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IN THE COURT OF COMMON PLEAS, CUYAHOGA COUNTY, OHIO

CASE NO. CV-08-663005

RYAN CARPENTER, Et Al.,

Plaintiffs,

-vs-

THE CLEVELAND CLINIC FOUNDATION, Et Al.,

Defendants.

DEPOSITION OF CRAIG H. LICHTBLAU, M.D., P.A.

Tuesday, August 18, 2009

12:30 p.m. - 2:40 p.m.

Video Conference

Consor & Associates

1655 Palm Beach Lakes Blvd., Ste.500

West Palm Beach, Florida 33401

Reported By:

Jamie Reynolds Bentley, Court Reporter

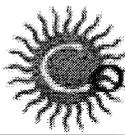
Notary Public, State of Florida

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1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 PAMELA PANTAGES, ESQ.

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6

7

8 On behalf of the Defendants:

9 ANNA CARULAS, ESQ.

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14

15 ALSO PRESENT:

16

VIDEOGRAPHER: EITAN ROSEN

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1 P R O C E E D I N G S

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3 (Plaintiffs' Exhibit Nos. 1 and 2 were marked for
4 identification.)

5 THE VIDEOGRAPHER: We are ready. We are now
6 going on video record. The time on the monitor is
7 12:42 p.m. Today is Tuesday the 18th day of
8 August 2009. We are here at 1655 Palm Beach Lake
9 Boulevard, West Palm Beach, Florida, for taking the
10 videotape, video conferencing deposition of Dr.
11 Craig Lichtblau. In the matter of Carpenter, et al
12 versus Cleveland Clinic Foundation, et al. The
13 case number, CV-08-663005. This matter has been
14 filed in the court of Common Pleas, Cuyahoga
15 County, Ohio. The court reporter is Jamie Bentley
16 of Consor & Associates Reporting. The videographer
17 is Eitan Rosen of Sunstream Video.

18 Will counsel please announce themselves to the
19 record.

20 MS. PANTAGES: Pamela Pantages for Ryan
21 Carpenter.

22 MS. CARULAS: And Anna Carulas on behalf of
23 The Cleveland Clinic.

24 Thereupon,

25 (CRAIG H. LICHTBLAU, M.D., P.A.)

1 Having been first duly sworn or affirmed, was examined and
2 testified as follows:

3 THE WITNESS: I do.

4 DIRECT EXAMINATION

5 BY MS. PANTAGES:

6 Q. Good afternoon, Doctor. Could you please
7 introduce yourself to the jury.

8 A. My name is Craig Howard Lichtblau.

9 Q. You are a physician?

10 A. Yes. I'm a medical doctor that specializes in
11 physical medicine and rehabilitation, also known as a
12 physiatrist.

13 Q. Please tell the jury what your role is in this
14 case.

15 A. I was asked by you, or your office, to define
16 this patient's impairment, disability and costs for
17 future medical care using a medical model. Impairment
18 is a loss of a body system. Disability is how that loss
19 of a body system affects one's ability to reintegrate
20 back into society. And the cost of future medical care
21 is my attempt to try to make this patient as whole as
22 possible. But realize, even if we give this patient
23 everything in the continuation of care plan that I've
24 described, we will fall tragically short of making him
25 normal.

1 MS. CARULAS: Note objection.

2 BY MS. PANTAGES:

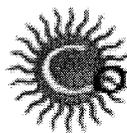
3 Q. Dr. Lichtblau, can you briefly tell us about
4 the education and training that you've had that
5 qualifies you as an expert witness in this area.

6 A. I graduated Florida State University with a
7 degree in biology. I graduated a foreign medical
8 school, American University of the Caribbean on
9 Montserrat with an MD degree. I passed an examination
10 which allowed me to take residency training in the
11 United States. The year I applied for physical medicine
12 and rehabilitation, the program changed nationally from
13 three years to four years. I had to do four years of
14 postgraduate medical education to become what's known as
15 board eligible. I completed my program at Washington
16 University Medical Center in St. Louis, Missouri. I
17 came home to my hometown. I practiced medicine for one
18 year. I flew to Rochester, Minnesota; passed a 400
19 question multiple-choice test. And then I came back
20 home to my hometown, practiced medicine another year. I
21 flew back to Rochester, Minnesota and passed at least
22 two out of three one-hour oral examinations, one-on-one
23 with professors. I became board certified in my
24 specialty in medicine in May of 1991, two years after I
25 graduated my program. About five or six years later, my

1 specialty started a recertification exam, which I did
2 not have to take because I'm boarded for life. However,
3 I took the exam in April of 2005 and passed the exam.

4 And, therefore, I am board certified and
5 recertified in my specialty in medicine. Board
6 certification is the highest amount of certification one
7 can get in their specialty. As far as my practice
8 experience goes, I came home to my hometown, I opened up
9 a private practice. Today that private practice is
10 10,000 square feet, nine incoming lines, greater than 25
11 employees, over 30,000 outpatients.

