SALE: That would be the only one on this  
23 issue.

1 THE COURT: It's your position if you ask him  
2 that question, that that rebuts his statement that he  
3 didn't see drops.

4 MR. SALE: That he did see drops.

5 THE COURT: I mean that he did see drops.

6 MR. SALE: Yes.

7 THE COURT: Okay.

8 MR. SALE: I will save the rest for rebuttal,  
9 Your Honor.

10 (The bench conference was concluded.)

11 BY MR. SALE:

12 Q Dr. DiPaola, I am going to have you look at  
13 question number 10 and ask you to read that for the  
14 benefit of the ladies and gentlemen of the jury. You said  
15 you didn't have any independent recollection, so I'm going  
16 to ask you if you saw that question, whether that's your  
17 answer.

18 A Number 10?

19 Q Yes.

20 A Shall I read this answer or the answer and the  
21 question in?

22 Q Yes. Read the question and your answer.

23 A "If the procedure, manner or circumstances under

1 which the aforementioned catheterization took place in any  
2 way deviated from the methods, practices and procedures  
3 normally used by employees of DiPaola, Harris and Goldberg  
4 or from standard medical practice in general, state with  
5 specificity what the differences were and any effect such  
6 differences may have had on the results, conclusions or  
7 accuracy of the catheterization." That's the question.

8 My answer: "I was not aware of the method,  
9 practice or procedures used for the catheterization."

10 Q When you gave that answer, were you referring to  
11 the catheterization done by Dr. Allen?

12 Would you like the rest of the document to help  
13 you with that?

14 A Could I look at that?

15 Q Certainly.

16 A It's too long ago. Ask your question again,  
17 please.

18 Q When you made that statement, your answer to  
19 number 10, were you referring to the catheterization done  
20 by Dr. Allen?

21 A Right at the moment I'm not sure. I can't even  
22 find that. Excuse me a second. The question said the  
23 aforementioned catheterization, and the aforementioned



1 catheterization was Dr. Allen's. So what I was saying was  
2 I was not aware of the method, practice or procedure used  
3 for the catheterization, meaning what the radiology  
4 procedure was I had no idea.

5 Q But you were referring to Dr. Allen's  
6 catheterization.

7 THE COURT: Yes, he was.

8 BY MR. SALE:

9 Q Okay. Now, you alluded earlier to the fact that  
10 your deposition was taken in that case. Do you still  
11 recall that?

12 A Yes.

13 Q Do you recall being asked about the production of  
14 urine in the deposition?

15 A Yes.

16 Q Do you recall what your answer was?

17 A I said I saw a few drops of fluid.

18 Q I'm going to ask you to look at the bracketed  
19 question at the bottom of page 100.

20 A Okay.

21 MR. McANDREWS: Your Honor, I would object.  
22 That's exactly what his deposition says. He has  
23 accurately recounted what his deposition testimony was.

1 THE COURT: I don't understand why you're asking  
2 him that.

3 MR. SALE: Your Honor, I would be able to show  
4 the bench what the question was.

5 THE COURT: You mean counsel cannot agree whether  
6 the answer says what it says or not. Either it says what  
7 it says or it doesn't. Does he say he saw drops or does  
8 he say that he did not see drops?

9 MR. SALE: It says not that I recall, Your Honor.

10 THE COURT: Would you please read the question  
11 and the answer and let the jury decide.

12 MR. SALE: Thank you.

13 A "Did you see urine withdrawn from the urinary  
14 bladder?"

15 "Not that I noticed. There was some moisture and  
16 some drops, but there was not any large volume."

17 BY MR. SALE:

18 Q Today you testified that you definitely recall  
19 that you saw drops; is that correct?

20 A Yes.

21 Q Was your recollection that definite when we took  
22 your deposition?

23 THE COURT: Are you proceeding to impeach him on

1 the basis of that prior answer?

2 MR. SALE: No. I have another question, Your  
3 Honor, that was asked.

4 A Would you ask that question again?

5 BY MR. SALE:

6 Q Was your recollection as definite on the day we  
7 took your deposition?

8 A Yes.

9 Q First of all, I'll ask you the date of that  
10 deposition.

11 A Thursday, August 10, 1989.

12 Q Does that comport with your recollection?

13 A Does what comport with my recollection?

14 MR. McANDREWS: Your Honor, we will stipulate  
15 that was the date of the deposition.

16 THE COURT: Okay.

17 Q Could you tell me -- could you read that question  
18 and answer where I don't believe it shows your  
19 recollection was quite as strong?

20 MR. McANDREWS: What page is this on?

21 MR. SALE: (Indicating.)

22 MR. McANDREWS: Go ahead, Doctor.

23 A This is what the question is worded.

1           "Okay. Best of your recollection, how much fluid  
2 was withdrawn when Dr. Allen catheterized Nicole Panousos?

3           "Answer: I think there was some drops in the  
4 catheter."

5           Q     So the most you saw were a couple or a few drops;  
6 was that correct?

7           A     Yes, sir.

8           Q     Did you confirm at the time that those drops were  
9 in fact from the bladder?

10          A     No, sir, I did not.

11          Q     Have you confirmed that since that time?

12          A     No, sir.

13          Q     Did you say that those drops could possibly have  
14 dripped out of the bladder previously?

15          A     I would not hazard any guess in the situation. I  
16 will speak to only what I'm sure of.

17          Q     Do you recall that you had mentioned that  
18 possibility at your deposition?

19               MR. McANDREWS: Once again, Your Honor, I want to  
20 object. He wasn't proffered as an expert in radiology,  
21 sonography or anything else. He was proffered as a  
22 witness who observed something. He testified to what he  
23 observed. They're asking him to speculate on what it was.

1 And that's not why he was proffered. That's not what he  
2 has testified to.

3 THE COURT: I understand that, but I don't think  
4 this goes to that issue. Go ahead.

5 MR. SALE: Your Honor, this is my last question.

6 THE COURT: All right.

7 BY MR. SALE:

8 Q Okay. I would ask you to read -- and for the  
9 fairness to the parties present, there were some  
10 objections to the question. If you could read the  
11 question and the objections and the answer for the people  
12 assembled here in the courtroom, the ladies and gentlemen  
13 of the jury. Thank you.

14 A Shall I read all this?

15 THE COURT: Do you want him to read the  
16 objections or can he pass over them?

17 MR. SALE: Your Honor, it's fine if he passes  
18 over them.

19 THE COURT: If you would read the question and  
20 then skip down to the answer, that would be sufficient.

21 BY MR. SALE:

22 Q Actually, we'll make it very easy. Just go ahead  
23 and read just the first question, first answer before we

1 get into all the objections.

2 No, I'm sorry. I didn't make myself clear.

3 A I know what you're saying. I just would like  
4 to --. You guys had fun with that one, didn't you?

5 "What are the other possible sources of fluid  
6 other than the urinary bladder?"

7 "Answer: There could be some fluid in the area  
8 dripping from the bladder, I guess. It is supposition. I  
9 don't know."

10 Next question: "You don't know any other  
11 possible sources?"

12 And the attorney said, "He's just said that.  
13 Next question."

14 You said, "No, he didn't say that."

15 And our lawyer said, "He did just say that."

16 And it goes on, continued for a while in the same  
17 vein.

18 Q You said one of the objections was posed by your  
19 lawyer; is that correct?

20 A Yes.

21 Q Did you see any other attorney who objected  
22 there?

23 A I didn't turn the page.

1 MR. McANDREWS: Your Honor, I object.

2 THE COURT: Sustained.

3 MR. SALE: Okay. I have no further questions.

4 THE COURT: Is there any redirect?

5 MR. McANDREWS: Just one question, Your Honor, if  
6 I may approach the witness.

7 THE COURT: All right.

8 REDIRECT-EXAMINATION

9 BY MR. McANDREWS:

10 Q Doctor, I've given you a transcript of the  
11 deposition Mr. Sale just gave you, and I highlighted the  
12 question right after the first one that Mr. Sale asked you  
13 to read. Would you read from page 100, line 21, through  
14 page 101, line 7?

15 MR. SALE: Your Honor, I would object. He's  
16 reading direct testimony. There's no impeachment or other  
17 proper purpose here.

18 THE COURT: Overruled. Go ahead.

19 A "Question: You actually saw moisture and drops?

20 "Answer: That I recollect, yes, because during  
21 our conversation -- during it we're talking about whether  
22 he was in or not in the bladder and whatever this large  
23 cyst was and the recollection was that there were some

1 drops in the catheter.

2 "Question: Would you have actually seen the  
3 drops in the catheter? Is that the basis for your  
4 recollection?

5 "Answer: Uh-huh."

6 Q Okay. The lighting in that room was sufficient?  
7 You could have seen that catheter?

8 A Yes, sir.

9 Q And that conversation mentioned is your  
10 conversation with Dr. Allen as he's inserting the catheter  
11 in Nicole?

12 A Yes.

13 MR. McANDREWS: That's all the questions I have,  
14 Your Honor.

15 THE COURT: Anything else?

16 MR. SALE: Yes. One question on redirect.

17 RECROSS EXAMINATION

18 BY MR. SALE:

19 Q The ultrasound room was kept very dark by Dr.  
20 Allen, wasn't it?

21 A Somewhat.

22 Q Somewhat or very?

23 A Somewhat.



1 Q Not very dark?

2 A You can't keep it completely dark because then  
3 you can't really see what you're doing. You keep it just  
4 dark enough to look at the scope.

5 MR. SALE: Thank you, Dr. DiPaola.

6 THE COURT: Okay. You may leave. Thank you.

7 (Witness excused.)

8 THE WITNESS: Am I --

9 THE COURT: Well, if we run into a difficulty, we  
10 will be back in touch with you. But you should go about  
11 your schedule as it normally is. If we run into a  
12 difficulty, we will seek to accommodate your schedule.

13 THE WITNESS: Thank you, Your Honor.

14 MR. GODARD: We would next call Dr. Bradley  
15 Rogers.

16 Whereupon,

17 BRADLEY RODGERS, M.D.,  
18 was called as a witness on behalf of the defendants, and  
19 after having been first duly sworn, was examined and  
20 testified as follows:

21 DIRECT EXAMINATION

22 BY MR. GODARD:

23 Q Good morning, sir. Let me call your attention to

1 the fact that I think that microphone swivels back and  
2 forth, if you need to adjust it to make you comfortable  
3 there.

4 Would you give us your full name and tell us your  
5 occupation?

6 A My name is Bradley Rodgers. And I'm a pediatric  
7 surgeon at the University of Virginia.

8 Q All right, sir. Do you hold any specific titles  
9 or positions at the University of Virginia?

10 A Well, I hold the title of professor of surgery in  
11 pediatrics, and I'm the chief of pediatric surgery at the  
12 University.

13 Q How long have you been chief of pediatric surgery  
14 at U-Va?

15 A Since 1981.

16 Q Would you tell us where and when you graduated  
17 from, first, undergrad. college and then progress forward  
18 and give us a brief resume of your general professional  
19 education?

20 A Yes. I think I can, the proper dates. I  
21 graduated from Dartmouth College in 1973 with a B.S. in  
22 biology.

23 Q And also magnum cum laude?

1       A     Yes, sir. And then I graduated from Dartmouth  
2     Medical School in 19 -- did I say '73? '63, wishful  
3     thinking. In 1964 I graduated from Dartmouth Medical  
4     School with a master's in medical science. In 1966 I  
5     graduated from Johns Hopkins Medical School with an M.D.  
6     degree. And then you want my past training.

7       Q     Then what did you do? Go into a residency  
8     program?

9       A     Then I trained in cardiac surgery and general  
10    surgery at Duke University Medical Center between the  
11    years of 1966 and 1973, serving for two years in that  
12    interval as assistant surgeon at the National Institutes  
13    of Health, Division of Cardiac Surgery.

14            In 1973 I served a year as chief resident in  
15    pediatric surgery at McGill University, Montreal  
16    Children's Hospital.

17            And then in 1974 I joined the faculty at the  
18    University of Florida as assistant professor of pediatric  
19    surgery in that institution.

20       Q     All right, sir. Did you ultimately become board  
21    certified in any of your specialties?

22       A     Yes. I currently hold board certification in  
23    general surgery, cardiothoracic surgery and what's called

1 a special certificate in pediatric surgery which is  
2 administered through the American Board of Surgery.

3 Q And are you also certified in critical care?

4 A Yes, sir. I hold the -- what's called a special  
5 certificate in critical care surgery which is administered  
6 by the American Board of Surgery.

7 Q All right, sir. Were you Phi Beta Kappa in your  
8 undergraduate days?

9 A Yes, I was.

10 Q And were you while in medical school elected to  
11 Alpha Omega Alpha?

12 A Yes, I was.

13 Q Could you tell us what that is?

14 A Alpha Omega Alpha is a medical honor society to  
15 which medical students are selected.

16 Q Sir, are you presently serving on the editorial  
17 boards of several national medical journals?

18 A I currently am serving on the editorial board of  
19 a national surgical journal entitled American Surgeon. I  
20 have served on the editorial boards of the Journal of  
21 Surgical Research.

22 Q Are you now or have you in the past served on the  
23 Advisory Council for Pediatric Surgery for the American

1 College of Surgeons?

2 A I have in the past. I've served two terms,  
3 actually, on the Advisory Council for Pediatric Surgery to  
4 the American College of Surgery which is the large  
5 national organization of surgeons. I'm not currently on  
6 that Advisory Council.

7 Q All right, sir. In the course of your 25 years  
8 since obtaining your M.D., have you had occasion to have  
9 works that you have authored published in the various  
10 medical journals in this country?

11 A Yes, sir, I have.

12 Q In fact, do some of those medical articles  
13 published total at least 107?

14 A At least 107, yes, sir.

15 Q Have you also been the author and/or coauthor of  
16 several sections or chapters of surgical textbooks  
17 published and circulated in this country?

18 A Yes, um-hum.

19 Q Including were you the author of the chapter in  
20 Problems in General Surgery published in 1984 by J. B.  
21 Lippencott and the section entitled Management of the  
22 Pediatric Patient Requiring Surgery?

23 A Yes, sir, I was.

1 Q And you published also in the Davis Christopher  
2 Textbook of Surgery?

3 A Yes.

4 Q And I believe there's about 14 different  
5 textbooks overall that you have authored sections or  
6 chapters in?

7 A I think that's correct.

8 Q In the course of your current practice and your  
9 position as chief of pediatric surgery at the University  
10 of Virginia, are you active in the performance of  
11 pediatric surgery?

12 A Very much so.

13 Q Are you active and experienced in evaluating  
14 infants with acute abdomens and making judgments  
15 concerning their candidacy for surgery?

16 A Very much so. It's an integral part of my  
17 practice.

18 Q Are you experienced and active in the  
19 postsurgical management of fluids and electrolytes in  
20 infants?

21 A Very much so.

22 Q And are you experienced and active in evaluating  
23 medical records and materials available and furnished to

1 you, including autopsy reports, for the purpose of  
2 formulating opinions and conclusions regarding causes of  
3 death in infants?

4 A I think so, yes, sir.

5 MR. GODARD: If Your Honor please, I would --

6 Q Well, before I do that, let me show you, if I  
7 may, Dr. Rodgers, what has been marked as Defendants'  
8 Exhibit 3 and just ask you if that is a copy of your  
9 curriculum vitae, including your list of publications and  
10 authorships.

11 A Yes. This is a copy of my curriculum.

12 MR. GODARD: If Your Honor please, I would  
13 proffer Dr. Rodgers as an expert in pediatric surgery, as  
14 an expert in the evaluation of pediatric candidates for  
15 surgery and in the postoperative management of fluids and  
16 electrolytes and of the cause of death in this case.

17 THE COURT: Is there any voir dire?

18 MR. SALE: Yes. Just a little bit.

19 VOIR DIRE EXAMINATION

20 BY MR. SALE:

21 Q Dr. Rodgers, are you a pediatric intensivist?

22 A Well, I hold the special certificate in surgical  
23 critical care which is the surgical equivalent of a

1     pediatric intensivist, that is correct.

2           Q     Have you ever served in pediatric intensive care  
3     postsurgery?

4           A     I've served as codirector of two pediatric  
5     intensive care units, one at the University of Florida and  
6     one at the University of Virginia.

7           MR. SALE: We have no objection.

8           THE COURT: We receive the testimony of this  
9     witness as an expert.

10          MR. GODARD: Thank you.

11                   DIRECT EXAMINATION (resumed)

12          BY MR. GODARD:

13          Q     Dr. Rodgers, do you know Dr. Robert Allen?

14          A     I do not.

15          Q     Have you ever even met him?

16          A     Not to my knowledge.

17          Q     Did there come a time when you were asked to  
18     review the medical records and certain materials  
19     pertaining to the medical treatment rendered to Nicole  
20     Panousos?

21          A     Yes, sir, I was.

22          Q     And did you in fact review the entire Fairfax  
23     Hospital record pertaining to her treatment?



1       A     Yes, I believe I've been supplied with the entire  
2     record from Fairfax Hospital.

3       Q     And have you in fact also reviewed the autopsy  
4     report that was provided with that record?

5       A     Yes, sir.

6       Q     Have you in addition to those records reviewed  
7     certain depositions and other materials?

8       A     Yes.

9       Q     Doctor, have you been able to formulate an  
10    opinion within reasonable medical certainty as to whether  
11    the failure of the radiologist to identify and drain the  
12    bladder presurgically in Nicole Panousos caused or  
13    contributed to her ultimate death?

14    A     Yes, sir.

15    Q     What is your opinion?

16    A     I don't think it had any impact at all on this  
17    case.

18    Q     Doctor, have you formulated an opinion as to  
19    whether the fact of her being taken to surgery on March 5,  
20    as opposed to that surgery being delayed for some 24  
21    hours, had any impact or cause or contributed to Nicole's  
22    ultimate death?

23    A     Yes, sir.

1 Q And what is your opinion?

2 A I think given her condition on the 5th of March,  
3 it would have been a mistake to postpone her surgery any  
4 further.

5 Q And Doctor, have you been -- perhaps I should ask  
6 you at this point, why do you say that? What's the basis  
7 for that opinion?

8 A Well, I think I tried to put myself in the place  
9 of the physicians caring for Nicole Panousos on the  
10 morning of her arrival to the hospital. They were clearly  
11 concerned about the degree of her abdominal distention and  
12 particularly the abdominal tenderness which accompanied  
13 that distention, which would lead a reasonable physician I  
14 think to believe that there was acute problem going on.

15 Q Doctor, from your review of the records, are you  
16 familiar with the findings made by Dr. Hodin at surgery  
17 and his actual performance of the surgery?

18 A Yes, sir.

19 Q Doctor, do you have an opinion within reasonable  
20 medical probability as to whether or not it would have  
21 been possible to successfully pass a catheter up the  
22 urethra and successfully drain the bladder prior to that  
23 surgery?

1 MR. SALE: Your Honor, I object. It's, first of  
2 all, to the form of the question. Secondly, the expert  
3 has not been identified as an expert as to  
4 catheterization.

5 THE COURT: With respect to the latter objection,  
6 I overrule it. And with respect to the first part of your  
7 objection, why in this question is it medical probability  
8 as opposed to medical certainty?

9 MR. GODARD: Well, I apologize. Sometimes some  
10 of us use those interchangeably, but I would modify the  
11 question to make it with reasonable medical certainty.

12 THE COURT: Come up.

13 (Counsel approached the bench and the following  
14 proceedings were held:)

15 MR. QUINN: This witness was deposed three times  
16 and testified at the medical malpractice review panel  
17 hearing. In their expert identification they limited him  
18 to the matters set forth in his de bene esse deposition at  
19 the medical malpractice review panel proceeding. We never  
20 questioned him on any other opinions he might have had in  
21 those three depositions and that testimony. Nowhere did  
22 any opinion come up about catheterizing the bladder,  
23 whether it would have been difficult or not. There are

1 identifications specifically limited to the medical  
2 malpractice review panel proceeding.

3 MR. GODARD: The question was part and parcel of  
4 the general proffer as to why it was appropriate for her  
5 to go to surgery. At his deposition taken by Mr. Quinn  
6 just a month ago, the doctor himself says that he will  
7 testify as to the appropriateness of the surgery. And  
8 this is simply part and parcel of that opinion. Mr. Quinn  
9 simply didn't ask him that question in his deposition.

10 MR. QUINN: Your Honor, he never testified to  
11 anything remotely close to this at the medical malpractice  
12 review panel hearing. In his de bene esse deposition he  
13 never testified to anything like this when we asked him  
14 what his opinions were in the three depositions we took of  
15 Dr. Rodgers. This is an entirely new issue, and they  
16 limited themselves to the testimony that he gave in the de  
17 bene esse deposition. This goes far beyond -- if Mr.  
18 Godard can show us something in the de bene esse  
19 deposition that refers to this issue, then I would agree.  
20 But he did not testify to this.

21 MR. GODARD: The de bene esse deposition wasn't  
22 taken and proffered by us. That was taken and proffered  
23 by Mr. Brandt in his representation of the surgical

1 defendant who is no longer in the case. The de bene  
2 esse -- therefore, I had nothing to do with the de bene  
3 esse. This is the discovery.

4 As Mr. McAndrews has pointed out, that's why Mr.  
5 Quinn wanted to redepose the doctor because he realized  
6 that he wasn't being proffered for the same purpose as he  
7 had been proffered at the review panel.

8 MR. QUINN: The de bene esse deposition was  
9 limited to those issues.

10 THE COURT: Let me ask you some questions. What  
11 are the surgical procedures performed on March 5th? What  
12 are you referring to in there?

13 MR. QUINN: It's in his de bene esse deposition.

14 THE COURT: What's that refer to?

15 MR. QUINN: The surgical procedures that Dr.  
16 Hodin performed, which was opening the baby up and  
17 thereafter. This witness has been more thoroughly deposed  
18 than any witness I think I have ever seen in any  
19 litigation, and he never ever mentioned anything about  
20 this opinion before. We assumed reasonably that his  
21 opinions were going to be based on the de bene esse  
22 deposition which simply said he couldn't tell the cause of  
23 death. He ruled out every conceivable cause of death

1 raised by the plaintiffs. It had nothing at all to do  
2 with this. He never mentioned one word about this. If  
3 you can show it in any of the depositions --

4 MR. GODARD: You didn't ask him the right  
5 question.

6 MR. QUINN: That's because you limited it.

7 THE COURT: What are you going to ask him?  
8 You're going to ask him about the catheterization, whether  
9 or not it would have been possible to --

10 MR. GODARD: Pass the catheter that Dr. Hodin  
11 passed at surgery, whether or not it would have been  
12 possible to pass that catheter before the abdomen was  
13 decompressed at surgery. The same question that I asked  
14 Dr. Hodin. And if they disputed that with Dr. Maron, Dr.  
15 Maron then came in and rendered the opinion that he didn't  
16 think it was possible. This is just countering Dr.  
17 Maron's opinion.

18 MR. QUINN: This was not an issue raised in the  
19 de bene esse deposition. It was limited to the cause of  
20 death. His testimony in the three depositions that were  
21 taken so far plus his de bene esse deposition has been  
22 limited to the cause of death. They told us it was going  
23 to be limited to what he has testified to in his de bene

1       esse deposition. This issue never came up. We never in a  
2       million years thought to question him about this. We have  
3       a right to question the witness. They made the statement.  
4       We relied on it. We didn't question it in this area. And  
5       it's extremely prejudicial to the plaintiffs to have this  
6       testimony come up for the first time from this very, very  
7       experienced witness who has been deposed three times.  
8       It's simply not fair to us. It's an unfair surprise. And  
9       they should be limited to the scope of their expert  
10      identification which was limited to the de bene esse  
11      deposition.

12               THE COURT: Where is the de bene esse deposition?

13               MR. QUINN: We have it. We have the entire de  
14      bene esse deposition.

15               THE COURT: How long is it?

16               MR. QUINN: It's 70 or 80 pages long.

17               MR. SALE: Which one?

18               MR. QUINN: The de bene esse deposition.

19               MR. SALE: Yes.

20               THE COURT: I'm going to put the burden on you to  
21      show me how this question is consistent with the de bene  
22      esse deposition.

23               MR. GODARD: May I just look at this for a

1 moment?

2 All right. Give me a moment.

3 MR. SALE: Your Honor, I proffer the original of  
4 the de bene esse deposition.

5 MR. GODARD: If Your Honor please, beginning on  
6 page 28, it goes on for several pages where Dr. Rodgers  
7 discusses the issue of the bladder; as the question at the  
8 bottom of the page indicates, whether or not the bladder  
9 had been called bladder would have made any difference.

10 THE COURT: Is there anything else before I rule?

11 MR. QUINN: He says here, it seems to me he's  
12 saying presuming she could have been catheterized before  
13 surgery.

14 MR. GODARD: Here on page 37 in the deposition,  
15 he talks about the standard of care not requiring  
16 preoperative catheterization.

17 THE COURT: Anything else?

18 MR. GODARD: That's all I can find at the moment.

19 THE COURT: I revise my ruling and sustain the  
20 objection.

21 MR. QUINN: Thank you, Your Honor.

22 MR. GODARD: Note my exception.

23 (The bench conference was concluded.)



1 BY MR. GODARD:

2 Q Doctor, do you have an opinion within reasonable  
3 medical certainty as to whether or not even had the  
4 bladder been identified and drained presurgically,  
5 emergency surgery would or would not nonetheless have been  
6 indicated?

7 A Well, I think it depends a great deal on how the  
8 child responded to bladder decompression. But the two  
9 things that physicians were worried about preoperatively  
10 were the degree of abdominal distention, which of course  
11 was bladder primarily, and the degree of abdominal  
12 tenderness. Once the bladder had been decompressed, the  
13 element of abdominal distention would have become much  
14 less prominent. In fact, it might have gone away  
15 completely, depending a little bit on how big the tumor  
16 was. And whether the element of abdominal tenderness went  
17 away or not I think is conjecture. If the abdominal  
18 tenderness did not go away after decompression of the  
19 bladder, then I think, as I've testified, it would be a  
20 mistake to postpone surgery.

21 Q All right, sir. Now, have you made an attempt in  
22 your review and evaluation of the records to yourself  
23 arrive at a conclusion as to the precise cause of Nicole's

1 cardiac arrest which led to her death?

2 A That's a very difficult question. I've been over  
3 and over these records many times. And one in a tragic  
4 situation like this would like to come up with some  
5 specific indicator that you could point to that was a  
6 cause of death or might show a sign that that was the  
7 cause of death. I don't think there's data here to  
8 support any particular cause of death over another.

9 The death, as I read it, from the records, was  
10 rather acute at the decompensation at about the hour of 8  
11 to 9 o'clock on the morning of the 6th. Things happened  
12 in a very big hurry, which tends to rule out some causes  
13 of death and tends to make you wonder about some other  
14 causes of death. As I put the whole record together, the  
15 demise is most reminiscent of a septic death, but there's  
16 no objective data here to support sepsis.

17 Q All right. I'm going to come back and ask you to  
18 delve into that a bit more, the possibility of septic  
19 death in just a moment. But first let me ask you  
20 specifically: Have you been able to form an opinion  
21 within reasonable medical certainty as to what role, if  
22 any, fluid overload and/or electrolyte imbalance  
23 contributed to the cardiac arrest?

1           A     Well, I think the data is fairly strong in terms  
2     of fluid and electrolyte balance, and I don't think there  
3     was any evidence that that played a significant role in  
4     the demise of this child.

5           Q     Doctor, from your review of the records, what was  
6     Nicole's general condition at the conclusion of the  
7     surgery at around 6:30 p.m. on the evening of March 5th?  
8     Was she in a stable condition?

9           A     I think she was -- the records would indicate she  
10    was in a stable condition, and I suspect that the surgeons  
11    felt that they had taken care of the problem and did not  
12    feel that she was in a life-threatening condition.

13          Q     Over the succeeding fourteen and a half hours  
14    that ensued before the ultimate cardiac arrest occurred on  
15    the morning of March 6, was there management of her fluids  
16    and electrolytes?

17          A     Was there management going on?

18          Q     Yes.

19          A     Yes. Oh, yes, there was.

20          Q     Now, let's go back at this moment to your  
21    evaluation of the autopsy report and what's in the medical  
22    records and your consideration of a septic cause of the  
23    death. Would you please elaborate on that and tell us,

1 first of all, what information were you able to derive  
2 from the autopsy report itself that was of assistance to  
3 you in your evaluation?

4 A Well, I think the autopsy is a particularly  
5 thorough autopsy and I think provides a great deal of help  
6 in trying to rule out certain causes of death. Sepsis is  
7 a condition that's caused by release of bacterial products  
8 into the blood stream. It's different from infection.  
9 Many of us have infections and don't get septic. But  
10 certain infections will release toxic products into the  
11 bloodstream and cause a cardiovascular collapse, which we  
12 term sepsis. Usually the septic death or septic episode  
13 is rather acute in onset, usually is associated with some  
14 signs of preceding infection, either an elevated  
15 temperature or an elevated white blood count, tenderness,  
16 cellulitis, redness, some sign that the patient has an  
17 infection that might lead to sepsis.

18 The autopsy in this particular instance indicates  
19 that there was no sign or no evidence of infection in the  
20 abdomen. Any time we have a septic problem  
21 postoperatively, the most immediate concern is whether  
22 there's an infection in the operative field, particularly  
23 in a case like this where the bowel had been opened and

1 the bowel is always contaminated with bacterial organisms.

2 There's no indication in the autopsy, and we'll  
3 presume there was no indication that there was an  
4 abdominal abscess or a sign of abdominal infection that  
5 might have led to sepsis. There were cultures taken of  
6 the urine and I believe of the blood in this child, and  
7 none of those cultures grew out any bacteria. She was on  
8 a lot of antibiotics which sometimes can suppress  
9 bacterial growth on culture.

10 Q Was the pathologist who reported the autopsy  
11 findings, did he report any specific cause of death or any  
12 identifiable cause of cardiac arrest? Would you like  
13 to --

14 A Let me review -- refer to the autopsy report  
15 itself.

16 I think my copy is paginated. You've got it.

17 Q Well, for expedition, I will let you look at that  
18 one. (Handing to witness.)

19 A I try to put myself in the position of the  
20 pathologist. I think the pathologist was as concerned as  
21 the clinicians were as to the exact cause of death in this  
22 child. And I think that in part accounts for the  
23 thoroughness of this autopsy report. I think they were

1 going to any extreme to try and figure out what the mode  
2 of death was. And that's extremely important in a young  
3 child who might have some illness that would be passed on  
4 to other children in the family. And so you don't want to  
5 miss what we call a congenital defect that might have  
6 caused death, unexpected death in this child.

7 The pathologist at the beginning lists all of  
8 their findings from the autopsy in a review type outline  
9 form; and really the only one that -- in here that might  
10 have led to a septic death was the first one, which they  
11 list as acute bronchopneumonia particularly in the left  
12 lower lobe, the lower part of the left lung. This, they  
13 go on to explain later on, is a very acute finding and  
14 probably is compatible with postoperative -- I'm sorry,  
15 postarrest changes in the lung. Her original X-rays did  
16 not show a left lower lobe pneumonia. But other than  
17 that, there was no sign of infection in the autopsy that  
18 might have accounted for a septic process.

19 Q So in short, in your opinion did this  
20 bronchopneumonia play any role in causing the cardiac  
21 arrest?

22 A I think this is all postarrest change.

23 Q All right.

1           Is there anything else in the autopsy that  
2 directly suggests a specific cause of the cardiac arrest?

3           A     Not that I can dig out of the autopsy. And I  
4 don't think they come up with a specific cause of death.

5           Q     All right, sir. Now, coming back to your stated  
6 opinion of a few moments ago that fluid overload and/or  
7 electrolytes played no role in causing the cardiac arrest,  
8 will you elaborate on that and tell us how and why you  
9 arrived at that conclusion?

10          A     Well, those are pretty complicated processes, and  
11 we probably should separate them into fluid overload and  
12 electrolytes.

13          Q     Let's do that.

14          A     Since they are interchangeably intertwined. And  
15 I think that the best place to do that is in the Intensive  
16 Care Unit records, which if you'll give me a second, I'll  
17 try and find the pertinent ones in my copy of the hospital  
18 chart. If we look at electrolytes first --

19          Q     Doctor, let me stop you long enough to suggest to  
20 you and to the Court that we have blowups of the very  
21 records that I think you are alluding to.

22          A     Okay.

23          Q     May I obtain those and show them to the doctor.

1 And if indeed these are the correct ones, we have an easel  
2 that we can put up here and allow you to step down.

3 THE WITNESS: May I step down?

4 THE COURT: Sure.

5 (The witness left the stand and went in front of  
6 the jury box.)

7 A I think we can illustrate it from this sheet  
8 which is -- on this copy is labeled 109.

9 This is a running cumulative collection of the  
10 laboratory studies that were obtained on Nicole Panousos,  
11 starting at 2 a.m. on 3/5, which I believe was probably  
12 her emergency room admission value, and running through  
13 the 7th.

14 And in this format the values that are abnormal  
15 are marked with an asterisk by the computer. The computer  
16 has a range of values which it accepts as normal.  
17 Anything out of that range it automatically marks with an  
18 asterisk.

19 But if one looks at her initial admission  
20 laboratory values, the electrolytes that we pay the most  
21 attention to are the first four here, the sodium, the  
22 potassium which is a K, the amount of chloride and the  
23 amount of bicarbonate in the blood. And electrolytes are



1 just chemicals that are in the blood that are necessary  
2 for normal cellular function.

3 And you can see that the most abnormal  
4 electrolyte here is the sodium, which is 131. The range  
5 of normal that they give for their laboratory is 136 to  
6 146. I would quibble a little bit with that in an infant  
7 of this age. These are adult normal ranges. And infants  
8 have a little bit of difference, and ordinarily we  
9 consider anything down to 132 as reasonably normal lower  
10 level. But nonetheless, this is a low level of sodium.

11 And this reflects given her clinical history,  
12 that she's lost sodium in her diarrhea and more likely in  
13 her vomiting. She loses excess amount of salt. Sodium is  
14 the major element of salt. And so she came in relatively  
15 salt depleted we would say. This is not a marked  
16 abnormality. But it certainly is an abnormality.

17 The potassium, chloride and CO2 are within what  
18 we'd consider normal ranges for a child of this age or  
19 even for an adult.

20 She was started on intravenous fluid therapy in  
21 the emergency room. It is recognized that she probably  
22 was dehydrated with this history. And by 8:50 or 8:30  
23 that morning, again on the 5th, her electrolytes are now

1 what I would consider in a normal range. Her sodium is  
2 still triggered by the computer as low, as 134. I would  
3 consider that normal for an infant of this age. But in  
4 any event, they have rehydrated her with the proper amount  
5 of salt in order to replenish the amount of sodium or salt  
6 in her body. Her other electrolytes, just sticking to the  
7 first four columns, are still normal. 3/5, 2000 hours --

8 Q Would be after the surgery?

9 A Is 8 o'clock p.m., I guess. Is postoperative.  
10 There are a lot of fluid shifts that go on with any  
11 operation. This particular operation I think lasted about  
12 four to four-and-a-half hours, and you can have any kinds  
13 of fluid shifts that you can imagine during the operation.  
14 And that's why they got a series of electrolytes right  
15 after the operation to sort of see where they stood with  
16 Nicole.

17 By this time her sodium is in the normal range.  
18 So the progression of her hydration and her replenishment  
19 of salt has gone along quite well and she's properly  
20 replenished.

21 Now, we have an abnormality in her potassium of  
22 2.9. And this is a significantly low potassium and  
23 probably reflects the fact that she was being given a lot

1 of fluids to rehydrate her that didn't have quite as much  
2 potassium as her body needed, and there are also potassium  
3 shifts that go along with dehydration.

4 But in any event, this would trigger the  
5 knowledge that this child needed to have potassium added  
6 to her I.V. at a higher level if there was already some in  
7 there or at least added if there was none in there at the  
8 time; and in fact, when we go back to the records, they  
9 did add potassium to her fluids at that point or maybe  
10 even a little earlier.

11 Her chloride, which is a funny I, is elevated at  
12 115 and probably reflects the fact that she was being  
13 given salt, sodium; and about the only way we have to give  
14 sodium is to lock it with chloride which is salt. And so  
15 she's been given a lot of sodium chloride to get her  
16 sodium up and in the process they have gotten her chloride  
17 up. And as far as we know, chloride of 115 is of no  
18 consequence to you. It's an abnormality. And it does  
19 affect your acid base status. It's a very complicated  
20 thing. It does affect your acid base status a little bit.  
21 And this number here, the bicarbonate of 15 would indicate  
22 she is slightly acidotic probably on the basis of her high  
23 chloride; that these two numbers are linked together just

1 the way the body handles chloride.

2 But in any event, the important number that I  
3 would fix on in this is the potassium of 2.9 which is a  
4 significantly low potassium for an infant of four months.  
5 And I would add potassium to the fluid, which they did.

6 Q Doctor, let me just stop you long enough to ask,  
7 when you refer to "they" doing this, who are the "they"?

8 A They globally, the physicians taking care of this  
9 child, the surgeons in the operating room,  
10 anesthesiologists in the operating room and surgeons and  
11 pediatric intensivists postoperatively.

12 Q Does the radiologist from your review of the  
13 record play any role?

14 A No, ordinarily the radiologist would not have  
15 anything to do with the fluid and electrolyte management  
16 of the child. This is the surgeon's responsibility and  
17 the intensivist, and that sort of depends on how those  
18 responsibilities are distributed in any given hospital.  
19 But the radiologist would have nothing to do with either  
20 writing the orders or expected to alter the fluid intake.

21 Q Let me ask you one other thing before you go on.  
22 The problems that you have pointed out postsurgically and  
23 the considerations that these caretakers had to have in

1 mind, are those usual or typical following a surgery like  
2 this or is there anything out of the ordinary about what's  
3 going on there?

4 A No. I think these are sort of the typical sorts  
5 of things, as I think I indicated earlier. They can go  
6 either way. You have a lot of fluid shifts in an  
7 operation of this magnitude that goes on for  
8 four-and-a-half hours, and they're going to continue to  
9 have a lot of fluid shifts for the first 8 or 12 hours  
10 just from the normal consequence of an abdominal  
11 operation. And so the physicians need to monitor these  
12 things on a regular basis until they look like they're  
13 stable and things are sort of settling out. So I wouldn't  
14 read any of this as anything particularly atypical for an  
15 abdominal operation on an infant of four months of age  
16 that lasted four to four-and-a-half hours.

17 Q From your review of the records did the  
18 physicians in fact continue to monitor these factors?

19 A Oh, yes. The record is clear on that. The  
20 fluids were changed. The nature of the I.V. fluids were  
21 changed in response to these blood draws. And I think  
22 they were right on top of it in terms of volume and  
23 electrolyte composition of the fluids that were being

1 administered to this child over this interval.

2 Q All right, sir. Tell us what ensued then over  
3 the succeeding hours.

4 A Well, I guess we had gotten to the 8:20 I.V.,  
5 which, as I said, I think the most remarkable thing to me  
6 or the element needing most attention is this potassium.  
7 These two will sort of fall in line with time.

8 And fluids were changed and potassium was added.  
9 And the electrolytes then were obtained again at 1 a.m. on  
10 the morning of the 6th. And you can see the potassium has  
11 been elevated into a more normal range. We'd be happy  
12 with anything in the 3.2 or above range, frankly, in an  
13 infant of this range.

14 The chloride is still up and probably still  
15 reflects the fact that she's getting salt, sodium chloride  
16 solutions. And the fact that her sodium is up and her  
17 chloride are up indicate that that's the case. The salt  
18 was then reduced in the amount of her I.V. fluids, and at  
19 5 a.m. they repeated this.

20 And this is the last electrolyte determination we  
21 have prior to her -- really prior to her demise. I think  
22 the cardiac arrest was basically the demise of Nicole  
23 Panousos. But this, let me get oriented here.

1           The 5 a.m. on 3/6 was the last prearrest  
2 electrolyte we have. The sodium is -- for all intents and  
3 purposes is normal. It's 1 higher than the adult computer  
4 normal value. But this is well within the range of error  
5 of the machine. The potassium, as I say, we would  
6 consider to be in an acceptable range. It is lower than  
7 the machine normal by 3.2, but that's a minimal reduction.  
8 Chloride is still a little high, and a factor bicarbonate  
9 is now in the normal range.

10           So I would have looked at these electrolytes at 5  
11 a.m. and I would have said, well, we made some progress.  
12 We still have to cut the amount of salt in her I.V. We've  
13 got plenty of sodium on board here and plenty of chloride  
14 on board, and I would have adjusted her I.V.s and been  
15 reasonably happy with that line of electrolytes. All the  
16 rest of these are really postarrest electrolytes. From 10  
17 a.m. on the 6th they're all postarrest electrolytes. And  
18 all kinds of things happen during an arrest, so it's hard  
19 to predict where they would go.

20           Q     So for all significant intents and purposes, just  
21 before the arrest, on the basis of these lab studies the  
22 electrolytes are essentially normal?

23           A     I don't think we can say they're normal. I mean

1 they are values that are outside of the normal range. The  
2 147 is a little bit higher than what we would accept as an  
3 absolute normal range. It's an insignificant amount  
4 higher. And the potassium is an insignificant amount  
5 lower. I think the electrolytes are an acceptable range  
6 at this point.

7 Q When you say insignificantly outside the normal,  
8 are they outside the normal enough to be a cause or  
9 contributing cause in the cardiac arrest in your opinion?

10 A No. No.

11 Q All right, sir. Shall we now turn our attention  
12 to the issue of whether or not she was fluid overloaded?

13 A Okay.

14 Q Do we have any records blown up here that assist  
15 you in discussing that issue?

16 A It's difficult because some of these are almost  
17 spread sheet type -- I need the one that has her urine.

18 These are labeled page 4 -- they're both labeled  
19 page 4.

20 The various ways we have to monitor a child or an  
21 infant's fluid status, there are a myriad of things that  
22 we look at to get an estimate of fluid status. One of the  
23 nice ways, if you have access to it, is body weight. If a



1 child loses a pint of fluid with diarrhea or vomiting, you  
2 can measure some changes in body weight. Unfortunately,  
3 in the postoperative period, we don't have access to that.  
4 There's so many things attached to the babies and so many  
5 things going on, that to get an accurate weight that would  
6 reflect how much weight the child has lost to give you an  
7 estimate of how much fluid you've lost is not possible.

8           The other things we look at are the vital signs.  
9 By vital signs we mean blood pressure and pulse basically;  
10 heart rate, respiratory rate plays a role in that. Those  
11 things can vary from all kinds of things, not just fluid  
12 status. If you're excited, your pulse will go up. If you  
13 are asleep, your pulse will go down. If you get excited,  
14 your blood pressure may go up or if you're nervous or  
15 whatever.

16           So all of the vital signs have to be interpreted  
17 in light of what's going on with the patient at that time.  
18 Is the patient in pain? Is he excited? Is he awake or  
19 asleep? The more objective things that we have are urine  
20 volume and urine specific gravity. How much fluid is this  
21 patient putting out of their body in the form of urine;  
22 and that is -- we use that to help guide our fluid intake,  
23 along with all the rest of these things. It's an amalgam

1 of information.

2 In this particular case I think some of the most  
3 helpful data comes from the urine output data, and this is  
4 part of the flow sheet. I think this must be an Intensive  
5 Care Unit flow sheet. But this is filled out by the  
6 nurses. And this child, of course, had a catheter by this  
7 time in her bladder so that the nurses could record on an  
8 hourly basis her urine volume and her urine specific  
9 gravity and other types -- how concentrated her urine was,  
10 all of which can sort of be plugged into the general  
11 Gestalt, almost, about the fluid management of this child.

12 This is from 3/5, the date of her surgery, and  
13 she was received from the recovery room to the Intensive  
14 Care Unit.

15 And the nurses record that she had, I'm not --  
16 225 is what I have interpreted it. It's a little unclear  
17 here. 225 cc.'s of urine in the bag when she arrived. So  
18 from the time the bag was last emptied, and we don't know  
19 exactly when that was she had put out 225 cc.'s of urine  
20 in the bag. And then they begin to watch it on a regular  
21 basis. We jump down here, two hours, and she put out 60  
22 cc.'s in this two-hour interval. The nurse would have  
23 emptied the bag here and then begin to calibrate how much

1 urine is put out in the bag, and two hours later she had  
2 put out 60 cc.'s of urine.

3 Well, then you have to go back to the size of the  
4 baby. This baby basically weighed 7 kilograms, 17-pound  
5 infant. She was a little more than 7.2 I think in the  
6 operative note. But basically it was -- for point of  
7 calculation was a 7-kilogram infant. And in the  
8 postoperative period we like to see an infant put out  
9 somewhere between 1 and a half cc.'s per kilogram per hour  
10 or 2 cc.'s per kilogram per hour. So in this child  
11 somewhere between 10, which would have been one and a half  
12 to rough it out or 15 which would be roughly two times  
13 their urine output. If they put out in that range, then  
14 we feel we're in reasonably good shape.

15 The urine specific gravity is a measure of how  
16 concentrated the urine is. When our body is dehydrated,  
17 it holds on to fluid. The kidneys hold on to fluid, and  
18 our urine becomes more concentrated, and the specific  
19 gravity may go up to 10. -- 1.030 would be a very high  
20 specific gravity. It would be an indication of  
21 dehydration. A normal specific gravity is somewhere in  
22 the range of 1.015 or below, in that range, which is an  
23 indication of relatively normal hydration.

1           So anyway, let's get back. She put out 30 cc.'s,  
2 roughly 30 cc.'s an hour in this first hour. So she's  
3 putting out good -- an excellent urine volume, in fact  
4 more than we would calculate, which again relates to her  
5 postoperative period. She gets a lot of fluid in the  
6 operating room to maintain everything. And we expect them  
7 to put out a lot more. We would be worried if this was  
8 below 15 cc.'s an hour. And so we're in good shape there.  
9 And the specific gravity indicates that this is relatively  
10 dilute urine. So she's well hydrated at this point.

11           We then go from 21 -- we drop down three hours,  
12 and her urine volume over this three-hour interval is  
13 listed as a hundred cc.'s. Roughly 30 cc.'s an hour. So  
14 her urine volume has remained relatively constant,  
15 somewhat more than we would calculate for her age, but we  
16 can get back to it. There are a lot of other things going  
17 on with this child. Her urine specific gravity is still  
18 in a reasonably normal range.

19           Q     Is she experiencing what has been termed  
20 postobstructive diuresis during this time?

21           A     I think she probably is right here. It's very  
22 hard to tell in this child whether she really had a  
23 postobstructive diuresis. We expect a bit of a diuresis

1 post -- immediately postoperatively frequently because of  
2 the fluids that are given in the OR. So if she had a  
3 postobstructive diuresis, it's quantitated right here.  
4 It's let's say double her calculated normal urine volume  
5 during this interval. So I can't say that she did not  
6 have a postobstructive diuresis. I can say that it was --  
7 if she had it, it was in this interval relatively short  
8 lived and relatively minor in terms of the extremes of the  
9 diuresis.

10 If we go on to the next date, it's a little  
11 different format. I guess it isn't. It's the same type  
12 of page. This is the 6th, the next day's running fluid  
13 volume. And the fluid volume from 12 p.m. on the 5th to 1  
14 p.m. on the 6th was 72 cc.'s. So she is still putting out  
15 more urine than we would expect. I suspect that this is  
16 the tail end of her postobstructive diuresis, the excess  
17 amount of fluid that you put out when in an unobstructed  
18 renal system.

19 Between 1 and 2 she is down to 20 cc.'s an hour,  
20 which is just about where you'd want to see her at this  
21 point. That's the upper limits of basal normal urine  
22 output, and we want a good urine output in this child. So  
23 from 2 a.m. right on down to 7 a.m., her urine volumes all

1 fell into what we would consider a normal or just very  
2 trivially elevated level. Certainly not too little urine,  
3 and pretty much exactly where we want her.

4 The urine specific gravities vary a modest amount  
5 in here from 1014 to 1011. All of these, as we said, are  
6 in the normal range. They don't indicate that she's got  
7 too much or too little fluid on board. She does have some  
8 sugar in her urine here, which will artificially elevate  
9 her urinary specific gravity when it's at that level. But  
10 her specific gravities are in pretty good order, I would  
11 say.

12 So looking at her urine output data, you would  
13 say this child was doing what you expect postop., was at a  
14 proper level of hydration postoperatively, and there's  
15 nothing in any of these numbers that would have alarmed me  
16 that we were either having too much fluid or too little  
17 fluid, which might be an indication we hadn't kept up with  
18 the little diuresis that she experienced for four or five  
19 hours postoperatively.

20 Q Now, did I cut you off?

21 A Well, we can go back to her vital sign.

22 Q All right. Let's do that. I was about to ask  
23 you if there were any other aspects of her clinical

1 condition that are monitored other than the intake and  
2 output.

3 A This is her ICU chart of her vital signs for the  
4 6th of March. I don't have the vital signs from the night  
5 before, but if we just look at the first 7 or 8 hours  
6 here, they're pretty reflective of the night before. And  
7 what -- these are all recorded by the nurse on an hourly  
8 basis. The child is on a monitor so that a lot of these  
9 numbers are derived directly from an electronic monitor.  
10 Some of them have to be derived from her own observations.

11 The first -- I don't know what this is. Oh, this  
12 is the overhead warmer to keep the child warm. We  
13 ordinarily, if their temperatures are at all low, which  
14 they usually are when they leave the operating room which  
15 is a cold environment, we tend to put them under a warmer  
16 to get their body temperature back up. The warmer was on  
17 up to it looks like 2 o'clock, and then it was turned off.  
18 Her temperatures the whole time are on the high side of  
19 normal and a little high. I usually use 101 degrees as my  
20 cutoff. Rectal temperature is a high temperature versus  
21 the high side of normal, and she was 101 or above, just  
22 over 101 for three hours here. And the rest were high.

23 Her heart rate is listed in here. In normal,

1 again, infants are different from adults. The normal  
2 heart rate for an infant, even in a basal environment, is  
3 going to be about 140 per minute as opposed to yours and  
4 mine that may be 60 or 80 per minute. They have a higher  
5 heart rate. And obviously, the temperature influences the  
6 heart rate. So these heart rates are all slightly higher  
7 than you would expect if they were just sleeping in their  
8 cot at home but not at all unusual for what we would  
9 expect in a postoperative infant.

10 This is the quality, what's called the quality of  
11 her heart rate. If you have irregular heartbeats, if for  
12 some reason you're throwing extra heartbeats in or your  
13 heart is just not functioning on a regular basis, which  
14 might be an indication for a problem, that would show up  
15 in here. And the nurses have recorded R, which is a  
16 symbol for regular heart rate.

17 Down in here, during her arrest, you can see they  
18 have labeled these irregular, which indicates that there  
19 was a problem with the heart rate down at that point.

20 This is the respiratory status. This child up  
21 until the point of her arrest at 8:20 or 8:30 that morning  
22 was on a ventilator. So this is not her own spontaneous  
23 respiratory rate. This is what she's being driven by by



1 the ventilator. She was still being breathed by a  
2 machine. Again, a fairly typical situation in a  
3 postoperative infant who's had a big abdominal operation.  
4 We normally would leave them on a ventilator until the  
5 next day. Just let them rest.

6 This child had been very irritable and had been  
7 awake for three or four days at home because of her  
8 discomfort. And we just want this child to rest  
9 postoperatively. So she is maintained on a ventilator  
10 during this status.

11 We move over to these columns. These are more  
12 nursing observation type things. These columns are blood  
13 pressure, and they measure blood pressure two different  
14 ways. There is an automatic machine that's on the  
15 patient's arm, and that's the first column, what's called  
16 a Dynamap. And that's just like you have your blood  
17 pressure taken in your physician's office. It blows up  
18 the cuff and listens to the noise.

19 And then in this child there was an artery line.  
20 A little, tiny I.V. catheter was put in the artery in her  
21 wrist so they could directly measure with a transducer her  
22 blood pressure. That's a little more accurate than the  
23 cuff pressure. And they were I think rightfully concerned

1 with -- during the operation, that this was a long  
2 operation and they needed to monitor and were going to  
3 have some fluid shifts and they needed to monitor her  
4 blood pressure.

5 But in any event -- and you need to remember or  
6 know that the blood pressure in an infant, a normal blood  
7 pressure is lower than it is for an adult. A normal adult  
8 blood pressure would be 120 over 80 if you were right  
9 perfect. In an infant the normal blood pressure would be  
10 about -- an infant of three months would be about 80 over  
11 60. So it generally tends to be a little lower blood  
12 pressure.

13 These blood pressures -- and if you look at the  
14 top number, we'll just concentrate on the arterial column  
15 here. The top numbers are all somewhere between 92 -- I  
16 guess 86 was the very lowest down here -- and the highest,  
17 I can't read that number, but somewhere up around 132,  
18 124. These blood pressures are slightly high for an  
19 infant of this age but probably reflect everything else  
20 that's going on.

21 There's indication in the nursing notes that the  
22 child on occasion was agitated. On several occasions pain  
23 medication was given, so the nurses felt she was

1 uncomfortable, which certainly would be expected. Infants  
2 certainly feel pain. So that I would have said that these  
3 blood pressures, although they vary over a modest range,  
4 are all perfectly consistent with what was going on in her  
5 postoperative course.

6 The next column over here that we'll pay  
7 attention to is what's called central venous pressure or  
8 CVP column. The CVP is an indirect measure of the volume  
9 of fluid in our vascular system. A single number of the  
10 CVP is not that helpful, but any trends in the CVP can be  
11 helpful if they're reliable.

12 The first two CVP numbers we got up here were 9.  
13 This is measured in centimeters of water or millimeters of  
14 mercury. And that's a normal CVP value for this child.  
15 So at least up to this point the numbers are absolutely  
16 normal.

17 We get down to this hour here of the hour of 5  
18 a.m. and 6 a.m. the CVP is 19. That's a high CVP for this  
19 child. The highest that you would expect in a child like  
20 this would probably be in the range of 12 to 15. Again,  
21 the absolute number doesn't help us that much but the  
22 trends do. But the fact that she has gone from 9 to 19  
23 would raise some eyebrows that that was a high value. And

1 so you'd look to see if there was something else going on.

2 The CVP in a child of this age is very difficult  
3 to measure. This is a small child, 7 kilograms in body  
4 weight. And the veins are very small, and the size of the  
5 catheter that you can put in the veins is very small. And  
6 so it's very difficult to keep those catheters  
7 functioning. They're really tiny. The lumen of a  
8 catheter that you would use in a child of 7 kilograms is  
9 probably one fifth of the size of the lumen of the  
10 catheter you use in a patient of my size. So it's smaller  
11 than a pencil lead, for instance.

12 So it's hard to keep the CVP working. And we can  
13 see from the nursing notes already at 2 a.m. there's a  
14 note here that said the CVP is positional. This is an  
15 indication that the CVP readings weren't constant, that  
16 the readings were jumping back and forth. And what we  
17 call the wave form, which is the pressure you are tracing  
18 that you measure on the CVP line, is very irregular. And  
19 that's usually an indication that the CVPs go inert or is  
20 going to die in an infant of this age. I mean it's just  
21 not going to function improperly.

22 Q You say "going to die." You mean the instrument  
23 is not going to be properly used?

1           A       Yeah, that the CVP catheter is not going to be  
2     able to be properly used as a pressure measuring device.  
3     We can still use it for an I.V. infusion. In a child of  
4     this age you don't have many veins. IVP lines are very  
5     precious too. So I'm sure they would still use it as an  
6     I.V. infusion port, but you would begin to worry about it  
7     in terms of its accuracy, in terms of its pressure  
8     measurement.

9                 In the next hour here which is 3 a.m., the next  
10    hour here is 2 a.m., there's a note that the CVP was  
11    checked by cardiopulmonary, and I presume that means  
12    cardiopulmonary technician. Most hospitals have  
13    technicians that run all this machinery and to keep them  
14    all working accurately. So the first thing the nurse  
15    thought is there's something wrong with the machine. And  
16    she called up somebody to check it. And then she says  
17    remains positional. So that even after the thing is  
18    checked, it's still positional and pretty variable. And I  
19    presume, I obviously wasn't the nurse, but there's no CVPs  
20    even recorded in these two hours. And it will probably  
21    mean that they just weren't getting any pressure at all  
22    during those two hours.

23                And then the next pressure that pops up is 19.

1 And that's at 500 hours, 5 a.m. And the nursing note  
2 indicates CVP recalibrated. Good wave form with patient  
3 on -- I think that's on left. And there are indications  
4 that they had to shift the position of the patient, get  
5 her on her left side in order to get any sort of wave form  
6 at all. So I think at this point you can pretty much  
7 reliably conclude that the CVP in terms of its usefulness  
8 for pressure measurement is gone.

9 Now, you can't do that willy-nilly. You've got  
10 to look at other things that are going on. Is there  
11 anything else about this baby that would suggest that  
12 their CVP is high? And there are other things you can  
13 look for. You can look for distention of the veins in the  
14 neck. If the veins are very distended, then maybe the CVP  
15 really is high here. Or if her vital signs have changed  
16 in any significant fashion, then maybe there is something  
17 going on and maybe you need to pay more attention to that  
18 number.

19 Q So were any of her other vital signs as recorded  
20 compatible with an actual CVP of 19?

21 A Well, I don't see any significant changes. Her  
22 pulse, which is a pretty good indication, if she has too  
23 much volume on board and her heart can't handle that

1 volume, usually the pulse will go up. This is not a  
2 significant change in her pulse. And certainly her pulse  
3 has ranged in that range the whole time. Her respiratory  
4 rate, as we said, is driven by the ventilator, so that's  
5 no help to us. She's not breathing harder, although the  
6 nurse's notes indicate that her lungs were clear, so they  
7 didn't hear any fluid in the lungs.

8 And her blood pressure here had -- I can't read  
9 this number right there. I think it's 124, but basically  
10 her blood pressures are in the same range they've been  
11 during that interval. So there's -- there's no  
12 corroborative evidence that there's a high CVP or excess  
13 fluid on board. And we've already seen her urine output  
14 was right at the same 17 cc.'s per kilo -- I mean 2 cc.'s  
15 per kilo per hour. So her kidneys aren't responding to a  
16 high CVP by putting out more fluid. Her heart is not  
17 responding by increasing her heart rate. Her blood  
18 pressure is not responding by dropping.

19 So I think it's reasonable. And we know we have  
20 had trouble with the CVP. I think it's reasonable to  
21 disregard that number. Very difficult number to rely on  
22 in a three-month-old infant. It's just the catheters are  
23 so small.

1 Q So putting all of those factors together, what is  
2 your conclusion to a reasonable medical certainty as to  
3 the state of Nicole Panousos's hydration as of just before  
4 the time she experienced her cardiac arrest?

5 A I think her hydration was right exactly where  
6 they wanted it. Her urine output was right where they  
7 wanted it. Her vital signs were right where they wanted  
8 them. And I would say that her hydration was right where  
9 we expect to put it at this point in her postoperative  
10 course.

11 Q So do you have an opinion within reasonable  
12 medical certainty as to whether or not her cardiac arrest  
13 was in any way related to her being overhydrated or  
14 overloaded with fluid?

15 A Absolutely not. There's no indication of that at  
16 all.

17 Q Are you familiar with the reports in the chart  
18 pertaining to chest X-rays that were taken postarrest?

19 A Postarrest, yes.

20 Q Yes. What did that X-ray show and in regard to  
21 the size of Nicole's heart?

22 A The postarrest X-ray, which I think was taken  
23 somewhere, correct me if I'm wrong, between the hours of



1 10 and 11 that morning, showed that the heart size was  
2 large.

3 Q What's the significance, if anything, of that?

4 A Well, it's hard to know. In terms of the  
5 significance of things leading up to the arrest, none. In  
6 terms of whether there really was signs of fluid overload  
7 on that X-ray, you'd have to see the X-ray and have a real  
8 professional radiologist read it. But this was taken with  
9 a portable X-ray machine, which notoriously increases the  
10 size of the heart size just because of the physics of how  
11 the machine works. And so most of us would not draw any  
12 conclusions with modest changes and visible heart size on  
13 a portable X-ray. Now, if the heart was three times the  
14 size, again, sort of any abnormal number, you would have  
15 to corroborate that with other data. But if the X-ray  
16 showed modest enlargement of the heart and it was a  
17 portable X-ray, we'd discount that.

18 The other thing is that during any arrest there  
19 are tremendous amounts of fluid given to the child, given  
20 to anybody. There are a lot of medications that have to  
21 be administered. When you remember that this child during  
22 the basal state required less than an ounce of fluid every  
23 hour, that was the most she would require for her basal

1 fluid requirements. And then during an arrest, there are  
2 ten different medicines that you have to give. There are  
3 I.V. drips that you have to start to stimulate her heart  
4 to keep going, and notoriously there's always excess fluid  
5 given during an arrest procedure, particularly in a small  
6 infant where the fluid volumes that we work with are so  
7 small.

8 And so I -- I -- without getting down and  
9 calculating the fluids, there's no question that she would  
10 have been given an excess amount of over 30 cc.'s during  
11 the arrest interval.

12 So she gets an excess amount of fluid and in  
13 fact, I think at 10 or 10:15 she was given a diuretic to  
14 try to get rid of some of that fluid. It was recognized  
15 that this child gets more fluid than she needs during an  
16 arrest just to get the medicines into her, and then they  
17 give her a diuretic which is a medicine that will make her  
18 pee out the excess fluid that she had. And she had a  
19 diuresis I think of about 370 or 350 cc.'s after the  
20 diuretic. So that's a big volume of urine for her but  
21 reflects the amount of fluid that she got during her  
22 cardiac arrest.

23 Q And so that which is seen on that chest X-ray and

1 that which is reported by the radiologist as being  
2 slightly or somewhat, whichever terminology you used,  
3 enlarged heart, do you attribute that, first of all, as  
4 being an accurate reflection that her heart was actually  
5 enlarged at that point?

6 A Well, I'd have to see the X-ray and go over it  
7 with a radiologist that knew the clinical situation. So  
8 it's hard for me to speculate too much. But if the  
9 official reading was mild or moderate enlargement, which  
10 I've forgotten the words they used, I would not put much  
11 credence to that in that setting.

12 Q All right. And if in fact it is somewhat  
13 enlarged, to what in summary would you attribute that  
14 enlargement at that point in time?

15 A To the fluids she had during the resuscitation.

16 Q Does that suggest that that was a cause of her  
17 cardiac arrest?

18 A No. That's all postarrest. All indications are  
19 that she is well hydrated and certainly not over hydrated  
20 prearrest. And we know from experience that a lot of  
21 fluids are given during the arrest. So that any fluid  
22 overload is a consequence of those fluids that are given  
23 during the arrest period.

1           Q     What I think is a final question regarding these  
2 charts, given all of these factors that you outlined were  
3 part of the consideration for these hours between her  
4 surgery and that 14 hours up to the time of her arrest  
5 that morning, given all of those factors, did any of that  
6 or the combination of all of that make her fluid and/or  
7 her electrolyte management impossible?

8           A     Oh, certainly not impossible. I mean I think her  
9 fluid and electrolyte management was basically that of a  
10 postoperative infant. I don't think -- I mean I don't see  
11 anything in here that made anything more difficult or less  
12 difficult. It's an hour-by-hour process that things are  
13 readjusted.

14          Q     All right. Thank you, Doctor. Now I think you  
15 can return to the stand and we'll wrap up.

16                 (The witness resumed the stand.)

17           THE COURT: Let's take a 15-minute break.

18           MR. GODARD: All right, sir.

19           THE COURT: Please don't discuss the case. You  
20 may go downstairs, if you like.

21                 (A short recess was taken.)

22           THE COURT: Okay. Go ahead.

23           BY MR. GODARD:

1 Q Dr. Rodgers, essentially in conclusion, is there  
2 anything else you can tell us that would enlighten us at  
3 all as to the cause of Nicole Panousos's death?

4 A Well, I don't -- as I stated earlier, I don't  
5 think I have the answer to it. I think we have a lot of  
6 useful negative information, if you will, and I think any  
7 time that you have an unexplained death, particularly  
8 perhaps in my practice an unexplained postoperative death,  
9 the things that you need to sort of run through and to  
10 search through the chart for include breathing  
11 difficulties or airway problems.

12 This child had normal blood gases recorded up  
13 until within a couple of hours of her arrest throughout  
14 the whole postoperative course; in fact, was improving in  
15 her respiratory status during that interval. We have been  
16 over cardiovascular signs. And I don't find any  
17 indication from the records that she was in cardiac  
18 failure. This is not the sort of arrest that you would  
19 expect from cardiac failure, or that she was fluid  
20 overloaded or underloaded. I think she was maintained in  
21 a reasonable range fluidwise.

22 Metabolically, were there metabolic derangements,  
23 I think we have pretty good laboratory values throughout,

1 and although there were some values that were slightly  
2 higher and some slightly lower from a perfectly normal  
3 range, there are certainly no laboratory values that were  
4 severely deranged enough to explain a sudden cardiac  
5 event.

6 Abdominal problems, her abdomen was described as  
7 soft.

8 Neurologic problems, she was awake and alert and  
9 appropriately responsive during the postoperative period.

10 And then infectious problems, which are  
11 frequently the hardest to document, and as I've stated  
12 before, I think her arrest is most reminiscent of a sudden  
13 septic event, but I don't have a good focus for that  
14 sepsis with the possible exception of her lungs. So I  
15 don't know. Very troublesome, but I don't know exactly  
16 why she arrested.

17 MR. GODARD: Thank you, Doctor.

18 THE COURT: You may cross-exam.

19 MR. SALE: Thank you, Your Honor.

20 CROSS-EXAMINATION

21 BY MR. SALE:

22 Q Hello, Dr. Rodgers. You may recall we have  
23 spoken before. I'm counsel for the plaintiffs in this

1 case.

2 A Yes, sir.

3 Q Dr. Rodgers, you initially represented a  
4 different party in this case; is that accurate?

5 A That's correct.

6 Q Do you recall who that was?

7 A I was initially contacted to review the records  
8 for -- with relationship to Dr. Hodin's participation in  
9 this case, that's correct.

10 Q Did you find any violation of the standard of  
11 care by Dr. Hodin?

12 A In this case?

13 Q Yes.

14 A I did not, no.

15 Q Who were you second called to review this case  
16 for?

17 A Well, I think I have currently been asked to  
18 review the case in terms of the impact that the  
19 misdiagnosis from ultrasound had on the total case. So I  
20 guess in that respect for Dr. Allen.

21 Q Okay. At an intermediate time, were you asked to  
22 evaluate the case by the hospital?

23 A Well, to tell you the truth, I got lost in the

1 middle of the whole case. I could well have been. I have  
2 been contacted by several people about this case since my  
3 original deposition which was for the behalf of Dr. Hodin.

4 Q Do you recall being contacted by counsel for the  
5 hospital?

6 A If you could tell me their names, I might --

7 Q John McIntosh, Crews & Hancock?

8 A McIntosh is a familiar name. I think they  
9 probably did contact me in the interval.

10 Q Did you agree to evaluate the case for them?

11 A Well, I had already evaluated the case in some  
12 detail for Dr. Hodin. And I felt that there was no breach  
13 of the standard of care either on the part of Dr. Hodin or  
14 on the part of the hospital personnel which basically were  
15 the intensive care personnel. So in that respect I agreed  
16 to basically reiterate the testimony I had given on Dr.  
17 Hodin's behalf.

18 Q Has that testimony changed in any respect?

19 A My testimony about the whole case?

20 Q About Dr. Hodin or the hospital?

21 A I don't think so.

22 Q Now, Doctor, can you tell me what are the most  
23 important indicators of hydration status?



1           A       I can tell you the indicators that we look at in  
2 terms of hydration status. To tell you one is more  
3 important than the other I don't think I would do. I  
4 think they're all important, and they're all sort of taken  
5 in the context of any given patient. And I think I  
6 reviewed those earlier for the jury.

7                       But the things that you look at are first and  
8 foremost the physical examination. Is there any  
9 indication on physical examination that there is  
10 overhydration in this infant? And the things on the  
11 physical examination that are most obvious are distention  
12 of the neck veins, which are the ones that are most  
13 superficial and relatively easy to see, and enlargement of  
14 the liver. When fluid backs up in the heart, the liver  
15 tends to enlarge very quickly actually in a  
16 three-month-old infant. So that those would be the  
17 physical examination findings that I would particularly  
18 look for.

19                      And then one would look for changes in the vital  
20 signs with fluid overhydration. One would ordinarily  
21 expect an increase in the blood pressure until the heart  
22 failed. And then would might see a fall in the blood  
23 pressure. You would see an increase in the heart rate

1 until the heart failed.

2 And then I would look at changes in respiratory  
3 rate, if they were available to us, as an indication of  
4 whether there was fluid backing up in the lungs or changes  
5 in respiratory pattern.

6 And then I'd look at CVP as an indication of the  
7 volume status of the patient.

8 And then I would look at laboratory values, what  
9 laboratory values we have available. The blood gases are  
10 sometimes helpful to indicate whether there's fluid in the  
11 lungs and interfering with lung function. Serum  
12 electrolytes are sometimes helpful. Urinary kidney  
13 function studies are sometimes helpful.

14 So there's a whole amalgam, if you will, of  
15 information that we try and look for. We don't always  
16 have all that data. But we try and get as much of it as  
17 possible.

18 Q Doctor, aren't urine specific gravity, urine  
19 output and CVP the most important indicators of hydration  
20 status?

21 A No. I don't -- CVP is certainly not the most  
22 important indicator. The absolute number of CVP is  
23 almost -- almost worthless unless it's really wildly

1 elevated or zero. Urine output is an important indicator.  
2 It certainly would be one I'd want to look at. I don't  
3 think I can tell you that one of these values or one of  
4 these observations is the most important observation. I  
5 wouldn't want to do it without as many as I could get.

6 Q Doctor, do you remember ever telling me that you  
7 thought the three most important parameters that we look  
8 at in the order of importance probably are urine volume,  
9 urine specific gravity and central venous pressure?

10 A I doubt if I put those in order of importance.  
11 But if you have got them there, I'll --

12 Q Well, I'd prefer that you look at your own  
13 testimony, because I would hate to misquote it.

14 MR. GODARD: Which deposition?

15 MR. SALE: Page 11.

16 Q First of all, Doctor, if you can look at -- I ask  
17 you to keep it open to page 11.

18 Q Can you tell me when was that taken?

19 A This was taken on May 7, 1990, which would have  
20 been the -- I guess the deposition prior to the review  
21 panel.

22 Q Well, can you look at the inside cover again and  
23 see if that was a discovery deposition or a testimonial

1 deposition, meaning it was presented to the review panel?

2 A Well, I didn't appear before the review panel.  
3 My videotape of my deposition was shown to the -- I guess  
4 shown to the review panel. I don't even know that for  
5 sure.

6 THE COURT: Excuse me. Why don't you just tell  
7 him. He may not be familiar with the procedures. So just  
8 tell him. If they object, they'll stand up and so forth.  
9 It was a what? A deposition what?

10 MR. SALE: Thank you. Yes, Your Honor.

11 THE COURT: Finish the sentence.

12 BY MR. SALE:

13 Q Yes. This is your deposition from the videotape,  
14 is that correct? At 8 p.m. in the evening is when they  
15 did the videotape?

16 A I guess this is a typed version of what I said on  
17 the videotape, yes.

18 Q Okay. Now, if I could have you refer to page 11.  
19 If you could tell me at that time what you said were the  
20 three primary indicators of hydration status.

21 A All right. Can I go back? Because of lot of  
22 these things taken out of context are sometimes hard to  
23 evaluate. And if you'll give me a minute and let me sort

1 of get back into the context of your questioning.

2 Q I'd be happy to do that, Dr. Rodgers.

3 A Yeah. See, if we could go back to page 10 of  
4 that, just the page before that, the question which had  
5 been asked to me in the third paragraph there is: "Are  
6 there any particular areas that you investigated to try  
7 and determine the answer to the reason for her cardiac  
8 arrest?" More or less what we've been through this  
9 morning.

10 My answer to that question is: "Well" -- I will  
11 read this, if I might. "Well, I've -- if I may get up to  
12 the board, I've put four areas that I think are important  
13 on the board and I've tried to abstract some of the  
14 information that we have about each of these areas. I  
15 think anytime that we have an unexpected death in a  
16 postoperative patient, the four most important things that  
17 we consider are illustrated here under these four general  
18 categories." And I had written them on the board. "I  
19 think there's always a question of hydration and certainly  
20 been a question in this case as to whether this child was  
21 properly hydrated. There's a question of electrolyte  
22 replacement and whether the electrolytes are in proper  
23 order and this has certainly been a question in the

1 Panousos case. I think sepsis always has to be  
2 considered. It's sometimes a difficult diagnosis to rule  
3 out antemortem," before death, "but it has to be  
4 considered and the signs of sepsis have to be considered.  
5 And lastly, I think any child on a ventilator, any small  
6 infant on a ventilator who has a sudden unexpected cardiac  
7 event has to be considered as a potential victim of a  
8 pneumothorax," which is air in the chest.

9 Your response or somebody's response to the next  
10 question of me was: "Would you please take each one of  
11 those possibilities that you reviewed and discuss them and  
12 use the board, please, if necessary and please explain to  
13 us why you were unable to conclude that that particular  
14 basic characteristic was responsible for the cardiac  
15 arrest in this case?"

16 And my answer was: "I'll try and take these one  
17 at a time and what I have done here in these two areas is  
18 to try and abstract information that's available to us in  
19 the chart, principally from the laboratory and from the  
20 intensive care unit records. And it seems to me that we  
21 need to look at the seven or eight hours immediately  
22 preceding this demise and see if there are clues in that  
23 interval that can tell us why this child suffered a

1 cardiac arrest and all of the consequences after that  
2 arrest."

3 And this is the section that you have marked.  
4 "If you think of the hydration of an infant and whether  
5 you have overly hydrated or under hydrated this infant, I  
6 think the three most important parameters that we look at  
7 in the order of importance probably are urine volume,  
8 urine specific gravity, and central venous pressure. It  
9 so happens in this case that we have access to data from  
10 all three of those, although many times we do not."

11 So I am focusing on the volume aspect of that. I  
12 think those are certainly three most important parameters,  
13 and I guess I did say that they are the most important  
14 parameters that we look at in the order of importance.

15 Q Now, going into surgery, you didn't have any  
16 information at all on urine specific gravity or urine  
17 output; is that correct?

18 A That's correct. We had some information that she  
19 had had no urine output.

20 Q Two of those indicators were actually missing  
21 presurgery, two of the three that you mentioned there.

22 A Correct.

23 Q Now, let's go to the postsurgical period.

1 Doctor, during a postobstructive diuresis, is urine output  
2 a reliable indicator of hydration status?

3 A Well, urine output alone, no, would no longer be  
4 a reliable indicator as long as the diuretic phase was in  
5 place. Diuresis implies more or less fixed high urine  
6 output. And so that would not -- that sort of eliminates  
7 that as a possibility. Again, I keep coming back to the  
8 many other aspects of things that we look at. But urine  
9 volume becomes difficult to interpret.

10 Q In that situation is urine volume more reflective  
11 of the relief of the obstruction than it is of the  
12 hydration status?

13 A Well, it's hard to say. As I think I indicated  
14 earlier, it's hard to say whether this increased -- mild  
15 increase of urine output which was experienced for I  
16 believe five hours postoperatively in this infant was in  
17 truth a postobstructive diuresis. I think we made  
18 probably too much of this postobstructive diuresis. It's  
19 a very variable phenomenon. Some people get it; some  
20 don't. Some get it real bad; some don't.

21 If this was a postobstructive diuresis, it was  
22 very mild. Her urine output was twice what we would have  
23 calculated it to be under basal conditions, under



1 perfectly normal resting conditions. We know that she  
2 gets a lot of fluid intraoperatively, and we know that we  
3 are going to expect fluid shifts postoperatively. The  
4 important thing is to watch the urine output and to keep  
5 up with it in terms of your fluid management. Not so much  
6 with the etiology necessarily of the 30 cc.'s an hour  
7 being a little bit more than normal is, but to keep up  
8 with that and keep it in your mind in terms of fluid  
9 replacement.

10 Q When you say it's hard to say whether Nicole  
11 truly had a diuresis, are you telling me you have no  
12 opinion whether or not she had a diuresis?

13 A She had a diuresis in the strictest sense of the  
14 word in that she put out more urine than her basal urine  
15 output would have been for that five-hour interval.  
16 Whether that was postobstructive diuresis or postsurgical  
17 diuresis, I can't tell you.

18 Q Okay. And certainly during the period of the  
19 diuresis, the urine output didn't tell you anything about  
20 her hydration status; is that accurate?

21 A I think so. Urine output in itself, that's  
22 right.

23 Q Now, Doctor, during a diuretic phase is specific

1 gravity of the urine a reliable hydration indicator?

2 A Well, ordinarily in a postobstructive diuresis,  
3 you would expect a fixed specific gravity. This is a  
4 mandatory diuresis or mandatory urine output. And  
5 ordinarily the specific gravity is fixed and it's usually  
6 fixed in a relatively low number, something below 10, 15.  
7 In this case there's quite a variability of her urinary  
8 specific gravity which I think, if anything, speaks  
9 against this being a postobstructive diuresis. But --.

10 Q You indicated some other reasons, though, why the  
11 urine specific gravity was possibly beyond a normal range,  
12 didn't you? Didn't you mention, for example, sugar?

13 A Yes. She has -- certainly by I think 1 o'clock  
14 on the 6th, there's glucose in her urine, which will  
15 elevate her urinary specific gravity in itself.

16 Q She had some blood in her urine too; right?

17 A Yeah. Blood will have very little effect on  
18 specific gravity. It's a very big molecule and doesn't  
19 have that much of an effect.

20 Q It will have some effect.

21 A I would guess trivial, if any.

22 Q Doctor, wasn't Nicole's potassium abnormality the  
23 most significant of all of her electrolytes?

1           A     I think so. I think of all the ones up until the  
2 point of her arrest, that was the most significant.

3           Q     Doctor, you testified that you don't know the  
4 cause of Nicole's death. Is that accurate?

5           A     That's correct.

6           Q     And you eliminated all the four suspects which  
7 would have been the normal primary suspects.

8           A     To eliminate them is probably a little too  
9 strong. There's no objective evidence to support any of  
10 the four primary suspects in this case.

11          Q     All right. Well, I understand in medicine we  
12 can't be totally certain. You gave your opinions to a  
13 reasonable degree of medical certainty eliminating each of  
14 those four suspects; is that correct?

15          A     I think so.

16          Q     Doctor, I want you to refer to a document that  
17 I'm going to show you here, which I'll tell you is the  
18 X-ray of Nicole at the time she first went to radiology,  
19 and ask you if you've ever seen this document before,  
20 which I would now mark for identification as Plaintiff's  
21 Exhibit No. 21.

22                (The X-ray was marked Plaintiff's Exhibit No. 21  
23 for identification.)

1 Have you seen that document before?

2 A I think so. I think this is in the hospital  
3 record.

4 Q Does that document tell you what the mass in  
5 Nicole's abdomen is expected to be based upon the first  
6 X-ray?

7 A Well, I don't know whether the jury has access to  
8 this or not. But these are the original X-rays that were  
9 obtained on Nicole when she came in on the 5th. The exact  
10 time of the X-rays is not stated on this. But the first  
11 is a flat and an erect abdomen and chest, belly and chest  
12 X-ray. And it says this is done in a six-month old infant  
13 with abdominal distention. The examination shows the  
14 chest to be normal. There is a distended abdomen with  
15 what appears to be a large, central, mid and lower  
16 abdominal pelvic mass. This would appear to be at least  
17 ten centimeters in diameter and appears to be reasonably  
18 central in location, in the middle of the abdomen, as  
19 judged by displacement of the bowel gas of which there is  
20 relatively little, however.

21 No bony abnormalities are noted. No abnormal  
22 calcifications are identified. The impression from that  
23 X-ray is there's a large central lower abdominal and

1 pelvic mass in the girl. Leading possibilities would be  
2 ovarian or hematocolpos. Hematocolpos is an accumulation  
3 of blood and mucous in the uterus in an infant child that  
4 may not have a completely open hymen. Of course, this  
5 could represent a large bladder, which would be unusual in  
6 a girl. And ultrasound is suggested for evaluation. So  
7 they suggest on the basis of the plane film -- and I don't  
8 know what these films are available; we might take a look  
9 at them -- three separate diagnoses.

10 Q Okay. I don't think we'll need to look at the  
11 film because further testing was done.

12 Do you recall today whether the diagnosis in the  
13 first X-ray report as to the mass was confirmed or changed  
14 by the report on radiology?

15 A On ultrasound?

16 Q Yes, on ultrasound?

17 A The ultrasound -- do you have that report maybe?

18 Q Sure.

19 A Could you tell me what page? I think mine is  
20 paginated.

21 MR. GODARD: Let me just hand you this.

22 BY MR. SALE:

23 Q Okay. Is the first X-ray, is that confirmed or

1 changed by the report on radiology?

2 A Well, I think --

3 Q Sonography.

4 A -- that the ultrasound confirmed the presence.  
5 It showed several things. We might just go down from a  
6 surgeon's standpoint of what the ultrasound showed. It  
7 confirmed the presence of a mass in the pelvis or the  
8 abdomen. The impression here on the ultrasound is very  
9 large unilocular -- which means just one locule, not a  
10 bunch of separate cysts -- unilocular cyst filling the  
11 abdomen, probably compressing the ureters with some  
12 fullness to the upper urinary tract. An ovarian cyst or  
13 mesenteric cyst would be the most likely possibilities.  
14 No retroperitoneal abnormalities are noted.

15 So the ultrasound showed the surgeon that he  
16 indeed was dealing with a pelvic mass, a lower abdomen or  
17 pelvic mass; that it was a cystic mass, and that puts us  
18 in a whole different group of diagnostic possibilities.  
19 And the suggestion was that this might be an ovarian or  
20 mesenteric cyst, either one of which would have been a  
21 fairly acceptable or reasonably common -- common is not  
22 the right word to say -- but a reasonably common diagnosis  
23 in this age child. So I guess the ultrasound led more

1 away from the bladder and more toward the ovary or  
2 introduced a new possibility of mesenteric cyst.

3 Q Doctor, based on what was found in ultrasound  
4 here, Nicole -- I'm sorry. Based on what was actually  
5 found in surgery here, did Nicole require emergency  
6 surgery?

7 A Wait a minute.

8 Q I am moving beyond this report and going to  
9 surgery. And based upon the findings in surgery, was  
10 emergency surgery required?

11 A I can't tell you that. As I stated a little bit  
12 ago --

13 THE COURT: Let me interrupt just for a second.  
14 I didn't understand your question. Would you ask it once  
15 more?

16 MR. SALE: Yes, I would be happy, Your Honor.

17 BY MR. SALE:

18 Q Based on the findings in surgery, I am beyond the  
19 ultrasound report --

20 A Correct.

21 Q Based on the findings in surgery, was the  
22 emergency surgery required in this case?

23 A I can't tell you that because emergency -- the

1 urgency or emergency of the surgery would have depended on  
2 her clinical symptoms as much as anything else which bear  
3 no resemblance to the anatomic problems that we had. And  
4 I've said before, if the bladder had been drained  
5 preoperatively and if that completely eliminated her  
6 abdominal tenderness, then would one could have taken  
7 another day to reassess where the residual cyst was. If  
8 the tenderness was still there, emergency surgery, if you  
9 will, would have been required.

10 Q So if the tenderness had been relieved by  
11 draining the bladder, emergency surgery was not required.

12 A I don't know whether the tenderness would have  
13 been relieved by draining the bladder. I don't know.  
14 See, those are questions I can't answer.

15 Q I am posing a hypothetical. You are an expert.

16 A But if I look back then with a retrospectoscope  
17 and if I could have guessed that relieving the bladder  
18 would have relieved all her abdominal tenderness, then I  
19 would have sent her back down for another ultrasound and  
20 we would have seen another cyst behind what had been this  
21 big cyst and then I would have gotten some other X-ray  
22 studies if she was perfectly normal once we had relieved  
23 the bladder distention.



1           Q     Doctor, would you do elective surgery as opposed  
2     to emergency surgery on a child that had been on Pedialyte  
3     for the two preceding days?

4           A     Well, when we operate on children, we have to put  
5     up with a certain amount of colds and diarrhea and  
6     everything else or we would never get anything done from  
7     the months of October to March. And so it's hard to say  
8     that somebody had been on Pedialyte. If a child came in  
9     let's say for an elective herniorrhaphy, to repair a  
10    hernia, which is one of the more common operations we do,  
11    and had diarrhea, been on Pedialyte but looked fine and  
12    was well hydrated, I would go ahead with the operation.  
13    If she looked like she was dehydrated or was having  
14    tremendous problems keeping Pedialyte down, I would not do  
15    elective surgery. So you have to sort of individualize  
16    these cases. The presence of diarrhea and the presence of  
17    Pedialyte ingestion in itself would not deter us from  
18    doing elective surgery on an infant of this size.

19          Q     Now, if she had been sick enough that all she  
20    could have was Pedialyte for two days, would you go  
21    forward with elective surgery?

22          A     Again, I'd have to look at the patient. Probably  
23    not. If she had been sick enough that she needed just

1     Pedialyte for two days, I probably wouldn't. But you  
2     would have to sort of look at the patient and make that  
3     decision.

4         Q     Now, Doctor, when you go into surgery, and you  
5     receive a report from ultrasound before you go in, do you  
6     expect the radiologist to tell you if he finds that the  
7     bladder is full?

8         A     I don't ordinarily get a report from the  
9     radiologist that the bladder is full. As a matter of  
10    fact, they usually want it full in order to ultrasound the  
11    pelvic structures. What I expect from the radiologist is  
12    a description of the anatomy that they see to the best of  
13    their capability of seeing it, and then usually the  
14    radiologist will provide an array of differential  
15    diagnoses. But whether I pay any attention to that array  
16    of differential diagnoses or not depends a whole lot on  
17    his experience versus mine. I mean every six months the  
18    differential diagnosis of a pelvic cyst would be different  
19    in a child. It's different in a child at three months  
20    than it is for a child of a year as a child of eighteen  
21    months. And the radiologist may not be aware of those  
22    changes, so I expect from the radiologist a descriptive  
23    anatomy down there. And then it's up to me to make a

1 differential diagnosis on that and act accordingly.

2 Q So you wouldn't care if he told you whether there  
3 was a large, full bladder or not?

4 A Well, I mean if he saw a large cystic structure  
5 in the abdomen -- in the pelvis extending up into the  
6 abdomen and felt that it was not bladder, then I've got to  
7 act on that.

8 Q What if he saw a large cystic structure that he  
9 thought was bladder? Would you expect to be told?

10 A Yeah.

11 Q Doctor, if a child had not urinated for 12 to 18  
12 hours, would you proceed with elective surgery?

13 A Well, if I knew that, I wouldn't. I don't  
14 ordinarily -- people who come in for elective surgery, I  
15 don't ordinarily ask them when they urinated last because  
16 I look at the child and see what they look like. But if  
17 the mother came in and said this child hadn't urinated for  
18 18 hours, I'd focus my attention on why she hadn't  
19 urinated for 18 hours and I would put off the elective  
20 surgery unless it had some bearing on why she hadn't  
21 urinated.

22 Q If the child had been in the hospital for 13  
23 hours, you would at least know the urination patterns over

1 that 13 hours, wouldn't you?

2 A I may not understand your question.

3 Q From the chart.

4 A If she has not urinated?

5 Q Yes. From the chart, wouldn't you know whether  
6 there has been urine in the preceding 13 hours?

7 A Yeah, but I don't ordinarily do elective surgery  
8 on people who have been in the hospital for --.

9 Q Now, Doctor, was the urine that was found in  
10 Nicole's bladder during the surgery, was that part of her  
11 body fluid? In other words, was that within her  
12 bloodstream or within any of the other fluid streams of  
13 her body that keeps that fluid in circulation?

14 A Well, that -- the urine in her bladder would be  
15 most properly categorized, I guess, in the extravascular  
16 space. It's certainly not urine in her bloodstream. And  
17 it's not what we usually think of as the extravascular  
18 space which is around the cells. This is fluid that's  
19 already been processed by the body and passed off. And  
20 the bladder in that respect just acts as a receptacle.

21 Q Doctor, you told me that with a child Nicole's  
22 age, that you would have expected urine output between --  
23 age and size -- of 10 to 15 cc.'s an hour. Is that

1 correct?

2 A That is correct.

3 Q So a thousand 55 cc.'s would have collected over  
4 a substantial period of time. Is that correct?

5 A That's correct.

6 Q Now, Doctor, I'm going to ask you -- you don't  
7 really need to come out here -- to look at the urine  
8 output numbers for Nicole Panousos and to tell me the  
9 difference between the fluid in and the fluid out if you  
10 exclude the extravascular fluid which is the urine intake  
11 and out and the surgery procedure.

12 A I may need a scratch paper for that, and maybe we  
13 can do it from those, if you'd like, so that --

14 Q That would be fine. If that would be easier, you  
15 can do it from those.

16 A It depends on where you want to start measuring.  
17 But the first emptying of the bag, we have it 235 cc.'s.  
18 That's what the nurses empty when the child comes back  
19 from the recovery room. What we don't know is when that  
20 thousand cc.'s was emptied or whatever they've got  
21 recorded, 1440 in OR urine, when that was emptied out.  
22 But we'll include this as her postoperative fluid loss,  
23 although some of it may be operative. And then we have

1 260, so we're down here at 385. I think this is their  
2 cumulative total for output.

3 And then this is our next sheet. And they start  
4 a whole new cumulative total. And so I guess if we use  
5 the 8 to 9 line sort of as the point of arrest --

6 Q Doctor, I don't want to interrupt you, but you're  
7 going over to the 6th. Do you have the 5th as well?

8 A Oh, I thought you wanted to go up to -- this was  
9 the 5th here.

10 Q I want you to go right up to midnight. I want  
11 you to go through the 5th.

12 A All right. So we stop at this. It looks like,  
13 depending on how you count this 235, that she had 385  
14 cc.'s total out during that interval.

15 Q Okay.

16 A Now, it's harder to calculate how much she had  
17 in, because some of that is going to be postoperative --  
18 I'm sorry, intraoperative fluids and they aren't on these  
19 charts.

20 Q So the intraoperative fluid is not on there.

21 A Yeah. This is the -- let me just look at this to  
22 get oriented myself. This is the postoperative fluids for  
23 the night of the 5th. And we sort of have to go across

1 here. This column is the amount of normal saline, and  
2 this is the salt that they're giving to keep it  
3 rehydrated, and her total volume of that is 160. And  
4 cumulative total here of the D5 third normal is 50, so we  
5 are cumulative to 210. That's right. 210 here. Here is  
6 another 10 that was given. That's 220. Here is -- that's  
7 blood. That doesn't count. 220.

8 Q Doctor, you can go to the total in the right-hand  
9 corner, if that will help you.

10 A Well, let me just -- let me just check and see  
11 what they've done here. 226. Here is her CVP line, her  
12 art. line. 236, 44. 254. 274. 314. So I would -- this  
13 would indicate that she got 314 cc.'s of fluid in  
14 postoperatively, and did you -- I hope you wrote down or  
15 maybe you can tell me what I calculated as her in.

16 MR. QUINN: 385.

17 A 314 and 385 out? Was that the number? Okay. So  
18 she -- if anything, a little shy on the inside compared to  
19 the outside.

20 BY MR. SALE:

21 Q Doctor, I'd just ask before we leave this, if you  
22 could check your arithmetic because they show at Fairfax  
23 Hospital that the input during this period was actually

1 887 minus 425. Is that accurate?

2 A Well, I don't know. I just calculated the  
3 numbers as we've got them here. We can go over it again.  
4 Let me check it. 160 plus 50 is 210. Wait. That may be  
5 another 10 there. I don't know what that -- some of you  
6 may know what that number is. This is 210 if you count  
7 that. I don't know what this number that's at 2300 hours  
8 is.

9 Q Let me see if we can help you with that, Doctor.  
10 It does appear to be somewhat obscured.

11 A I don't know why that was erased. Maybe that  
12 fluid -- it looks like 60 -- it looks like 10 cc.'s  
13 cumulative of 60. And maybe that indicates it wasn't  
14 given. I don't know. But let's count that in and say it  
15 was given. So I'm going to have to go back here. 210 --  
16 no, I'm sorry. 220. We're going to count this as 60.  
17 We'll count this as 10 cc.'s in. So 220, 230, 260, 266,  
18 276, 284, 294, 314, 354. 354.

19 Q Do you see an additional 12 written on there  
20 which apparently would have been from another source?

21 A Yeah. I don't know where that's from.

22 Q Okay. Can you tell by looking at that -- you  
23 mentioned before you don't know in OR. But did they



1 transpose that number as you now look at that chart?

2 A The OR number?

3 Q Yes.

4 A No. Not in these flow values.

5 Q In the totals.

6 A Now, in OR total I think they've got 425  
7 indicated down there. That's the crystalloid that was  
8 given in the operating room.

9 Q Doctor, do you recall what the fluid  
10 preoperatively given Nicole amounted to?

11 A I -- the amounts?

12 Q Yes.

13 A I do not.

14 Q Okay. Well, I'm going to give you an exhibit  
15 which shows preoperative fluid, and if you could tell me  
16 whether that will give you that number.

17 A This is from 9 a.m. on 3/5. And there are no  
18 other numbers on there, so I'll assume that's the whole  
19 preoperative fluid. That's 240 cc.'s preoperatively.

20 Q All right. Now, can you tell me the difference  
21 between the amount that Nicole excreted as urine outside  
22 of the surgery and the amount that she was given?

23 A I'm going to have to write these numbers down.

1           You just gave me 224? 240.

2           Q     240.

3           A     So we've got 240 as the preoperative number. And  
4     what number did I come up with here? Did I agree? This  
5     was 300 -- 340? 344?

6           Q     Doctor, if it would help for the jury, can you  
7     draw that on the chart here for me?

8           A     Okay. We have preop. 240 cc.'s. We have  
9     intraop., and without checking back and seeing the op.  
10    sheet itself, I'll take that at face value what the nurses  
11    have recorded as 425 cc.'s. And then we have postop. to  
12    12 midnight. Does anybody remember the number I came up  
13    with? 3 -- 160 plus 60 is 420, 430, 466 -- wait. That's  
14    too high. 160 plus 06 is 220, 230, 260, 266, 70, 284,  
15    294, 314, and 40 is 354. And you want me to total those.

16          Q     If you would, please.

17          A     It looks like 1,019 cc.'s.

18          Q     Now, if you exclude again the intraoperative  
19    urine, which we all agree was intravascular, what do you  
20    come up with?

21          A     Her urine output?

22          Q     Right.

23          A     Okay. We had 2 -- we've got 225, 60 -- I think

1 there was another 60 down there or 70. This must be  
2 wrong.

3 Q You're right.

4 A Okay. 100. So I've got 225, 285, 385  
5 cumulative.

6 Q Could you subtract 385 from 1019?

7 A We have out urine 385 cc.'s. And you want to  
8 subtract that from here.

9 Q Right.

10 A Okay. 385 is 4, that's 3. All right? 6. 634?

11 Q That's what you came up with.

12 A Well, you better check me. Yeah. I think that's  
13 right. 634.

14 Q All right. You can retake the stand, Doctor.

15 (The witness resumed the stand.)

16 How much fluid would a child Nicole's age have  
17 within her vascular system?

18 A If she was normally hydrated?

19 Q Right.

20 A Normal child?

21 Q Yes.

22 A 8/10 of her body weight, so 7 kilos, 7,000 cc.'s  
23 times 8/10 is about 550 cc.'s.

1 Q Would that be in the bloodstream?

2 A That would be intravascular.

3 Q 506 cc.'s in her bloodstream.

4 A Correct.

5 Q Okay. And Doctor, Nicole had symptoms of  
6 diarrhea, spitting up, Pedialyte, the three to five days  
7 before entering the hospital. Have you seen that in the  
8 records?

9 A That's -- I think that's correct from the  
10 admission ER sheet.

11 Q Okay. With those conditions, would you expect  
12 Nicole's urine to be at the high end or the low end of the  
13 10 to 15 cc.'s that you expected?

14 A Well, I think she was dehydrated. And so we  
15 would expect it at the low end.

16 Q So how long of a period would it have taken 1050  
17 cc.'s to accumulate?

18 A Well, I don't think I can tell you that. The  
19 mother -- I believe the mother's testimony was she was  
20 urinating, so she was not totally obstructed at that  
21 interval. And we don't know what percentage of the urine  
22 formed was being excreted and what percentage was being  
23 retained. If you assume that she was totally obstructed

1 in her urine up to that point, I'll have to figure it out.  
2 But it's probably four or five days.

3 Q Four or five days.

4 A Do you want me to figure that exactly?

5 Q No. That's fine, Doctor.

6 Now, in addition to the expectation of a  
7 postobstructive diuresis --

8 A Are we going to leave this number right now?

9 Q Yes.

10 A Because I think that -- I think it would be  
11 unfair to leave that number just hanging there.

12 Q Your Honor, I'd be happy to allow his counsel to  
13 address this.

14 Yes, we're going to leave it right now.

15 A Whatever.

16 Q Dr. Rodgers, you testified that even with the  
17 symptoms found, this was urgent surgery and probably  
18 emergency; is that correct? Is that how you still feel?

19 A Yeah.

20 Q So if Dr. Hodin had waited and done further  
21 testing, you don't believe that that would have been  
22 proper -- improper by the surgeon?

23 A I don't think that would have been proper to

1 delay the surgery until the next day in a child with a  
2 large abdominal mass who was tender and had a low-grade  
3 fever, no.

4 Q But if the bladder had been drained, then it  
5 would be proper.

6 A I'm not sure I understand your question because I  
7 think I answered it a minute ago. If the bladder had been  
8 drained and the pain went away and the child's belly felt  
9 normal to me, then I think we could have waited a day and  
10 done some more X-ray studies or whatever time interval it  
11 took to get more X-ray studies. If the bladder had been  
12 drained and the belly still was tender, my feelings would  
13 be exactly the same. It's a child that should be  
14 explored.

15 Q So the issue would come again down to tenderness?

16 A It comes down to the clinical exam of the patient  
17 and her abdominal exam.

18 Q Okay, Doctor. Just going to one last few  
19 questions here. Going to the CVP, does good wave form in  
20 a CVP after recalibration, is that consistent with proper  
21 function?

22 A Well, it's certainly one of the things you want  
23 to see, one of the criteria which you have of function,

1     yeah.

2           Q     It is consistent with proper function?

3           A     Well, excuse me. . You need to know what sort of  
4     interval the wave form was good for and a lot of other  
5     things. But that's certainly one of the -- one of the  
6     things that you'd want to see to be sure that your CVP  
7     line was giving you reasonably accurate numbers.

8           Q     Okay. Now, Doctor, in addition to wanting to see  
9     good wave form on recalibration, would you also want to  
10    see that the CVP flushed well with good blood return?

11          A     Yeah. The flushing well is less of a help to us.  
12    Almost all the CVPs will flush reasonably well. You like  
13    to see good blood return through the thing that indicates  
14    the tip may be free and not obstructed with anything.

15          Q     But that does indicate that it is working  
16    correctly, properly.

17          A     That's one of the things that would be necessary  
18    to be sure it was working properly, correct.

19          Q     Okay. Are you aware that in the early morning  
20    hours that Nicole Panousos's CVP flushed well with good  
21    blood return?

22          A     Let me refresh my memory on the -- I'm looking at  
23    the nurse's notes here on the ICU.

1 Q I'm not trying to test your memory. I was asking  
2 if you are aware. If you are not, maybe I can help you.  
3 I am going to show you integrated progress notes, the  
4 bottom note and see if there is any indication the CVP was  
5 flushing well with good blood return.

6 A This is a note written at 1300 hours on 3/6 and  
7 it describes the events, some of the events of the night  
8 before. The nursing progress note. It says difficult to  
9 obtain accurate CVP reading tonight due to line being  
10 positional. CVP range 9 to 19 tonight. CVP flushed well  
11 with good blood return.

12 Q Okay.

13 A So yes.

14 Q And again, that's consistent with proper function  
15 rather than improper function.

16 A Well, that turned it around a little bit. You  
17 have to have good blood return to make proper function.  
18 Just because you have good blood return, if there are a  
19 lot of other things happening, you can't rely on that  
20 being proper function. Do you see what I mean?

21 Q Now, you referred, Doctor, to the postarrest  
22 X-rays and indicated that the heart was mildly enlarged;  
23 is that correct?



1           A     Well, that was my recollection from the X-ray  
2 report. Maybe if we have those films, we can look at them  
3 and see exactly. I have not -- as I said, I have not seen  
4 the X-rays, and just looked at the report.

5                     Do you have those?

6           Q     Well, I don't think we need to get into them,  
7 because I think in fact you said you would defer to a  
8 radiologist as far as interpretation of those.

9           A     Well, again, it depends a whole lot on my  
10 radiologist. Reading children's films are a whole lot  
11 different than reading adults' films, and the radiologist  
12 would have to have a good clinical impression of the  
13 clinical situation, so it's very common we read our own  
14 emergency obtained films in the ICU.

15          Q     Now, Doctor, you testified that the enlargement  
16 was due to the fluid given during resuscitation. Is that  
17 correct?

18          A     If the enlargement was there, I would say that's  
19 the reason, yes.

20          Q     Now, how much fluid did you indicate was given  
21 during the resuscitation?

22          A     Well, it's hard to -- it's very hard to know. If  
23 you look down at the resuscitation records that are kept,

1 those are all kept -- recorded for the most part after the  
2 arrest. There's so many things going on during the  
3 arrest, that it's hard to assign one person just to mark  
4 down what's happening. And so that represents somebody's  
5 best recollection. And there are a lot of fluids listed  
6 in there -- I guess we could show that to the jury if you  
7 like -- that don't even have volumes associated with them,  
8 drips and things. But I know from every pediatric arrest  
9 I've ever been in that a lot of volume is given during  
10 that arrest.

11 Q What totals did you come up with by looking at  
12 that chart?

13 A I started to total it and I gave up, because so  
14 many of them are drips. There's no way to come up with a  
15 meaningful total from the chart.

16 Q Did I hear you on your direct say between 30 and  
17 35 cc.'s?

18 A I don't -- I can look at it again and see. But  
19 I --

20 Q I thought that's what you said. But I wanted you  
21 to give the best testimony you can. I am just wondering  
22 if that was your recollection.

23 A These are the hours and the types of drugs that

1 are given and the things that we don't have in terms of  
2 volume. She was given atropine on two occasions, and they  
3 do record the volume of that because it's a little, tiny  
4 volume. But she was given Dopamine here at 30 cc.'s. I  
5 don't know whether that's 30 cc.'s an hour drip or what.  
6 She was given volume one milligram which is mixed up in a  
7 variable amount of fluid and Narcan. All of these drugs  
8 are mixed with saline.

9 The things that you can count for sure look like  
10 13 and 17 is 30 plus another couple. But there's so many  
11 things in here that you can't count. Here is 50 cc.'s I  
12 guess of normal saline. This is an Isuprel drip, which is  
13 a cardiac medication. It's -- I think it's impossible to  
14 tell from that chart precisely how many was given during  
15 the arrest. And that would be typical of most arrests.

16 Q Okay. Doctor, you just looked at the types of  
17 medications that were given during the arrest; is that  
18 correct?

19 A Did I just look at that?

20 Q Yes.

21 A Yes.

22 Q Are those powerful heart stimulants?

23 A Well, they're all heart -- no, they're not all

1 powerful heart stimulants. They're all cardiac  
2 medications, yes.

3 Q Some are stimulants?

4 A Some are stimulants.

5 Q Would you normally expect those stimulants to  
6 succeed in resuscitation of the patient?

7 A Of the patient or the heart?

8 Q Of the heart.

9 A Yes.

10 MR. SALE: I have no further questions.

11 THE COURT: Mr. Godard?

12 REDIRECT EXAMINATION

13 BY MR. GODARD:

14 Q Doctor, we do have the X-rays here that Mr. Sale  
15 alluded to. Would you like to look at those and make your  
16 own interpretation?

17 (The witness left the stand and went in front of  
18 jury box to the X-ray box.)

19 Now, just for the record, Doctor, is there an  
20 indication on the side here of the identification of the  
21 patient?

22 A The patient Nicole Panousos is identified here  
23 and the date is identified there as 3/5.

1 Q We'll ask that this be marked as Defendants'  
2 Exhibit No. 4. Go ahead, Doctor.

3 (The X-ray was marked Defendants' Exhibit No. 4  
4 for identification.)

5 A I'm not -- it's hard to tell what time this  
6 film -- it looks like it was taken at 1850 something. So  
7 that's 6 p.m. This is a postop., the immediate postop.  
8 film. And one would look at this film and make nothing of  
9 it. What you're looking at is the heart is the white  
10 thing in the middle. And the lungs are the black things  
11 out here, and these are the diaphragms here, so everything  
12 down there is the abdomen. And this looks like a  
13 perfectly normal postoperative film at 6 o'clock or 6:55,  
14 I believe the hour is, on the 5th. The lungs are normal,  
15 the heart looks all right, what have you.

16 Now, the next -- let me get the dates, times  
17 here. The times -- this is -- this film here --

18 Q Which we'll now mark as Defendants' No. 5.

19 (The X-ray was marked Defendants' Exhibit No. 5  
20 for identification.)

21 A -- is the postarrest X-ray. This was taken on,  
22 again, Nicole Panousos, 3/6. And you can read, I believe,  
23 10 o'clock right here. So this would have been the one

1 they ordered right after the arrest. And again, looking  
2 at the -- let's start with -- sort of take it piecemeal I  
3 think.

4 Here the right lung looks normal. There's no  
5 sign of any fluid overload in the lung, and there's no  
6 sign of any air over that lung, which would be one of the  
7 things that I think I mentioned that you worry about with  
8 a sudden arrest in a child, that she might have blown her  
9 lung out and pushed air in here. There's no sign over  
10 there or here.

11 The heart size is right here. It looks larger  
12 than the one we had on this side. But the whole chest  
13 looks larger. See how broad the chest cage is there and  
14 how we're almost a half an inch broader. And that relates  
15 to how far the X-ray tube is away from the patient. And  
16 those things are variable. So that's why we wouldn't make  
17 too much of the heart size.

18 It looks like there may be a little infection in  
19 the left lung here, but no air over that lung. So I think  
20 if I saw this X-ray in the postoperative ICU in the  
21 postarrest stage, I would make some note that the heart  
22 size was slightly bigger than it had been. But again,  
23 there's no fluid in the lungs. When the lungs accumulate

1 fluid, they turn white. And there's no fluid accumulation  
2 in the lungs. There's no air over the lungs. So I think  
3 I can't argue with the interpretation that that's slight  
4 enlargement or there is enlargement of the heart. I don't  
5 think it's enough to be of any significance, and I think  
6 there is enough variables in terms of how these X-rays are  
7 obtained to account for that.

8 Q All right, Doctor. Thank you. Now, as long as  
9 you're here, in case you need to use the chart again, I  
10 will give you the opportunity to please explain the  
11 significance of the 684 --

12 A 634 is what I came up with.

13 Q 634 difference that Mr. Sale had you calculate.

14 A It worries me to leave that number hanging there.  
15 The implication is that she got 634 cc.'s more fluid than  
16 she needed. Here we have her output measured at 385 and  
17 her intake measured at 1019. In fact, you can't draw that  
18 conclusion from this number. You need to look at the  
19 patient.

20 The patient came in dehydrated. We know that.  
21 And so that this preop. fluid, let's say, was just to  
22 correct her dehydration. And we know during surgery they  
23 kept giving her fluid, so she wasn't fully corrected

1 probably, although her electrolytes were in good order.  
2 And we know that any time you have an operation on the  
3 abdomen, you pour fluid into the abdomen. The body -- we  
4 irritate the abdominal cavity when we operate in there and  
5 particularly when you've operated as much as was operated  
6 on here and in the pelvis, and so the body pours fluid in.  
7 That's what we call third space loss. It's outside the  
8 bloodstream and it's lost to the bloodstream, but it's in  
9 the peritoneal cavity and it has to be replaced with I.V.  
10 fluids.

11 So that it's not just as simple as saying, well,  
12 this child put out 425 cc.'s of urine. We'll give her 425  
13 cc.'s and we will be in good shape. It doesn't work that  
14 way at all, and you need to look at their blood pressure  
15 and their pulse and their skin turgor and their perfusion  
16 and everything else to be sure.

17 So I am uncomfortable with any implication being  
18 drawn from that 635 cc.'s or 634 cc.'s, that this surely  
19 isn't 634 cc.'s more than this child needed at that stage.

20 Q To carry this process one step further, Doctor,  
21 this figure, the 240 preop., represents the amount of  
22 fluids that we know she received from the time she came in  
23 the hospital up to the time of surgery.



1           A     Correct.

2           Q     Now, do we know how much urine her kidneys put  
3 out during that same time?

4           A     We have no idea except it's somehow in that  
5 thousand four hundred that they drained intraoperatively.

6           Q     The point being that -- how much was drained from  
7 the bladder at surgery? Was it approximately a thousand  
8 cc.'s?

9           A     Yes, 1040 or something like that.

10          Q     And indeed, do we know how much of that thousand  
11 cc.'s had been produced or had in effect been urinated at  
12 least into the bladder during the same time that this 240  
13 was going in?

14          A     We have no idea.

15          Q     All right. So does that add to the  
16 insignificance of the figures here?

17          A     Well, I guess it does. That figure -- I mean if  
18 anything is to be drawn from that figure that she got that  
19 much fluid excess, that would be improper, and I wouldn't  
20 want to leave anybody with that understanding. There are  
21 a lot of fluid shifts that went in on in this child.

22                 She had been sick for, depending on whose record  
23 you look at, four or five days beforehand. She had been

1 vomiting and had diarrhea for portions of that time. She  
2 had lost fluid. By everybody's account she was dehydrated  
3 when she arrived. So we're already behind and behind an  
4 unknown amount. So there's no simple way to calculate  
5 exactly how much fluid she needs. You need to look at the  
6 patient and look at as many numbers about the patient as  
7 you can put together to make some educated guess about  
8 where you are.

9 Q So is it your opinion that the ultimate cardiac  
10 arrest experienced by Nicole Panousos on March 6 was not  
11 influenced or caused by overhydration? Has that changed?

12 A Clearly not. Clearly not. In somebody that's  
13 overhydrated, if you are going to die from overhydration,  
14 you die from congestive heart failure. And congestive  
15 heart failure doesn't happen in 10 minutes or 20 minutes.  
16 You go, you begin to breathe hard. Your lung function  
17 begins to deteriorate as fluid gets backed up. Your heart  
18 begins to enlarge and get irregular in its beat. A lot of  
19 other things happen. That's a slow process. And that's  
20 why I say this death is much more reminiscent of a septic  
21 death. This death happened basically from eight to nine  
22 o'clock, in that period of time. And --

23 Q How do we know that these things you just

1 described didn't happen over a succeeding period of hours?

2 A Well, we have objective numbers in terms of her  
3 pulse and her heart rate, in terms of her blood gases, in  
4 terms of her blood pressure. We have subjective measures  
5 in terms of the nurse's notes that indicate that her  
6 perfusion or capillary refill was normal and everything  
7 else. There was no indication whatsoever from subjective  
8 or objective information that this child was failing in  
9 the two, three hours, three, four hours even before her  
10 demise. It's not fair to call that her demise, but before  
11 her arrest at 8 o'clock in the morning.

12 Q Had the child been developing congestive heart  
13 failure from overloading with fluids, would there have  
14 been such objective changes in these vital signs?

15 A Yes. If she had been going into congestive  
16 failure from fluid overload, we would have seen these  
17 changes that I think we have talked about in terms of her  
18 heart rate and her blood pressure. We would have seen her  
19 blood pressure begin to go up and then gradually  
20 deteriorate. We would have seen her heart rate get faster  
21 and faster and faster. We would have seen her liver get  
22 bigger. We would have seen her blood gases, the measure  
23 of how good her lungs were functioning, begin to

1 deteriorate. And in fact her blood gases were getting  
2 better. Her blood pressure was stable. Her pulse was  
3 stable.

4 And virtually the only thing we have that even in  
5 any way suggests fluid overload is a CVP of 19. And there  
6 are a lot of contemporaneous nurse's notes that indicates  
7 there's problems with that line. The CVP at 10 o'clock  
8 after the new line was put in, when the child arrested,  
9 Dr. Hodin took this line out because they had been having  
10 trouble with it and put a left venous line in. And the  
11 CV -- first CVP that's recorded there is 8. If she had  
12 been fluid overloaded, that was before she got her Lasix.  
13 If she had been fluid overloaded as a cause for her death,  
14 the CVP would have been 19 or 20 or even worse when they  
15 first recorded her CVP.

16 Q So what is your ultimate conclusion as to the  
17 significance of that final CVP indication of 19?

18 A I think it's -- it's of no importance. I think  
19 it's a malfunctioning system.

20 MR. GODARD: Thank you, Doctor.

21 (The witness resumed the stand.)  
22  
23

RECROSS-EXAMINATION

BY MR. SALE:

Q Doctor, I have just a few more questions. I'd like to bring you back to your chart for just a minute here. I hate to keep bringing you over here. But I think we may have missed a few numbers that were taken to the total that did not show up in the chart.

(The witness left the stand and went in front of the jury box.)

Let me ask you, do you see 70 albumin anywhere in this chart?

A No, I don't. The two numbers that are recorded down here --

THE COURT: Excuse me. Let's just after the question, we're going to need to take a break, and I would like to have this witness finished before we do, so your question is did you see albumin. The answer was no. Go to your next question and we'll get this wrapped up.

MR. SALE: Okay. Thank you.

BY MR. SALE:

Q So the albumin is not reflected in the total you gave; is that correct?

A Correct. It should not be.

1 Q Why should it not be?

2 A Well, albumin and blood are intravascular fluids.  
3 And they're given to replace what is lost in the OR. All  
4 the rest of these are what we call crystalloid, which are  
5 basically water with electrolytes in them, and aren't used  
6 as volume expanders but are used to increase the intravas-  
7 -- the whole total body water. So when you make  
8 calculations on the basis of fluid numbers, you don't  
9 count the colloid, which is albumin and blood, which is  
10 just to replace what's lost in the operating room. You're  
11 looking at crystalloid, which is her body's needs for  
12 water basically, water and electrolytes during the course  
13 of the day.

14 Q Okay. So the hospital should not have properly  
15 recorded the albumin and the blood inputs?

16 A No, no, it has to be recorded. You keep track of  
17 colloids and you keep track of crystalloids, but they're  
18 separate functions. And you can add them on if you want.  
19 But the physician would have kept those separate. The  
20 colloid, the albumin and blood, is used to replace losses.  
21 It's an intravascular fluid. It's given to trauma victims  
22 and everybody else. This was lost blood. This child had  
23 lost her blood in the operating room. The crystalloid is

1 used to replace more gradual fluid losses from diarrhea  
2 and vomiting and fever and everything else. These are the  
3 metabolic needs of the body. The colloid is purely to  
4 expand her intravascular volume.

5 Q Was there any number in there that was not given  
6 intravascularly?

7 A Any number here?

8 Q Yes. Were any of the fluids recorded here that  
9 were not given through an I.V. into her vascular system?

10 A No. They're all -- well, the arterial line is  
11 given intraarterially, but they're given into her  
12 vasculature, yes.

13 Q What is a Jackson-Pratt drain? You can go ahead  
14 and sit down.

15 (The witness resumed the stand.)

16 A Jackson-Pratt drain is a soft plastic or Silastic  
17 drain that is used to -- fairly commonly to drain certain  
18 spaces in the body, particularly postoperative where you  
19 might expect fluid to accumulate.

20 Q Okay. You remember that they recorded the output  
21 from the drains?

22 A Um-hum.

23 Q So they did report that output.

1           A     My recollection is they had reported 30 cc.'s of  
2     loss, is that correct, from the --

3           Q     Well, it's not a -- I'm not trying to get you to  
4     give an exact number. But they reported the output from  
5     the drains of fluid loss.

6           THE COURT:   Yes.

7           BY MR. SALE:

8           Q     Now, is a CVP of 19, is that consistent with  
9     congestive heart failure if the CVP is to be believed?

10          A     You can't make any conclusions from one CVP  
11     number. There are probably people in this room that have  
12     a CVP of 19 and are not in congestive heart failure. If  
13     their CVP had been 5 four hours ago and now is 19, that's  
14     an indication they're going into congestive heart failure.  
15     But a number of 19 doesn't help you much.

16          Q     If you had two 9s and then a couple hours later  
17     two 19s, if that was an accurate number -- I am presuming  
18     it's accurate. I'm giving you a hypothetical because you  
19     said you don't believe it is accurate. Would that be an  
20     indication of onset of congestive heart failure?

21          A     It might be.

22          Q     Doctor, I'm going to have you look at Nicole's  
23     death report. Here is my sheet. I don't know if you have



1 it available to you.

2 A Is this the autopsy?

3 Q This is the autopsy. You're free to use mine. I  
4 have indicated a part of that report which shows the  
5 reading made with the CVP during the initial period of the  
6 arrest. What was the CVP reading during the arrest?

7 A The part that you have underlined or highlighted  
8 here says, "Dopamine and Isuprel drips were begun within  
9 the first 10 minutes, although there was some question as  
10 to the patency of the CVP line, although readings were up  
11 to 25 at that time and there appear to be free blood flow,  
12 although there was some leak at the entry site. For this  
13 reason a cut down was performed on the right saphenous  
14 vein and the Dopamine infusion was started at this level."  
15 So that they've got here the number of 25.

16 Q Okay. In addition to the number being 25, there  
17 appeared to be a free blood flow; isn't that correct?

18 A Right.

19 Q Okay. You indicated, Doctor, that one of the  
20 indicators of congestive heart failure is clinical  
21 appearance of the patient. Is that correct?

22 A Correct.

23 Q Would that include perfusion?

1           A       That would include peripheral perfusion, correct.

2           Q       I hand you again the death report and ask you to  
3 read the first paragraph and tell the lady and gentlemen  
4 of the jury what that says about Nicole's perfusion in the  
5 period before the arrest.

6           A       The part you have highlighted again says,  
7 Subsequently, her CVP was noted to rise to 19, and there"  
8 was some apparent -- and "was apparently some change in  
9 the child's overall appearance, with poorer peripheral  
10 profusion, although her pH status remained unchanged at  
11 that time.

12          Q       So in fact, her perfusion was poorer in relation  
13 to an earlier period.

14          A       Well, I think that depends on who you want to  
15 rely on. You've got contemporaneous nurse's notes that  
16 fly in the face of that. And this note is written by -- I  
17 don't know who signed that note some days later. I didn't  
18 notice the date at the bottom of it. I would certainly go  
19 by the contemporaneous notes more than a postmortem note.

20          Q       So you would assume that this note was incorrect?

21          A       On that point. I would have to assume that,  
22 looking at the nurse's notes which are written at the time  
23 that things are happening.

1 Q Okay. I'll give you the signature page of the  
2 report and ask you from both signature and the dictation  
3 by-lines if you can tell me who prepared that report.

4 A The signature is -- the name is Earl Hodin, and I  
5 presume that's his signature, although you can't tell, and  
6 it was dictated on 5/7/87 and transcribed 5/8.

7 Q Are there any other initials there besides Earl  
8 Hodin as far as dictating that?

9 A Well, to tell you the truth, the signature is  
10 probably James Clayton. Yeah, the dictation thing here is  
11 JEC, so I guess JEC slash EH slash and then the typist.  
12 There are two typists listed: SKR and slash KAB. So I  
13 guess the first of those, JEC must have dictated the note  
14 for Earl Hodin, and I think the signature looks more like  
15 J. E. Clayton than Earl Hodin, but I am guessing at that.

16 Q You have looked at the records enough in this  
17 case to know that doesn't even look to be like Earl  
18 Hodin's signature?

19 A As I say, I am guessing at it. I have never seen  
20 Earl Hodin's signature I don't believe.

21 Q I want to show you, Doctor --

22 THE COURT: We're going to take a break. We'll  
23 start again at 2 o'clock. Don't discuss the case or draw

1 any conclusions.

2 MR. SALE: Your Honor, I would be willing to  
3 dismiss the witness.

4 THE COURT: Well, it's up to you. But I made it  
5 very clear we were going to break at this time and you've  
6 had ample opportunity. You know that, and so you need to  
7 have him dismissed and not come back or whatever you  
8 choose. It's up to you.

9 MR. SALE: I will be willing to dismiss him.

10 MR. GODARD: Thank you very much.

11 THE COURT: Thank you very much, and you are  
12 excused. See you at 2 o'clock.

13 (Witness excused.)

14 (At 1:15 p.m. the trial was recessed to reconvene  
15 at 2 p.m.)  
16  
17  
18  
19  
20  
21  
22  
23

AFTERNOON SESSION (2:07 p.m.)

THE COURT: Okay. Who will your next witness be?

MR. McANDREWS: Dr. Lipsit, Your Honor.

Whereupon,

EDWARD ROBERT LIPSIT, M.D.,

was called as a witness on behalf of the defendants, and  
after having been first duly sworn, was examined and  
testified as follows:

BY MR. McANDREWS:

Q Doctor, would you please state your full name?

A Edward Robert Lipsit.

Q What is your current business address?

A We have several office locations. One of them is  
3022 Williams Drive in Fairfax.

Q You are a medical doctor, sir?

A Yes.

Q What is your specialty?

A Diagnostic radiology and I specialize in  
ultrasound.

Q Where did you get your medical education?

A I went to Georgetown University School of  
Medicine. I graduated in 1975. My training then  
continued: internship and residency in radiology at

1 George Washington. I then had a fellowship in diagnostic  
2 ultrasound. And then following that, I was chief of  
3 ultrasound at G.W. for two years.

4 Q Where was your fellowship in diagnostic  
5 ultrasound? What institution?

6 A It was at Johns Hopkins.

7 Q Since when have you been in private practice in  
8 radiology?

9 A Since 1981 I've been practicing in Washington.

10 Q Have you had any teaching positions?

11 A Yes. Currently I'm assistant clinical professor  
12 at George Washington. My group also provides radiology  
13 services for Columbia Hospital for Women. So I'm on the  
14 staff there. And I give periodic conferences there.

15 Q Are you certified in any specialties?

16 A In diagnostic radiology.

17 Q When did you become certified, sir?

18 A At the completion of my residency in 1979.

19 Q What institution or entity certifies  
20 radiologists?

21 A The American Board of Radiology. It's a  
22 standardized exam. There's a written examination, and  
23 then there's an oral examination as well.

1 Q In what states are you licensed?

2 A I'm licensed in Maryland, the District of  
3 Columbia, Virginia, and California.

4 Q Could you please give the jury your definition of  
5 diagnostic ultrasound?

6 A It's -- it's a noninvasive procedure. It's a  
7 very safe test because it just utilizes sound waves rather  
8 than other forms of imaging, rather than X-rays. Sound  
9 waves are produced by a crystal. We call it a transducer.  
10 But it's a very small crystal. They used to use quartz  
11 crystals. Now there's some sound wave crystals.

12 A current is applied to the crystal. And very  
13 high frequency sound waves are generated. These sound  
14 waves could pass into the body. And it's the pattern of  
15 reflections from the organs in the body which can then  
16 create an image through the use of a small computer.  
17 Images are actually created, two dimensional images on a  
18 TV monitor. And those images, even though they're a  
19 little abstract, it's really like anything else. If you  
20 are familiar with what you're looking at and you do a lot  
21 of it, you become familiar with patterns and you interpret  
22 those patterns and not invasively, without sticking  
23 needles into anybody; you can get an image and hopefully

1 make a diagnosis.

2 Q Since you went into private practice in 1981,  
3 what percentage of your professional activities have you  
4 devoted to sonography?

5 A 70 to 80 percent.

6 Q Has that percentage remained fairly constant  
7 through the present?

8 A Yes. The group that I practice with, what I  
9 liked about it, quite frankly, was that it's very heavily  
10 oriented towards diagnostic ultrasound. We do general  
11 X-ray procedures as well, but we do a tremendous amount of  
12 ultrasound. That also ties in with Columbia Hospital for  
13 Women because naturally there will be a lot of -- many  
14 obstetrical exams. So we perform a lot of ultrasound.

15 Q Have you yourself ever performed ultrasounds on  
16 infants?

17 A Yes.

18 Q Let me ask you specifically on infants under six  
19 months of age.

20 A Yes.

21 Q Have you done that from the time that you entered  
22 private practice?

23 A At that time and also before. During the course



1 of my radiology training, there was a rotation through  
2 Children's Hospital, National Medical Center. And we saw  
3 a tremendous number of children when we were there,  
4 obviously. In addition, when I was at Johns Hopkins, they  
5 have a very large neonatal intensive care nursery. And I  
6 was frequently in contact with neonates in their intensive  
7 care nursery. Finally, at Columbia Hospital for Women we  
8 have a large intensive care nursery as well.

9 Q Are you a member of any professional societies  
10 that deal with either radiology in general or sonography  
11 in particular?

12 A Yes. I'm a member of the American College of  
13 Radiology. I'm also a member of the American Institute of  
14 Ultrasound and Medicine, which is the largest organized  
15 body, society for individuals who perform sonography.

16 Q A summary of your credentials here indicates  
17 you've published approximately ten articles on various  
18 topics within sonography. Is that accurate to your  
19 recollection?

20 A Yes.

21 Q Have you delivered any presentations on the  
22 subject of sonography?

23 A Yes, ongoing lectures, either at George

1 Washington or at Johns Hopkins -- I like maintaining my  
2 affiliation with Hopkins -- and at Columbia Hospital for  
3 Women.

4 Q Have you given any presentations to conferences  
5 or seminars devoted to ultrasound in general that would  
6 draw in other medical practitioners?

7 A Yes. There is a continuing medical education  
8 series at Columbia Hospital. And I've participated in  
9 that. And I've also lectured at the national convention,  
10 AIUM convention.

11 Q Do you feel that you are familiar with the  
12 standard of care that is applicable to reasonable or was  
13 applicable to reasonable and prudent sonographers  
14 practicing in Virginia back in 1987?

15 A Yes, I do.

16 MR. MCANDREWS: Your Honor, at this point I would  
17 proffer Dr. Lipsit as an expert in the field of radiology  
18 generally and in the field of diagnostic radiology in  
19 particular.

20 THE COURT: Is there any voir dire?

21 MR. SALE: No, Your Honor. We would accept Dr.  
22 Lipsit as an expert on the issue of the standard of care.

23 THE COURT: Okay. We will receive his testimony

1 as that of an expert. You may go ahead.

2 MR. McANDREWS: Thank you, sir.

3 BY MR. McANDREWS:

4 Q Did there come a time when someone from our  
5 office contacted you to review a case involving Nicole  
6 Panousos?

7 A Yes.

8 Q Can you give a brief summary of the materials  
9 that you reviewed?

10 A Well, initially I was simply shown the ultrasound  
11 images. And I looked at the images. I analyzed them. I  
12 gave my interpretation of the images. And then I was  
13 informed what the ultimate diagnosis was. And I was  
14 surprised.

15 Q Okay. Let me just hold on. I want you to give  
16 the jury what you have reviewed, the materials you've  
17 looked at in forming your opinion. So you've reviewed the  
18 films.

19 A I've looked at the films plus a number of  
20 depositions of the parties involved. I also received a --  
21 I think it's called a statement of facts and statement of  
22 supplemental facts.

23 Q Was that in the proceedings before the medical

1 malpractice review panel?

2 A Yes.

3 Q Did you review depositions of Dr. Allen?

4 A Yes.

5 Q Did you review any depositions of the mother,  
6 Mrs. Sandra Panousos?

7 A Yes.

8 Q Did you review depositions of any other treating  
9 physicians who cared for Nicole while she was at Fairfax  
10 Hospital in March 1987?

11 A I reviewed some excerpts from I believe Dr.  
12 Hodin's deposition. That's the only one that I recall.

13 Q Did you review the chart from Nicole Panousos's  
14 admission to Fairfax Hospital?

15 A Yes. Yes, I did.

16 Q As a result of the materials that you reviewed,  
17 did you form any opinions as to whether Dr. Allen's  
18 performance of that sonographic study on March 5, 1987,  
19 complied with the appropriate standard of care?

20 A Yes, I did.

21 Q Would you please tell the members of the jury the  
22 opinion that you formed?

23 A Well, my feeling was that both the performance of

1 the examination and the interpretation were within the  
2 guidelines of the standard of care.

3 Q Okay. Let's at the very beginning make one thing  
4 clear. Would you agree, based upon review of the written  
5 report, that the written report incorrectly identifies  
6 bladder and tumor?

7 A Yes.

8 Q Given that, tell the jury why you feel that Dr.  
9 Allen's performance of that sonographic examination was  
10 within the standard of care.

11 A Well, my feeling is that the examination as  
12 presented to me was properly performed; that the analysis  
13 of the examination was logical; it was reasonable. I feel  
14 that the possibilities that were mentioned in the report  
15 were quite reasonable and logical and in fact probable.  
16 And because of that, I felt that it was within the  
17 standard of care.

18 Q Okay. Doctor, at this point let me have you look  
19 at the sonographic films and try to explain to the jury  
20 why, based upon the films that were taken, you feel that  
21 analysis was logical and reasonable. I'm going to put the  
22 machine up over here. Here are the sonogram films.

23 MR. MCANDREWS: Your Honor, may the witness step

1 down?

2 THE COURT: Yes.

3 (The witness left the stand and went in front of  
4 the jury box to the view box.)

5 MR. McANDREWS:

6 Q Before putting them on the view box, let me just  
7 ask you, is it reasonable and customary in Virginia or was  
8 it reasonable and customary back in 1987 to have a  
9 sonographic technician take some preliminary films?

10 A Yes.

11 Q What is your understanding of the purpose of  
12 those films?

13 A Well, the sonographer will document much of the  
14 anatomy in the abdomen or pelvis. It's pretty much a  
15 check list where the organs of the abdomen and pelvis are  
16 looked at. They're located. There's a determination as  
17 to whether they're normal or abnormal. And the way the  
18 doctor does that is by looking at the images and making  
19 sure that all bases are covered and that all of the organs  
20 in the abdomen and pelvis are on the films.

21 Q What was your understanding of the knowledge of  
22 Nicole's abdomen at the time she arrived at the sonography  
23 suite on March 5, 1987?

1       A       Apparently the abdomen was distended or swollen,  
2       and it was a problem-solving mission. Why is this  
3       infant's abdomen distended? Is there a mass in there?  
4       What kind of mass? Are there organs that are enlarged?  
5       Problem solving.

6       Q       Let me let you look at these films. In light of  
7       that knowledge of Nicole's condition, can you explain to  
8       the jury what is on these films?

9       A       To me the series of films indicates a very  
10      systematic pattern of examining the abdomen and pelvis.  
11      And the reason why I say that is because they're starting  
12      from high up at the diaphragm down completely low to the  
13      bottom, to the pelvis. This film is taken very high. All  
14      the images are clearly marked. So they're labeled.

15             You have to understand that the individual is  
16      looking at a TV monitor. And there's a moving picture on  
17      the monitor. And to me a large percentage of the  
18      examination is the impression that one gets from watching  
19      that TV screen. So you look at the TV screen. You're  
20      thinking. And when you find landmarks, when you find  
21      these items on your mental check list, you freeze the  
22      image; you take a picture so that there can be no  
23      confusion. Everybody knows that the organ has been looked

1 at and whether the organ is enlarged, whether the organ  
2 looks normal. This was done.

3 We're starting here. And it says sagittal right  
4 kidney. So not only do they mark right kidney but also  
5 the plane or the orientation. Sagittal means lengthwise.  
6 Transverse would be crosswise.

7 It's as if the exam table is right here. The  
8 infant's head is that way, up here. The infant's feet  
9 down here. This is the skin surface. So the crystal that  
10 I was talking about, the probe is placed on the skin  
11 surface. The sound waves project out in a fan-like  
12 manner. And we get a very thin slice. The depth to the  
13 image is perhaps a millimeter or two. It's very, very  
14 tiny. But you do get depth, and there's some width to it  
15 or length.

16 Here we're seeing the right kidney. And here  
17 we're seeing liver tissue, and here we're seeing  
18 diaphragm. And again, I know this looks abstract, but  
19 again, it's like anything else. You look at thousands of  
20 these, or you go through extensive training, and you start  
21 coming up with patterns. And this is clearly liver tissue  
22 and kidney.

23 On these images we're just looking at more. More



1 liver, gall bladder, transverse or crosswise images of the  
2 kidney. So there are half a dozen pictures isolating the  
3 kidney, the liver and the gall bladder. This is an  
4 examination of what we would call the right upper  
5 quadrant, in other words, up high under the right ribcage.

6 Q Okay. Let me ask you to look at the next series  
7 of pictures and tell what additional information that  
8 gives.

9 A To tell you the truth, there's more of the same  
10 here, more pictures, again showing the right kidney not  
11 only crosswise but also lengthwise. This is the outline  
12 of the kidney. And there's a principle in ultrasound: If  
13 it's black, it's fluid. If it's white, it's solid tissue  
14 or it could be a hollow structure filled with material.  
15 The reason why I say that is because what you're hoping is  
16 for the sound waves to strike the object and be reflected  
17 back towards that crystal. Believe it or not, 1 percent  
18 of the time you are sending out sound waves. 99 percent  
19 of the time the crystal is actually receiving or  
20 listening.

21 So these black areas indicate that there is some  
22 urine fluid up high in the kidney. I would quantitate  
23 this as being mild to moderate dilation of the kidney.

1 Mild to moderate. No more than that. If this was severe  
2 dilation, you would barely see kidney. You would see huge  
3 black holes. So it's a matter of degree.

4 That's really about all we're seeing on this  
5 picture.

6 Q Let me just ask you about that dilation. Is that  
7 something you would expect to see in a normal infant?

8 A No. No. You would not.

9 Now, they systematically moved over to the left  
10 side. So the left upper quadrant is being examined, the  
11 area under the left ribcage. And I mean we're progressing  
12 in a logical fashion here. On the left side, they went  
13 way up high under the ribcage to look at spleen, and the  
14 spleen is normal.

15 Again, I guess you sort of have to take my word  
16 for it. But the size and the pattern is normal. You'll  
17 notice it's filled with white dots. Again, solid tissue;  
18 white echoes. The left kidney looks similar to the right  
19 because it's being affected in the very same way. It has  
20 these black areas indicating that there is mild to  
21 moderate fluid build-up in the kidney.

22 Q Is that the hydronecrosis we've heard mentioned  
23 before?

1           A       That is correct. That's correct. And here, by  
2       the way, is the left side of the diaphragm, that white  
3       line. Again, the diaphragm is a solid structure, so the  
4       sound waves hit the diaphragm and bounce back very  
5       strongly, and we get a curved right white echo or line.

6           Q       Now, we moved down, and again this is clearly  
7       labeled sagittal mid pelvis. This is informing anybody  
8       who comes along later on where you are, because the probe  
9       is a free-standing probe. It's in your hand. And you  
10      have it in contact with the skin surface. And you try to  
11      keep it in place, because if the probe comes off the skin,  
12      it's a wipe-out. In fact, what you do is you put some  
13      gell or mineral oil on the skin because you must maintain  
14      contact 100 percent of the time. If you don't, air gets  
15      in-between and the image is ruined.

16                 So we're in contact here with the skin. Sagittal  
17      or lengthwise, again, feet, head, skin surface of the  
18      abdomen or belly. The table is down here. And there are  
19      two masses. These masses are fluid filled because, as I  
20      said before, if they're black, they're fluid. And if  
21      they're totally black, it means that there's no  
22      significant material or solid tissue on the inside. These  
23      masses, and I will call them cystic masses, meaning fluid

1 filled, they have relatively thin walls to them.

2 And there's some labeling here, bladder. But  
3 that's arbitrary. The individual who performed the scan  
4 at the time typed those words on the screen, indicating  
5 that that was the impression of the individual when they  
6 were doing the study, when they were looking at the TV  
7 monitor. And then they are documenting it so that folks  
8 who come along later, they can see these pictures.

9 Q This is the last of the films taken by the  
10 sonographer?

11 A Yes. Now, what happened here, they're spending a  
12 lot of time on the pelvis because they're taking another  
13 set of films of the pelvis. And again, we're seeing the  
14 two masses.

15 I particularly like this image because it  
16 really -- it gives you an idea as to the size  
17 relationships. The larger mass -- I know the concept of  
18 anterior, posterior or front and back I think has been  
19 discussed or mentioned. I'm looking at this case as much  
20 from top, bottom or superior, inferior. And the reason is  
21 because of the pictures. Now, if this is the head and  
22 these are the feet, and this is the skin surface and this  
23 is the table, this mass is above or on top of this mass.

1 And you don't need ultrasound training to identify that  
2 relationship.

3 Now, both of these masses have very thin walls.  
4 And as best as you can determine from the representative  
5 images, they look crystal clear. They look very clear.  
6 So they're fluid filled.

7 The other thing that this scan tells us, because  
8 we've looked all through the abdomen, is that there is no  
9 free fluid in the abdomen. It's not as if the abdomen was  
10 distended because there was just fluid everywhere  
11 surrounding all the structures. No. There are two  
12 fluid-filled masses.

13 Q Now, you've taken the sheet that has the two  
14 films. Do you know who did these two films?

15 A I don't know exactly who did them. I mean it's  
16 part of the examination.

17 Q The previous testimony has indicated Dr. Allen  
18 did.

19 A Okay. Fine. I have no reason to think not.

20 Now, on these films we're sort of focusing on the  
21 lower mass. Again, if you look at the relationship, here  
22 is one mass. Here is the other. Everybody is talking  
23 about front and back. But I still feel that we should be

1 talking more about top and bottom, one that is sitting on  
2 top of the other. If the person or individual was  
3 standing up, this is the way the exam would look, because  
4 this is up towards the head and that's down toward the  
5 feet.

6 By convention we look at images this way. Now,  
7 you'll notice that there is a structure which they have  
8 labeled catheter, again, indicating that at the time of  
9 the examination they spotted a structure which they felt  
10 was catheter. They labeled it. And you can see that it's  
11 two white lines with a black center. And going back to  
12 the principles of ultrasound, the front wall of that tube  
13 sends back a reflection. The back wall of the tube sends  
14 a reflection. And in-between it's hollow. But not only  
15 that, if there was air in the catheter, you wouldn't  
16 appreciate that. If there is fluid in the hole in the  
17 catheter, in that channel, then that shows up as black.  
18 So we've got front wall, the channel in-between, and then  
19 the back wall. So it does look like a catheter.

20 On these two representative images, the catheter  
21 looks like it is closely related to the lower mass. I  
22 must tell you, I can't tell for sure exactly where the end  
23 of the catheter is. I can just follow a segment of it,

1 and it's in relationship to the lower mass. These two  
2 films are documentation. At the time of the sonogram,  
3 you're looking at a TV monitor and a conclusion would be  
4 drawn based on where they saw that catheter on the TV  
5 screen.

6 Q Let me interrupt you here, Doctor. You indicated  
7 the radiologist who was interpreting the study would be  
8 looking at a monitor.

9 A Correct.

10 Q Now, once he has seen that image that there is a  
11 photo of here, if some fluid comes out of that catheter,  
12 what conclusions would he be reasonable in drawing?

13 A If fluid is coming out of the catheter, it just  
14 makes sense that the catheter has to be in contact with a  
15 structure that contains fluid.

16 If you're putting a catheter into the urethra and  
17 you are getting back fluid, it makes all the sense in the  
18 world that that fluid is coming from the bladder because  
19 the bladder will be the fluid-containing structure in the  
20 pelvis.

21 Q What is your understanding based on your review  
22 of the records and the testimony that you've seen of the  
23 purpose for Dr. Allen using the catheter in the study?

1       A       Well, there was a real challenge here. There was  
2       a massively distended abdomen in a very young patient.  
3       And it seemed like nobody really knew why. And the  
4       problem that was presented in the Radiology Department was  
5       why does this abdomen look the way it does. And the goal  
6       of the sonogram was to determine why. Is it because of a  
7       big, solid mass? Is it because of blood filling the  
8       abdomen? Is it because of a fluid-filled mass? And the  
9       sonogram and Dr. Allen correctly identified two  
10      fluid-filled structures being responsible for this  
11      distention.

12             What he then did was to try to be more specific,  
13      instead of just saying there are two fluid-filled masses,  
14      I don't know what they are, that's what's causing the  
15      problem, and this is just speculation on my part. But I  
16      think some people might have said the sonogram has been  
17      completed. I've gone as far as I can. That wasn't the  
18      case here. He said I'm going to try to refine this. I'm  
19      going to try to take it one step further, provide more  
20      information. So with the permission of the clinicians,  
21      from what I gather -- and again that was an appropriate  
22      thing to do -- he decided to take a very soft tube. And  
23      the logic behind this, the thinking was if I can put a



1 tube in, if I can see the tube, and if I can get some  
2 fluid back, that it makes logical sense that I'm in the  
3 bladder and I can identify the bladder. And what he was  
4 trying to do was to make sure that one of these structures  
5 was the bladder.

6 You can have situations where the bladder is  
7 totally empty and depressed and you simply do have two  
8 abnormal cystic masses. The likelihood here was extremely  
9 high that one of those masses was abnormal because you're  
10 not going to have two bladders. But what he was trying to  
11 do was to determine, well, maybe one of these masses is  
12 the bladder and the other one isn't. And that's why -- I  
13 believe that's why he did this.

14 Q Looking at the structure that catheter is  
15 adjacent to, would that be consistent with a bladder in a  
16 four-and-a-half month old infant?

17 A You know, I think so. It's certainly down low in  
18 the pelvis. It is thin-walled. It is fluid-filled, and  
19 from a sonogram, which again it's a noninvasive test --  
20 it's just using sound waves; you get a lot of information  
21 from it only to a certain extent -- and that looks like a  
22 bladder.

23 Q Can you characterize at all based upon this film

1 and what you know of Nicole's size, would that appear to  
2 be a typical size for a child of her age, larger, smaller?

3 A It would be -- that's hard to say. Again, I've  
4 just got two images, two representative images. It would  
5 not be inconceivable. That could be a bladder.

6 Q Let me just ask you before you resume your seat  
7 on the stand, on the easel there is an illustration Dr.  
8 Allen made while he was on the stand. It has been labeled  
9 as Defense Exhibit No. 6. Is that drawing of those two  
10 large masses within Nicole's abdomen consistent with what  
11 you yourself see on these films?

12 A The only -- and this is just my opinion. The  
13 only difference I would have made in these drawings would  
14 be the relationship in terms of size between these two.  
15 And again, it's only from the submitted images that I  
16 looked at. I would have tended to make this even a little  
17 larger and this one even a little smaller, quite frankly.  
18 But the relationship is correct. Superior and inferior or  
19 up high, down low. And the only reason why I would have  
20 made this a little larger is because this spanned all the  
21 way up under the diaphragm, but it's very close to the way  
22 I would have drawn it.

23 Q When you say under the diaphragm, can you

1 indicate how high up on yourself?

2 A Well, the diaphragm would be up here. On several  
3 of those images you can see that mass way up high under  
4 the liver tissue. That's all I mean. It wasn't actually  
5 under the diaphragm. It was up high under the spleen and  
6 under the liver tissue. It was filling the abdomen. And  
7 that's why the clinical impression was grossly distended  
8 abdomen.

9 Q Okay, Doctor, if you want to resume your seat on  
10 the stand.

11 (The witness resumed the stand.)

12 BY MR. McANDREWS:

13 Q Doctor, the chart has been moved into evidence in  
14 this case. In that chart is a pathology report on the  
15 mass that was ultimately removed from Nicole's abdomen.  
16 And that report indicates it was a presacral teratoma.  
17 Can you please tell the jury what the usual appearance of  
18 a presacral teratoma is on a sonogram?

19 A Well, in my opinion there were a number of very  
20 unusual aspects to this case. Probably at the top of the  
21 list is the fact that a cystic teratoma, it's not a very  
22 common mass, but when seen, it usually does not look like  
23 this. The fact of the matter is even though it's called

1 cystic teratoma, it is rarely purely cystic. In fact, the  
2 word teratoma means tissue from other parts of the body.  
3 And it's an unusual type of mass in that it often has --  
4 it can have some fat or some mineral content, some  
5 calcium, some skeletal elements. It's -- it's a strange  
6 type of mass. But this one was purely cystic and thin  
7 walled, and that is most unusual.

8 Q Are presacral teratomas common in young children?

9 A Well, they're not -- no, they're not common. And  
10 again, of the varieties of presacral teratomas that one  
11 can have, to have a presacral teratoma that is totally  
12 internal, that is not creating any deformity of the  
13 adjacent spine, and that is purely fluid-filled with a  
14 thin wall, that is extraordinarily unusual.

15 Q You mentioned there was some build-up of fluid or  
16 collection of fluid in the kidneys. We now know that  
17 Nicole's bladder had almost a liter of fluid in it. Is  
18 the degree of build-up of fluid in the kidneys that you  
19 observed on those films consistent with that degree of  
20 bladder distention in your opinion?

21 A Well, let me also state that by far that was the  
22 largest bladder I've ever seen. And I even -- there was a  
23 comment that stuck out in my mind in terms of Dr. Hodin's

1 deposition where he stated that that was certainly the  
2 largest urinary distention, largest bladder that he had  
3 ever seen. The fact is, if you've got 4 or 500 cc.'s --  
4 14 ounces or 15 ounces of fluid in your bladder, you're  
5 very uncomfortable. This four-and-a-half-month old had --  
6 it was 1,055 cc.'s. That was twice the amount that an  
7 uncomfortable adult would have. So that was really a  
8 massive distention of the bladder. Interestingly, and  
9 what also made this somewhat unusual in terms of trying to  
10 put this whole thing together, the dilation of the kidneys  
11 was only mild to moderate. Unusual.

12 Q Let me ask you to assume that Dr. Allen obtained  
13 some fluid out of the catheter, a few drops of fluid.  
14 Would that justify him concluding based upon what he saw  
15 in the films and what came out of that catheter, those few  
16 drops of fluid, justify a conclusion that that smaller  
17 pelvic mass was in fact the bladder?

18 A It would be a logical conclusion.

19 Q Would it be a reasonable conclusion?

20 A It would be. We know now it was incorrect. But  
21 it was logical.

22 Q What's your understanding of Nicole's demeanor  
23 while this study was being performed?

1           A       I mean obviously I wasn't there. But clearly,  
2       there was a great deal of discomfort, as one could  
3       imagine. One could only guess as to the amount of  
4       discomfort that the infant had at the time. The abdomen  
5       was massively distended. And, you know, I don't know how  
6       else to answer that.

7           Q       Would the child's urinary history from the time  
8       of arrival at the emergency room at roughly midnight  
9       through the ten hours or so that ensued until she arrived  
10      at the sonography suite have been significant in  
11      interpreting this study?

12          A       It's a piece of information. We like to have as  
13      much information as possible. I couldn't see that as  
14      being particularly important or critical. And the reason  
15      for that is that if there is some urination, you can still  
16      have obstruction of the bladder, obstruction to the  
17      kidneys; and if you flip that around, if there hasn't been  
18      urination, it could be for a number of different reasons.  
19      The baby could be dehydrated, especially if there's been a  
20      limited oral intake or if the baby has been running a  
21      fever, has been sick. This kid could have been dehydrated  
22      at the time. So it's another bit of information. Is it  
23      critical? In my opinion, no.

1 Q It would not be unreasonable one way or the  
2 other. You just would factor that in, that information?

3 A I think I probably would have asked. I might  
4 have filed it away in the back of my mind. It might even  
5 have -- again, I just don't see how it would have been  
6 critical in terms of my reaching the diagnosis during the  
7 performance of the sonogram. You always want to have as  
8 much clinical information as possible. But I don't see it  
9 as being critical.

10 Q Can you explain to the jury briefly what the  
11 radiologist, the sonographer's role or authority is as far  
12 as ordering additional diagnostic studies or radiological  
13 studies?

14 A You know, as a sonographer, I do all the cases  
15 myself. I have a sonographer, but I also examine every  
16 patient. I see myself as a consultant. The first thing  
17 that I do is I make sure that there's an indication for  
18 the study. A request will come to me to perform a study.  
19 I make sure that the communication is proper, that I am  
20 performing the proper study that was ordered. I perform  
21 the study, and then I report to the clinician or the  
22 primary care doctor.

23 I never know as much about the patient as the

1 primary referring physician. I see myself as a  
2 consultant. I try in a relatively brief period of time to  
3 learn as much about the person as possible. But by the  
4 same token, my primary responsibility I think is to  
5 perform a proper examination and to get that information  
6 to the referring doctor.

7 Q Back in 1987, if you had a situation where you  
8 have seen the films you just saw, you've seen the images  
9 on the television monitor or the monitor screen for the  
10 sonogram machine, and you've gotten a few drops of fluid  
11 out of a catheter, did the standard of care require the  
12 sonographer or the radiologist to introduce some sort of  
13 contrast material through the catheter to further confirm  
14 that it was indeed in the bladder?

15 A I really don't think so. I think that if a  
16 thorough procedure is performed, you form an impression.  
17 You try to come to a logical conclusion. 50 or 60 times a  
18 day I examine people. And I try to approach 100 percent  
19 accuracy; but quite honestly, what I'm doing is giving a  
20 highly probable impression throughout the course of the  
21 day. I am taking a noninvasive test. I'm trying to take  
22 pictures generated by sound waves. And I'm trying to come  
23 up with highly probable, very, very probable diagnoses.



1 I think that if the individual performing the  
2 examination performs a thorough exam, comes to a  
3 conclusion, and then forms what we call a differential  
4 diagnosis, just the term itself indicates that we deal  
5 with probabilities, but forms a -- a sort of a menu of the  
6 most likely possibilities in order of highest probability  
7 to lowest probability. I think that's adequate. And this  
8 is a judgment call. This is a judgment that any  
9 consultant, anybody doing an imaging procedure has to go  
10 through this exercise.

11 And very often the only time that you know for  
12 sure that you can put a label on an internal structure is  
13 when the pathologist has that structure or when it's being  
14 looked at under the microscope. But of course, that's  
15 impractical. So what we're doing is we're coming up with  
16 tests that are getting better and better and less and less  
17 invasive because you don't want to hurt anybody. You're  
18 trying to not hurt them. And yet, you're trying to come  
19 up with a diagnosis that is highly probable. And that's  
20 the way, you know, I see my function, and that's the way I  
21 think most radiologists or sonographers see their  
22 function.

23 Q While we're talking about the catheter and the

1 fluid that was observed coming out of that catheter, as  
2 you indicated at the outset of your testimony, it's become  
3 clear that that smaller lower structure that was initially  
4 identified as bladder was not in fact the bladder.

5 A Correct.

6 Q Can you give any explanation to the jury based  
7 upon what was seen on those films and your understanding  
8 of infant anatomy in a young female like this as to how  
9 some fluid might have ended up in that catheter?

10 A Yes. This is just a theory on my part, but I  
11 think it's a very good one, quite frankly. In this  
12 particular case the anatomy was grossly distorted.  
13 There's no question about it. And it's one of the things  
14 that makes this case so unusual. You're dealing with an  
15 unusual mass which is presenting or appearing on a  
16 sonogram in an unusual fashion. And there is a gross  
17 distortion of the normal anatomy. The bladder is  
18 massively distended. It's stretched way up high into the  
19 abdomen. Now, the bladder is fixed down low in the  
20 pelvis.

21 You have the opening, the urethra, which in an  
22 infant female is a very, very short segment. It's really  
23 the opening to the bladder. And then you have an area

1 called the bladder neck, which is simply the lower portion  
2 or the base of the bladder.

3 Now, the bladder is like a balloon. And it  
4 becomes more and more like a balloon as you distend it.  
5 The wall gets thinner and thinner. And it becomes  
6 relatively pliable. It becomes fairly soft. Now, if this  
7 bladder, which should be living in the pelvis but instead  
8 is up way high under the liver tissue, if it is being  
9 pulled and stretched from its point of fixation, which is  
10 down low in the pelvis, well, that bladder neck has been  
11 distorted and stretched.

12 Now, the catheter on those films is passing just  
13 behind what's called the pubic bone, which is the bone  
14 that's in front of all the pelvic organs. And it looks  
15 like it's closely applied to the undersurface of the pubic  
16 bone.

17 Now, even though the catheter looks like it is  
18 next to or in adjacent to the lower smaller mass, which  
19 mimicked the bladder, in fact, knowing what we know now --  
20 this is all retrospective. We're all geniuses in  
21 retrospect. But looking back on it, I think that catheter  
22 was probably within a distorted and stretched bladder  
23 neck; I think that catheter was in contact with the

1 bladder. However, most of the bladder was up high in the  
2 abdomen where it shouldn't be, and the catheter was in a  
3 stretched, distorted bladder neck; and that's the only way  
4 you're going to get fluid out of that catheter. It had to  
5 be in contact with the bladder because on the operative  
6 report there was no mention whatsoever of the teratoma,  
7 the lower mass being perforated or rupturing. There was  
8 no evidence of that. So the fluid was coming from the  
9 bladder. But it looked like the lower structure, but  
10 instead, it was skirting or closely applied to the lower  
11 structure and the tip was probably in communication with  
12 the bladder up high. And to me that's a very logical  
13 scenario. But only when you tell me what these two masses  
14 are, and I've got the answers in front of me, I can  
15 reconstruct the scenario.

16 Q Would that be consistent with the theory that the  
17 teratoma was compressing the urethra up against the pubic  
18 bone and the urethra was between the two?

19 A Again, I'm trying to be -- I'm trying to do now  
20 what I do every day when I do an examination, and I send  
21 out a report to a clinician. I'm trying to look at the  
22 facts and be logical and not come up with the exception to  
23 the rule. And the fact is over a thousand cc.s in a

1 neonatal bladder, extraordinary dilation. To me that  
2 translates into significant obstruction. And to get that  
3 degree of obstruction, you're obviously compressing the  
4 base of the bladder, the bladder neck in order to create  
5 that appearance.

6 Q What is an IVP, Doctor?

7 A An intravenous urogram. It's an invasive  
8 procedure where one takes a needle, inserts it into a  
9 vein. You inject a solution that we call a dye, but in  
10 reality it's a solution filled with particles. And the  
11 particles, the molecules contain iodine. And the iodine  
12 shows up very nicely on X-ray. You inject the material.  
13 Normally functioning kidneys will extract that iodine,  
14 those molecules, from the bloodstream; and that makes it  
15 quite convenient because the kidney soaks it up. It then  
16 excretes it into the urine. And so you can see on X-ray  
17 kidneys, the ureters, which are the connection between the  
18 kidneys and the bladder, and the bladder itself. But it's  
19 dependent upon enough of that iodine getting into the  
20 urine so that you can see it on X-ray.

21 Q Given the degree of bladder distention that we  
22 know of in this case and that backup of fluid in the  
23 kidneys, would it have been of any additional diagnostic

1 usefulness in Nicole's case?

2 A Possibly. The reason why I say possibly is  
3 because firstly, and this is without question, intravenous  
4 urography is usually very poor in neonates. They often  
5 have difficulty in concentrating their urine. If you --  
6 if you're practicing in a pediatric age group, certainly a  
7 neonatal age group, intravenous urography is usually not  
8 performed because it's not particularly good in terms of  
9 visualizing the urinary tract and it has to do with the  
10 neonatal kidneys.

11 The other point is if there's a compromise in  
12 renal function or if there's back pressure on the kidneys,  
13 it can often make the image fairly indistinct because  
14 there's an inability of that iodine to be properly  
15 extracted by the kidneys and excreted into the urine.

16 The other thing I'd like to state is that it's  
17 not a totally innocuous procedure because you are  
18 injecting a material which, although uncommon, can be  
19 associated with various allergic reactions.

20 But the other point that I want to make is that  
21 it always results in some depression in renal function.  
22 But the way we can -- the reason why we can get away with  
23 that is that in the adult population it's subclinical,

1 meaning that even though you can measure -- with  
2 sophisticated tests you can measure changes or decreases  
3 in renal function, in reality it really doesn't matter.  
4 It doesn't create any damage to the kidney and it's  
5 transient and you can get away with it. So it's a helpful  
6 test in adults. But it's not commonly employed in  
7 neonates.

8 Q Just to summarize, it's your opinion that Dr.  
9 Allen's performance of the sonogram was reasonable and was  
10 within the standard of care for a reasonable physician in  
11 Virginia --

12 THE COURT: Do you object?

13 MR. SALE: Your Honor, I object. Summaries have  
14 been disallowed.

15 THE COURT: Sustained.

16 BY MR. McANDREWS:

17 Q One final area. In communicating his opinions to  
18 Dr. Hodin, what is your knowledge of what was communicated  
19 to Dr. Hodin, your understanding of what was communicated?

20 MR. SALE: Your Honor, I would object again.

21 THE COURT: What relevance does that have? I  
22 sustain the objection.

23 MR. McANDREWS: Okay. That's all the questions I

1 have right now, Doctor.

2 THE COURT: Okay. Would you stand and stretch.

3 (A stretch break was taken.)

4 CROSS-EXAMINATION

5 BY MR. SALE:

6 Q Dr. Lipsit, you were approached regarding this  
7 case by Mr. Godard; is that correct?

8 A Yes.

9 Q Did you tell him that having some fluid produced  
10 through the catheter was an important part of the  
11 examination?

12 A Absolutely.

13 Q And that was before you reviewed the case?

14 A When I was shown the films, I wasn't at that  
15 point aware of whether fluid had or had not been produced,  
16 and I told him at the time that I had to know that. That  
17 was important. That's what I recall.

18 Q Was that because looking at the films, you really  
19 couldn't tell whether the catheter was in the bladder?

20 A Couldn't be a hundred percent certain.

21 Q Now, you've been a witness on behalf of Mr.  
22 Godard's firm before, haven't you?

23 A In this case.



1 Q Never before that?

2 A No, I haven't been a witness, no.

3 Q Have any of your associates been a witness for  
4 Mr. Godard before?

5 A I think one of my partners has.

6 Q Did Mr. Godard's firm ever represent you or one  
7 of your partners in a legal action?

8 MR. McANDREWS: Your Honor, I'm going to object  
9 to that. What relevance does that have to this case?

10 THE COURT: I sustain the objection.

11 BY MR. SALE:

12 Q Now, Dr. Lipsit, you did review the films at the  
13 initial review of this case in connection with your  
14 formulation of opinions; is that correct?

15 A Yes.

16 Q Now, Dr. Lipsit, do you also take films, stills,  
17 when you do a sonography?

18 A Yes.

19 Q Now, the stills that you take, do you try to take  
20 the ones that will best confirm what you see?

21 A Yes.

22 Q Do you try to take the films that are most  
23 representative of what you see?

1           A     Yes.

2           Q     But you said from the stills you saw here, you  
3     couldn't confirm that the catheter was in the bladder.

4           A     Well, the films are always representative. I  
5     mean looking at the TV monitor is what really counts  
6     during the course of the exam. You know, I thought I had  
7     made that clear.

8           Q     But from the films themselves, the still life,  
9     you couldn't tell for sure.

10          A     Very often all the films show is that you've been  
11     thorough and systematic in your search. That's really the  
12     purpose of the films.

13          Q     So that made the fluid all the more important  
14     because when looking at the stills, you again couldn't  
15     tell if the catheter was in the bladder.

16          A     I totally agree.

17          Q     Now, was there anything in the radiology  
18     itself -- I'm sorry -- in the sonography when Dr. Allen  
19     did his examination, that indicated that Nicole was  
20     difficult to evaluate clinically?

21          A     You know, I couldn't tell that from the images.  
22     No, I couldn't tell that from the scan.

23          Q     Okay. So your answer is no.

1 Now, is your opinion based on the fact that Dr.  
2 Allen did in fact produce urine?

3 A Yes.

4 Q Is your opinion based on the fact that Dr. Allen  
5 in the oral report to Dr. Hodin did not confirm that one  
6 of the masses was the bladder?

7 A I'm sorry. I don't understand your question.

8 Q All right. It might be better then just to have  
9 you review that. I'm going to hand you Plaintiffs'  
10 Exhibit No. 8. And I'm going to ask you by reviewing  
11 that --

12 MR. McANDREWS: What is that?

13 Q Plaintiffs' 8, the sonography report. Can you  
14 tell me in the written report did Dr. Allen confirm that  
15 one of the masses was not the bladder?

16 A From reading the report, it indicated to me that  
17 he confirmed that one of the masses was the bladder.

18 Q Okay.

19 A That's how I interpret this report, that one of  
20 the masses was the bladder.

21 Q Okay. Now, from what you have seen of the films,  
22 would it be appropriate to confirm that one of the masses  
23 was the bladder?

1           A       From those films I would have come to that  
2 conclusion.

3           Q       So if this was the oral report to confirm that  
4 one of the masses was indeed the bladder would have been  
5 correct.

6           A       Yes.

7           Q       And again, though, that's based upon the  
8 production of a few drops of urine.

9           A       Absolutely.

10          Q       Now, is a return of urine the same as a few  
11 drops?

12          A       Yes.

13          Q       So fluid -- return of fluid or return of urine,  
14 that's just the same --

15          A       Fluid is fluid.

16          Q       Now, would a little moisture in the catheter,  
17 would that be enough to be sure you were in the bladder?

18          A       Well, the moisture would have to come from  
19 somewhere. You start out with a dry catheter. You know,  
20 we can split hairs on this. My feeling is that anything  
21 from droplets to more than droplets indicates that you're  
22 in a fluid-filled structure. That just makes sense.

23          Q       You indicated some droplets could have been in

1 the bladder neck. Is that accurate?

2 A Yes, sure.

3 Q What about some droplets being in the urethra or  
4 the vagina. That's also possible, isn't it?

5 A Well, the vagina would have been markedly  
6 compressed, but the answer is there could have been fluid  
7 in the vagina, absolutely.

8 Q Have you ever done this procedure yourself,  
9 catheterization?

10 A Many times.

11 Q Have you ever missed the urethra and inserted the  
12 catheter into the vagina?

13 A Absolutely. Usually that's when I -- when I  
14 first started out. I think anybody who's first in  
15 training and first starting out, that may happen.

16 Q So that happened when you first started out.

17 A Yes.

18 Q Now, you would have asked about Nicole's history  
19 before --

20 A By the way, let me also state that in inserting  
21 the catheter into a vagina, I have never produced fluid  
22 out of a catheter. In fact, that's how I knew I was in  
23 the vagina because I wasn't getting fluid.

1 Q Okay. Now, you would have asked about Nicole's  
2 urination history when you did this radiology; is that  
3 correct?

4 A As part of my information gathering, yes, I think  
5 I would have.

6 Q Now, if Dr. Allen had seen two masses and he only  
7 told Dr. Hodin he saw one, would that violate the standard  
8 of care?

9 A Well, he would not have been reporting what was  
10 on the examination. And the examination showed two  
11 fluid-filled masses or structures. So yeah.

12 Q Is your answer yes?

13 A Yeah.

14 Q I'm going to show you Plaintiffs' Exhibit No. 21,  
15 which is the X-ray radiology, and ask you if you've seen  
16 that exhibit before.

17 A If I have, I don't recall seeing it. If it was  
18 part of the -- if it was part of the patient's chart, then  
19 I probably saw it, but it's been a long time. So I don't  
20 recall it.

21 Q Okay. Now, can you tell me what the -- since you  
22 don't recall seeing it, can you tell me what the first  
23 X-ray upon entry to the hospital for Nicole Panousos

1 shows?

2 A The first X-ray report, the one that you have  
3 outlined in yellow?

4 Q Yes.

5 A Should I read it?

6 Q Sure.

7 A Okay. "Impression: There is a large central  
8 lower abdominal and pelvic mass in a girl. Leading  
9 possibilities would be ovarian or hemocolpos. Of  
10 course, this could represent large bladder which would be  
11 unusual in a girl, and ultrasound is suggested for  
12 evaluation."

13 Q How many masses did that report refer to?

14 A It refers to one mass, I believe.

15 Q Now, did you see anything in the records  
16 indicating that Dr. Hodin ever saw that report?

17 A I don't recall that.

18 Q Would that typically have been the basis for the  
19 surgeon calling for further radiological testing?

20 A You know, again, this is just conjecture on my  
21 part. But I think that in a neonate with a distended  
22 abdomen, sonography is a very reasonable choice. This  
23 report would do nothing to stop one from getting a

1 sonogram, and in fact it might encourage one to get a  
2 sonogram. But it's very logical to get a sonogram if you  
3 have a distended abdomen in a neonate.

4 Q Okay. I will ask it this way. If you had taken  
5 that X-ray, would you have reported the findings in the  
6 normal course of your practice to the pediatric surgeon?

7 A I notify the clinician whenever there's a  
8 positive finding.

9 Q So is your answer yes?

10 A Absolutely.

11 Q Now, I don't want you to go into the other X-ray  
12 reports there. I just want you to look at them for  
13 identification. Do you see some X-ray reports in the  
14 hours after surgery on that sheet and on the following  
15 sheet?

16 A I see some reports from 3/6. You'll have to tell  
17 me what the date of the --

18 Q The initial examination was 3/5?

19 A It was on 3/5.

20 Q Right.

21 A Well, I have reports here from 3/6.

22 Q So there are some other reports in there.

23 A That's a whole bunch.



1 Q Who has signed that report?

2 A Has signed which --

3 MR. McANDREWS: Your Honor, I'm going to object  
4 to the relevance.

5 THE COURT: Sustained. I sustain the objection.  
6 Go to your next question.

7 MR. SALE: Your Honor, could I --

8 THE COURT: Do you know who signed it?

9 MR. SALE: Yes, I do.

10 THE COURT: It's in evidence. Tell them who  
11 signed it.

12 BY MR. SALE:

13 Q Are those signed by David Bralier?

14 MR. McANDREWS: We will stipulate to that, Your  
15 Honor.

16 THE COURT: Stipulated to. Yes. Go ahead.

17 BY MR. SALE:

18 Q Do you know David Bralier?

19 A Yes.

20 Q Who is he?

21 A He used to be on the staff at Children's  
22 Hospital. And when I did my training at Children's  
23 Hospital as part of my radiology residency, which was over

1     ten years ago, David was there.

2           Q     Now, I'm not asking you this as a pediatric  
3     surgeon, because I know you can't speak to what a  
4     pediatric surgeon would rely upon. But as another  
5     radiologist, would you rely on a report by David Bralier?

6           MR. McANDREWS: Objection, Your Honor. What is  
7     the relevance to what he has testified to?

8           THE COURT: What is the relevance?

9           MR. SALE: Your Honor, it's relevant for what Dr.  
10    Hodin knew and what anybody reviewing these X-ray reports  
11    could have relied upon in any course in the clinical  
12    training. We've heard a lot of witnesses for Dr. Allen  
13    say that these reports were unreliable.

14          THE COURT: How does what Dr. Hodin would have  
15    reviewed --

16          MR. SALE: I asked him whether he relied upon  
17    them as a radiologist.

18          THE COURT: Okay. You may answer. Would you  
19    have relied upon them as a radiologist?

20          THE WITNESS: Yes. Yeah.

21          BY MR. SALE:

22          Q     Now, from your review of the medical records, is  
23    it your impression that Dr. Hodin understood from Dr.

1 Allen's review from his sonography that Nicole had two  
2 fluid-filled masses in her abdomen?

3 A Firstly, you know, I can't be sure exactly what  
4 Dr. Hodin did or didn't know. I really can't be. And in  
5 fact, you know, the report was typed up after the fact. I  
6 really don't know what was communicated between the two  
7 individuals. I can't possibly comment on that.

8 Q So your opinion is basically given on the written  
9 report and assuming the oral report was more or less the  
10 same?

11 A My opinion is based on the sonogram which, you  
12 know, I like to think I'm an expert at sonography. And  
13 I -- to be honest, I don't want to wander past that  
14 because I'm -- that's all I can really comment on with  
15 confidence.

16 Q Okay. Now, if Dr. Allen had told Dr. Hodin that  
17 Nicole only had one fluid-filled mass in her abdomen, you  
18 told me that would violate the standard of care. Is that  
19 correct?

20 A Yeah. Yeah. Yeah. There were two fluid-filled  
21 masses mentioned in the body of the report. So if the  
22 information wasn't communicated that there were two  
23 masses, one of which he thought was the bladder which made

1 sense, for some reason he -- I'm trying to get to the gist  
2 of your question. I'm trying to figure it out.

3 Q Your answer was fine.

4 You told me you couldn't tell from the records  
5 what Dr. Hodin had understood or may not have understood.  
6 I'm showing you Plaintiffs' Exhibit No. 5 --

7 A Right.

8 Q -- and asking you to look at that exhibit.

9 A Yeah.

10 Q It's already been testified that Dr. Hodin and  
11 Dr. Clayton's names appear on there. And I want you to  
12 tell me what was Dr. Hodin's or whoever prepared that  
13 report, what was their understanding of Nicole's anatomy  
14 from that report?

15 MR. McANDREWS: Objection, Your Honor.

16 THE COURT: Sustained. There are umpteen reasons  
17 why I sustain that objection. But the first one is the  
18 premise of your question. What did whoever prepared it  
19 understand. I think that's such an inappropriate question  
20 in a court of law that I sustain the objection.

21 BY MR. SALE:

22 Q Is that a medical record?

23 A It looks like a medical record, yes.

1 Q What kind of medical record is it?

2 A It's entitled Death Summary.

3 Q Okay. Is that prepared in the normal practice of  
4 medicine?

5 MR. McANDREWS: Objection, Your Honor. Once  
6 again, what relevance does it have? We'll stipulate it's  
7 a medical record.

8 THE COURT: It's a medical record and it is  
9 prepared, I'm sure, in the normal practice of things.  
10 What is it you want to get out? Are you trying to  
11 establish -- are you trying to establish what was  
12 communicated by this person, the defendant in this case,  
13 by what some unknown person who prepared the report said?  
14 Are you trying to prove the communication or lack thereof  
15 on the basis of the language in this report?

16 MR. SALE: Your Honor, we're trying to prove --  
17 Dr. Hodin has already testified that he first thought that  
18 there was one mass, possibly septated, and certainly if  
19 there had been more than one mass, that if there had been  
20 one mass -- more than one mass, neither of them were the  
21 bladder. That was Dr. Hodin's testimony. And we're  
22 simply trying to relate that to the facts that were the  
23 foundation for this witness's opinion.

1 THE COURT: Well, you may rephrase questions. Go  
2 ahead.

3 BY MR. SALE:

4 Q Does that death summary indicate objective  
5 findings from the surgery?

6 A Yes.

7 Q What are those findings?

8 A Let me read through this. Well, I could read  
9 this paragraph, which seems like an objective summary of  
10 what was found at surgery. Would you like me to read  
11 that?

12 Q Yes.

13 A "Once the bladder was decompressed, a second  
14 cystic mass was discovered filling the posterior pelvis,  
15 and which ultimately was revealed to have been the cause  
16 for compression of the bladder neck and thus the cause for  
17 the obstructive uropathy," which means the backup of  
18 fluid. "This small cyst," small cyst, "was biopsied and  
19 found to have columnar epithelium and was thought to  
20 represent a rectal duplication cyst." Interestingly, at  
21 the time this was done, they actually thought it was  
22 something else because it was so unusual. That was my  
23 comment. That wasn't in the report.

1 Q Okay. Now, the first part tells the impression  
2 from radiology, does it not?

3 A Yes.

4 Q What is that impression?

5 A "Because of the impression of a very large  
6 unilocular cyst filling the abdomen with probable  
7 compression of the ureters, an ovarian or mesenteric cyst  
8 was felt to be the most likely possibility.

9 Catheterization of the bladder at that time produced no  
10 urine. On this basis, an exploratory laparotomy was  
11 performed on the afternoon of the fifth of March, which  
12 ultimately revealed a hugely distended urinary bladder  
13 which was decompressed intraoperatively, and from which  
14 approximately 1 liter of urine was drained."

15 Q Now, that indicated that the impression was of a  
16 very large unilocular cyst. Is that correct?

17 A Correct.

18 Q Does it indicate that there was an impression  
19 also of another cystic mass?

20 MR. McANDREWS: Your Honor, the document speaks  
21 for itself. He's been over it twice already. It's  
22 repetitious.

23 THE COURT: Sustained.

1       A     There were two cystic masses stated in the  
2     report.

3               BY MR. SALE:

4       Q     Not in the report I showed you. I'm sorry. I  
5     will give it right back. Does this report indicate that  
6     there were two --

7               MR. McANDREWS: Your Honor, I object. We covered  
8     this.

9               THE COURT: I sustained the objection. You may  
10    read it to the jury. How many you think are in there,  
11    read it to the jury and they'll draw their conclusion. In  
12    closing argument, argue to the jury what conclusion you  
13    want them to reach, that this doctor didn't do something  
14    or that he did do it. Argue it. But don't ask these  
15    witnesses to draw the conclusions before you read it to  
16    the jury. It's in evidence. So they're certainly  
17    entitled to know it and they can draw their own  
18    conclusions, particularly with the help of your argument.

19              MR. SALE: Thank you, Your Honor.

20              BY MR. SALE:

21       Q     Does the written report that you said you relied  
22    on to confirm for yourself that Dr. Allen complied with  
23    the standard of care, does that written report -- does



1     that indicate that one of the masses was a large urinary  
2     bladder?

3           A     No. It mentions two masses.

4           Q     Does it say that one is a large uncatheterized  
5     urinary bladder?

6           A     No, it doesn't say that one is a large  
7     uncatheterized urinary bladder.

8           Q     Isn't that what the physiology shows on that  
9     drawing?

10          A     That's what we know it to be.

11          Q     And that's what you visualized when you looked at  
12     those films. Isn't that correct?

13          A     No. That's not what I said.

14          Q     Okay.

15          A     What I said was that there were two cystic  
16     masses. Now I know that the larger one was the bladder.

17          Q     Okay. At the time they thought the smaller one,  
18     I'm referring to the smaller one, at the time they thought  
19     the smaller one was the bladder; is that correct?

20          A     Yes.

21          Q     And that was confirmed to be the bladder.

22          A     That was the impression.

23          Q     Now, was the surgeon told by that report, if the

1 oral report was the same, that we had a large urinary  
2 bladder that was uncatheterized?

3 A No.

4 Q Did the standard of care require that the surgeon  
5 be told that there was a large urinary bladder  
6 uncatheterized if that was found in radiology?

7 A No, because prospectively what was stated was  
8 logical.

9 Q What was stated was that there were two masses;  
10 right?

11 A That's correct.

12 Q Okay. And they didn't get much urine; right?

13 A I don't know that. All I know is that in the  
14 deposition, Dr. Allen indicated that droplets came out of  
15 the catheter, and that fulfilled my criteria for a return  
16 through the catheter. It was in contact with a  
17 fluid-containing, fluid-producing structure.

18 Q Would those droplets have drained the large lower  
19 mass?

20 A Would those droplets have drained it?

21 Q Yes.

22 A Not completely.

23 Q So if it was undrained and it was still large,

1 you shouldn't tell the surgeon that there was an  
2 undrained, large urinary bladder in the patient going to  
3 surgery?

4 A It's obvious that he thought that the smaller  
5 mass was the bladder. We've been through this. And I  
6 already stated, not more than 25 minutes ago, that the  
7 smaller mass would not have been inappropriate for a  
8 neonatal bladder.

9 Q But the smaller mass was still large, wasn't it?

10 MR. McANDREWS: Your Honor, I'm going to object.  
11 He's answered the question. If counsel doesn't like the  
12 answer, he can deal with the later. But the question has  
13 been asked and answered three times already.

14 THE COURT: Sustained.

15 BY MR. SALE:

16 Q Do you know that in the course of the sonography  
17 here, one of masses, meaning the lower mass, was  
18 identified to be a full bladder?

19 A It was identified to be a bladder and it was  
20 labeled as such.

21 Q It was labeled a full bladder?

22 A It was labeled bladder.

23 Q It wasn't labeled full bladder?

1           A       It's labeled bladder.

2           Q       Would you like to look at the sonography and see  
3 if that would help you find whether it was labeled full  
4 bladder?

5           A       I remember the picture. It said bladder on it.

6           Q       It just said bladder.

7                   So that report that you read did not indicate  
8 what was on the sonography that there was a full bladder  
9 inside this child; is that correct?

10           MR. McANDREWS: Objection, Your Honor. It's been  
11 asked and answered.

12           THE COURT: Sustained.

13           MR. SALE: I have no further questions.

14           THE COURT: Is there any redirect?

15           MR. McANDREWS: No, sir. This witness can be  
16 excused.

17           THE COURT: Okay. You're excused. Thank you for  
18 coming. Watch your step.

19                   (Witness excused.)

20                   Let's take a 15-minute break, and you're free to  
21 go downstairs if you would like.

22                   Who will your next witness be?

23           MR. McANDREWS: Other than moving in admission of

\* \* 500 \*



1 THE COURT: I deny your motion.

2 How long would you like for closing argument?

3 MR. McANDREWS: Approximately 15, 20 minutes.

4 MR. SALE: Yes, Your Honor. Approximately 30  
5 with 10 for rebuttal.

6 THE COURT: A total of 30 divided up as you see  
7 fit.

8 MR. SALE: Yes.

9 THE COURT: And you may have a total of 30.

10 MR. McANDREWS: Okay. Thanks.

11 THE COURT: Okay. Let's take up the instructions  
12 that are in dispute. Let me hear the defense objection to  
13 16.

14 MR. McANDREWS: Your Honor, our basic objection  
15 is that, if anything, there has been evidence of an  
16 intervening subsequent negligence. No testimony about  
17 some sort of concurring negligence on the part of any  
18 other physician in the plaintiffs' case, and we feel it is  
19 an inappropriate instruction for that reason.

20 THE COURT: Okay. I overrule the objection and I  
21 grant 16.

22 Let me hear the plaintiffs' objection to M as in  
23 Mary.

1 MR. QUINN: M.

2 THE COURT: Intervening cause.

3 MR. QUINN: My number 16 was essentially  
4 submitted in response to this. I don't think there has  
5 been any testimony at all of intervening negligence in  
6 this case. Our position is that both instructions really  
7 are not appropriate. However, if this instruction is  
8 going to be granted, ours should be granted as well.

9 THE COURT: Okay. I grant M as in Mary. I  
10 direct your attention, please, to 22, and let me hear your  
11 objection to 22.

12 MR. McANDREWS: Your Honor, I believe there has  
13 been insufficient evidence that any of the complications  
14 that arose, number one, were foreseeable on the part of  
15 the radiologist in performing this. Number two, they were  
16 postop. complications anticipated by the surgeon and by  
17 others. The radiologist is not the one involved in those.  
18 Beyond that, it's hard to understand precisely what  
19 negligence they're talking about. They have not put on  
20 any affirmative proof of negligence in their own case in  
21 chief, so what negligence this instruction is designed to  
22 have Dr. Allen foresee or anticipate is unclear from their  
23 own evidence.

\* \*502 \*



1           An intervening cause is an independent event, not  
2 reasonably foreseeable, that completely breaks the  
3 connection between the defendant's negligent act and the  
4 plaintiff's injury. An intervening cause breaks the chain  
5 of events so that the defendant's original negligent act  
6 is not a proximate cause of the plaintiff's injury in the  
7 slightest degree.

8           The fact that a doctor's efforts on behalf of his  
9 patient were unsuccessful does not, by itself, establish  
10 negligence.

11           A doctor has a duty to use the degree of skill  
12 and diligence in the care and treatment of his patient  
13 that a reasonably prudent doctor in the same field of  
14 practice or specialty in this State would have used under  
15 the circumstances of this case.

16           If a doctor fails to perform this duty, then he  
17 is negligent.

18           You must determine the degree of care that was  
19 required of the defendant by considering only the expert  
20 testimony on the subject.

21           An employer is responsible for violations of the  
22 standard of care by an employee acting within the scope of  
23 his or her employment. Defendant Fairfax Radiological



INSTRUCTION NO. 13

An intervening cause is an independent event, not reasonably foreseeable, that completely breaks the connection between the defendant's negligent act and the plaintiff's injury. An intervening cause breaks the chain of events so that the defendant's original negligent act is not a proximate cause of the plaintiff's injury in the slightest degree.



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.

AT LAW NO. 98695

ROBERT ALLEN, M.D.,

and

FAIRFAX RADIOLOGICAL  
CONSULTANTS, P.C.,

Defendants

FINAL JUDGMENT ORDER

This cause came before the Court on Tuesday, December 3, 1991, for trial by jury on the merits. The parties were present in court personally along with their counsel of record.

Prior to empaneling the prospective jurors, plaintiffs argued a motion in limine previously submitted to the Court. They moved for exclusion of the opinion of the Medical Malpractice Review Panel in the case. The Court denied this motion in limine.

A panel of jurors was placed in the jury box and duly sworn. Following voir dire by the Court and counsel, thirteen (13) were found to be acceptable to the parties. Each party then exercised three (3) peremptory strikes. The remaining seven (7) jurors were sworn to well and truly try the issues presented in this case.

On Tuesday, December 3, 1991, a court reporter was present and placed under appropriate oath to well and truly record the proceedings taken that day and thereafter.

Counsel for the parties then gave their opening statements to the jury. Plaintiffs then began presentation of their evidence and proof. They called as witnesses Sandra Panousos, Linda Stover, RDMS, Richard Karsh, M.D, by videotape deposition de bene esse, Earl Hodin, M.D., and Arthur Maron, M.D. Plaintiffs twice moved to admit into evidence Dr. Hodin's office notes to be admitted as medical records. The Court sustained defendants' objections to admission of Dr. Hodin's office notes, and such records were not admitted into evidence. Plaintiffs objected, as eliciting opinion testimony, to Defendants' questioning of Dr. Hodin, on whether he would have gone forward with surgery if the bladder had been identified by Defendants and if it were not possible to catheterize the bladder. Plaintiffs' objection was overruled. Plaintiffs attempted to call Mark Tabackman, Ph.D. but the Court sustained the defendants' objection to Dr. Tabackman's testimony as a witness. On Wednesday, December 3, at approximately 2:15 p.m., plaintiffs rested their case. The defendants, by and through counsel, moved to strike plaintiffs' evidence. After giving all parties ample opportunity to argue the merits of defendants' motion to strike, the Court denied the motion.

Thereafter, defendants presented their evidence and proof. They called as witnesses Defendant Robert Allen, M.D., Anthony DiPaola, M.D., Bradley Rodgers, M.D., and Edward Lipsit, M.D. Plaintiffs attempted to challenge Dr. Lipsit's credibility by asking him whether defense counsel had ever represented him or one of his partners in a legal action. The Court sustained defendants' objection to this question. The defendants rested their case on

Thursday, December 5, at approximately 3:30 p.m. They renewed their motion to strike plaintiffs' evidence. The Court withheld its ruling on the motion. Plaintiffs moved for a partial directed verdict on negligence. Following argument on the merits of the plaintiffs' motion, the Court denied it.

The parties, by counsel, submitted and argued their respective proposed jury instructions, the Court granting some and refusing others as to each party, to which action the parties noted their respective objections to adverse rulings. Plaintiffs objected to defendants' proposed jury instruction on intervening superseding negligence as unsupported by defendants' evidence or expert opinion. The Court overruled plaintiffs' objection, and the instruction was read to the jury. Thereafter, the Court instructed the jury on the law, and counsel for each party delivered their final arguments to the jury.

The jury retired to deliberate its verdict at approximately 5:30 p.m. on December 5 and continued deliberating until approximately 10:15 p.m. The jury returned and empaneled for further deliberations on Friday, December 6, at 8:30 a.m. At approximately 1:00 p.m. the same day, the jury informed the Court that it had reached a unanimous verdict. The jury was brought into open court and returned its unanimous verdict in favor of each defendant. At the plaintiffs' request, the jury was polled and in response, each of the seven (7) jurors confirmed the unanimous verdict as his or her separate verdict. Thereupon, the Court discharged the jury from further service.

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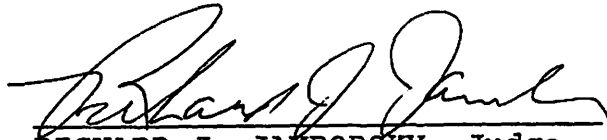
Counsel for plaintiffs then moved in open Court for judgment notwithstanding the verdict in favor of plaintiff. After affording all parties an opportunity to be heard on the merits of said motion, the Court denied the motion.

IT APPEARING TO THE COURT, based upon the verdict of the jury and the evidence produced at trial, that the defendants are each entitled to judgment in their favor, it is therefore

ORDERED, that judgment be, and hereby is entered on the verdicts and in favor of Defendant Robert Allen, M.D., and Defendant Fairfax Radiological Consultants, P.C. The objection of the plaintiffs is duly noted.

ENTERED this 10<sup>th</sup> day of January, 1992.

AND THIS ORDER IS FINAL.

  
RICHARD J. JAMBORSKY, Judge

WE ASK FOR THIS:

GODARD, WEST & ADELMAN, P.C.

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ALL EXCEPTIONS NOTED BELOW  
SEEN AND OBJECTED TO:

FEHRENBACHER, SALE, QUINN & DEESE

By

  
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Attorneys for Plaintiffs

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PLAINTIFFS' EXCEPTIONS TO FINAL JUDGMENT ORDER

Exception No. 1: Plaintiffs except to the Court's denial of Plaintiffs' motion in limine to exclude the opinion of the Medical Malpractice Review Panel for the reasons stated in Plaintiffs' Motion In Limine. In sum, Plaintiffs except to the denial of this motion on the bases that Defendants had not identified that opinion as an exhibit to Plaintiffs by the deadline stated in the Status Conference Order; that Defendants had not moved for leave to file the revised exhibit list out of time nor had the Court granted such leave sua sponte; that because Defendants had not identified, and did not call, any of the Medical Malpractice Review Panel members as witnesses; and that Defendants had not established any foundation for introduction of the opinion. Due to denial of Plaintiffs' motion, Defendants were permitted to argue that opinion to the jury even though it was never introduced into evidence, and even though no foundation existed for introduction of the opinion or argument based thereon. Further, when Defendants failed timely to identify the opinion as an exhibit and failed to name any member of the panel as a witness, Plaintiffs ceased interviewing panel members and other preparation for impeachment of the opinion. The Court's denial of Plaintiffs' motion denied Plaintiffs the opportunity to impeach the opinion.

Exception No. 2: Plaintiffs except to the Court's sustaining Defendants' objections to admission of office notes of Earl Hodin, M.D., the attending pediatric surgeon. As medical records, Dr. Hodin's office notes were admissible as an exception to the hearsay rule.

Exception No. 3: Plaintiffs except to the Court's overruling of Plaintiffs' objection to Defendant's questioning of Dr. Hodin as to whether he would have performed surgery immediately if the bladder was properly diagnosed but could not be catheterized. Plaintiffs objected on the basis of opinion (a) seeking enforcement of the Court's grant of Plaintiffs' motion in limine preventing treating physicians of Plaintiffs' decedent from giving opinion testimony against Plaintiffs, and (b) preventing Dr. Hodin from giving opinion evidence for Defendants when Dr. Hodin had not been identified or qualified by Defendants as an expert witness.

Exception No. 4: Plaintiffs except to the Court's sustaining Defendants' objection to Plaintiffs' questioning credibility of Defendants' expert witness, Edward Lipsit, M.D., based on his representation by Defendants' counsel in prior litigation. This question was highly probative of the bias and overall credibility of the witness, especially since the witness testified that his expert testimony was personally solicited here by Defendant's counsel, and since Dr. Lipsit told counsel the critical foundation fact of such testimony for Defendants' counsel to communicate to Defendants. Plaintiff was thus prohibited from impeaching the credibility of the witness.

Exception No. 5: Plaintiffs except to the Court's denial of Plaintiffs' motion for directed verdict on negligence. All of evidence demonstrated Dr. Allen's diagnosis of a single fluid-filled mass. The only support for a "two-mass" theory could be Dr. Allen's written sonography report which Dr. Allen and Defendants' counsel admitted did not make any sense, and therefore could not be the basis for an expert opinion or denial of a directed verdict. Dr. Allen's expert, Dr. Lipsit, stated that Dr. Allen's diagnosis of a single fluid-filled mass would violate the standard of care because the examination showed two fluid-filled masses. Dr. Allen admitted that he gave Dr. Hodin an oral diagnosis of one mass. A directed verdict of negligence should have been entered by the Court.

Exception No. 6: Plaintiffs except to the Court's overruling of Plaintiffs' objection and grant of Defendants' request for a jury instruction on intervening, superseding negligence. No evidence was submitted on intervening, superseding negligence. Defendants' own expert, Bradley Rodgers, M.D., testified that he had found no violation of the standard of care by either Earl Hodin, M.D., nor by Fairfax Hospital, the only two intervening health care providers.

Exception No. 7: Plaintiffs except to the Court's denial of Plaintiffs' motion J.N.O.V. for the reasons stated in Exception No. 5 hereto.

Exception No. 8: Plaintiffs except to all other adverse rulings by the Court against Plaintiffs noted in the Final Judgment Order or noted on the record in the trial transcript of this case.

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.

CLERK OF CIRCUIT COURT  
FAIRFAX, VA.

At Law No. 98695

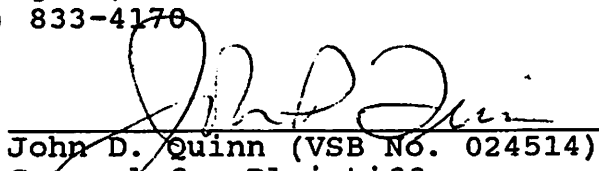
NOTICE OF APPEAL

The plaintiffs, Nikolaos and Sandra Panousos, hereby give notice of appeal to the Supreme Court of Virginia from the final judgment order of this Court entered on January 10, 1992, and further give notice that the trial transcript covering the testimony and other incidents of trial will be filed, all in compliance with the Rules of the Supreme Court of Virginia.

NIKOLAOS AND SANDRA PANOUSOS  
Plaintiffs  
By Counsel

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

By:

  
John D. Quinn (VSB No. 024514)  
Counsel for Plaintiffs



V I R G I N I A:

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

FILED

1992 FEB -7 PM 1:37

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

CERTIFICATE

I, John D. Quinn, Counsel of Record for Nikolaos and Sandra Panousos, hereby certify that:

1. Appellants are Nikolaos and Sandra Panousos, 10641 Lakeside Oak Court, Burke, Virginia 22015, (703) 250-7820.

2. Counsel for Appellants are John D. Quinn and Stephen Sale, Fehrenbacher, Sale, Quinn & Deese, P.C., 910 16th Street, N.W., Suite 500, Washington, D.C. 20006, (202) 833-4170.

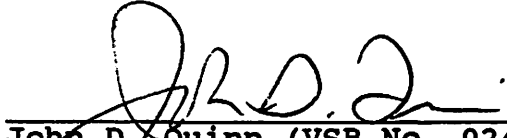
3. Appellees are Robert Allen, M.D., 8316 Arlington Boulevard, Suite 206, Fairfax, Virginia 22031 and Fairfax Radiological Consultants, P.C., c/o Its Registered Agent, John H. Rust, 4165 Chain Bridge Road, Fairfax, Virginia 22030, (703) 698-8550.

4. Counsel for Appellees are Gary A. Godard and George A. McAndrews, Godard, West & Adelman, P.C., 3975 University Drive, Suite 220, P.O. Box 1287, Fairfax, VA 22030, (703) 273-4800.

5. A copy of the transcript has been ordered from the court reporter who reported the case.

6. A true copy of the foregoing notice of appeal was this

7th day of February, 1992 sent via first-class mail, postage prepaid, to Gary A. Godard and George A. McAndrews at the address stated above, they being the only opposing counsel in this matter.

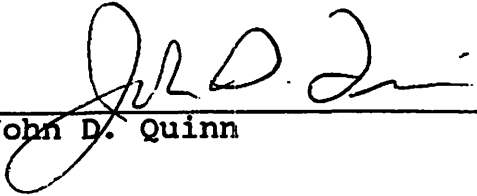


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John D. Quinn (VSB No. 024514)  
FEHRENBACHER, SALE, QUINN  
& DEESE, P.C.  
910 16th Street, N.W.  
Suite 500  
Washington, D.C. 20006  
(202) 833-4170

CERTIFICATE OF SERVICE

I hereby certify that a true copy of Plaintiff's Notice of Appeal and Certificate were this 7th day of February, 1992 served via first-class mail, postage prepaid, upon Gary A. Godard and George A. McAndrews, Godard, West & Adelman, P.C., 3975 University Drive, Suite 220, P.O. Box 1287, Fairfax, VA 22030, (703) 273-4800.

  
\_\_\_\_\_  
John D. Quinn

### ASSIGNMENTS OF ERROR

Plaintiffs/Appellants Nikolaos and Sandra Panousos respectfully submit that the trial court committed the following reversible errors:

(1) delivery of a jury instruction on intervening cause when Defendants/Appellees failed to introduce either facts or expert testimony (a) that any other person or event caused an injury to Nicole Panousos, and (b) that an intervening cause was so overwhelming and unforeseeable that it superseded Appellees' negligence;

(2) denial of Appellants' right to establish the bias and prejudice of Appellees' standard of care expert, Edward R. Lipsit, M.D., by cross-examination regarding his previous representation in a medical malpractice case by counsel for Appellees; and

(3) denial of Appellants' motion in limine and granting Appellees leave to argue the decision of the Medical Malpractice Review Panel to the jury in their opening and closing arguments without a foundation or actual admission of the decision into evidence.

V I R G I N I A:

1

MEDICAL MALPRACTICE REVIEW PANEL

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

Claimant(s),

vs.

✓  
ANTHONY DIPAOLA, M.D., STEPHEN HARRISON, M.D.,  
DIPAOLA, HARRISON & GOLDBERG P.C.,  
ROBERT M. ALLEN, M.D., FAIRFAX  
RADIOLOGICAL CONSULTANTS, P.C.,  
EARL HODIN, M.D. EARL HODIN M.D.P.C.,  
and FAIRFAX HOSPITAL SYSTEMS, INC.,

Health Care Provider(s)

O P I N I O N

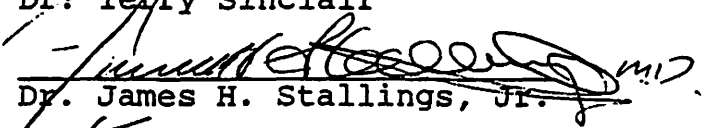
It is the opinion of the undersigned members of the medical malpractice review panel that the evidence does not support a conclusion that the health care provider, ROBERT M. ALLEN, M.D., failed to comply with the appropriate standard of care.

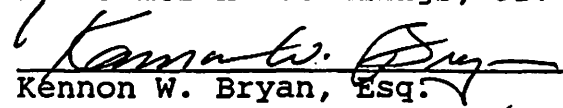
Entered this 3rd day of May, 1990.

Attested to:

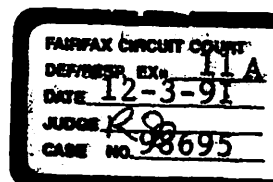
  
Quinlan H. Hancock, Chairman

  
Dr. Terry Sinclair

  
Dr. James H. Stallings, Jr.

  
Kennon W. Bryan, Esq.

  
Gregory D. Haight, Esq.



V I R G I N I A:

1

MEDICAL MALPRACTICE REVIEW PANEL

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

Claimant(s),

vs.

ANTHONY DIPAOLO, M.D., STEPHEN HARRISON, M.D.,  
DIPAOLO, HARRISON & GOLDBERG P.C.,  
ROBERT M. ALLEN, M.D., FAIRFAX  
RADIOLOGICAL CONSULTANTS, P.C.,  
EARL HODIN, M.D. EARL HODIN M.D.P.C.,  
and FAIRFAX HOSPITAL SYSTEMS, INC.,

Health Care Provider(s)


O P I N I O N

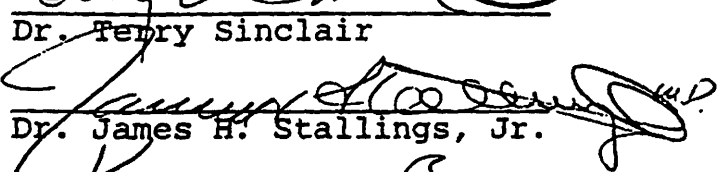
It is the opinion of the undersigned members of the medical malpractice review panel that the evidence does not support a conclusion that the health care provider, FAIRFAX RADIOLOGICAL CONSULTANTS, P.C., failed to comply with the appropriate standard of care.

Entered this 23rd day of May, 1990.

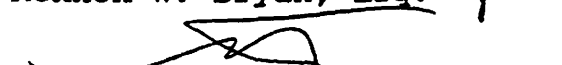
Attested to:

  
Quinlan H. Hancock, Chairman

  
Dr. Terry Sinclair

  
Dr. James H. Stallings, Jr.

  
Kennon W. Bryan, Esq.

  
Gregory D. Haight, Esq.

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L98695  
12-5-91





ABD



EMERGENCY

BLADDER

BREAST

MASS

SHIFTS  
ELECTROLYTE  
HYDRATION  
CONGESTIVE