12 When I started my practice, I became a
13 consultant to Children's Medical Services for the State
14 of Florida. This is for pediatric patients that are
15 financially challenged. I've had over 3,000 pediatric
16 experiences through CMS. I opened the first inpatient
17 rehabilitation unit at our trauma hospital for the north
18 part of Palm Beach County. I was the medical director
19 for 16 years. And during that medical directorship, I
20 had over 6,200 admissions. I am still on staff at that
21 hospital. I am still admitting patients to the
22 hospital. I am currently the medical director to the
23 Florida Institute of Neurologic Rehabilitation. This is
24 a 127-bed transitional living facility that specializes
25 in the long-term care and treatment of traumatic brain



1 injury and spinal cord injury.

2 So in a sense, I've been practicing 100 hours
3 a week on average; inpatient, outpatient, transitional
4 living, rehabilitation medicine, pediatric, adolescent,
5 adult, and geriatric rehabilitation medicine. My
6 experience has been ongoing for the last almost 20
7 years.

8 Q. And of the children that you mentioned that
9 come under your care, do you have experience with
10 children like Ryan who are profoundly deaf and have
11 cochlear implants?

12 A. Yes, I have come across a couple in my career,
13 however, it's rare.

14 Q. Are you licensed to practice medicine --
15 obviously, you are. I'm sorry. In what states are
16 licensed to practice medicine?

17 A. I'm licensed to practice medicine in the state
18 of Florida.

19 Q. And do you spend at least 50 percent of your
20 professional time in active clinical practice?

21 A. It's greater than that. I spend 80 percent of
22 the -- my professional time is taking care of patients.
23 Twenty percent of my time is forensic work. Out of the
24 20 percent of the forensic work that I do, at least 50
25 percent of that is on my own patient population where I

1 am not an expert witness; I'm the treating doctor.

2 In this particular case, I'm an expert
3 witness. That is about 10 percent of my professional
4 time. I have no doctor/patient relationship. My role
5 was to define this patient's impairment, disability and
6 costs for future medical care using my own knowledge,
7 training and clinical practice experience taking care of
8 this type of disability.

9 Q. Dr. Lichtblau, I think that our court reporter
10 has marked your CV as Exhibit 1; is that correct?

11 A. Yes.

12 Q. And could you just take a look at that and
13 make sure that that's a complete accurate CV?

14 A. Yes, it is. I've already reviewed it.

15 Q. And does your CV fairly summarize all of the
16 things that we've been touching upon with respect to
17 your education, training, experience and qualifications
18 to be an expert witness in this case?

19 A. Yes.

20 Q. At some point in time, I contacted you and
21 asked you to participate in Ryan's case, correct?

22 A. Yes. You asked me to define the patient's
23 impairment, disability and costs for future medical
24 care.

25 Q. And did I send you some materials to assist

1 you in doing that?

2 A. Yes. This large notebook are the medical
3 records that have been provided to me to evaluate this
4 patient.

5 Q. And would those records include the records
6 from Ryan's birth and stay in the neonatal unit at
7 Cleveland Clinic?

8 A. Yes.

9 Q. And would they also include his subsequent
10 care records, including the two surgeries he had to
11 implant the cochlear implants into his head, and the
12 ongoing therapy that he's had over the course of his
13 life?

14 A. Yes. But I need to clarify, I've made a
15 mistake on the record. This is just part of the
16 records. I actually have a huge box in the office, a
17 very large box, there is probably 25 inches of records
18 in there. It is just too hard to carry to the Sunstream
19 Video. But I have voluminous medical records regarding
20 this patient's birth, care and treatment, and ongoing
21 treatment.

22 Q. Any other materials that you -- that I sent
23 you to assist you in your role in this case?

24 A. I don't think so.

25 Q. And are those the materials that -- that

1 lawyers like me typically send to you when you've been
2 asked to participate in a medical/legal case like
3 Ryan's?

4 MS. CARULAS: Objection.

5 THE WITNESS: Yes.

6 BY MS. PANTAGES:

7 Q. And did you review those materials?

8 A. Yes.

9 Q. You have been contacted by other lawyers to
10 offer opinions in the manner that you are offering
11 opinions here today, correct?

12 A. That was correct.

13 Q. You and I have never worked together before,
14 nor have you worked with any of the other lawyers in my
15 law firm; is that true?

16 A. That is correct.

17 Q. All right. Tell us what else you did
18 besides -- well, strike that.

19 You formulated -- I think we've marked it as
20 Exhibit 2 -- you developed a very large report in this
21 case, correct?

22 A. Yes. It's a very large report, because there
23 are some facts in this case that have to be defined.

24 And that was what I tried to do.

25 Q. All right. And going through the copy of the

1 report that I have, I note that the report is
2 essentially divided up into seven different sections; is
3 that true?

4 A. That's correct.

5 Q. All right. I'd like to -- and why is it
6 divided up into the seven sections in the manner that it
7 is, Doctor?

8 A. Because what we're trying to do is define
9 impairment, disability and costs. And the sections --
10 each section lays the foundation for those opinions.

11 Q. All right. Let's go through each section.
12 And I'm going to ask you what each section -- what it
13 was that you did in each section and what the sections
14 mean.

15 The first section, I believe, is Ryan's report
16 that you did for him, it's called comprehensive medical
17 evaluation --

18 A. Yes.

19 Q. -- right?

20 A. That's correct. And that's basically your
21 history and physical examination, and review of
22 voluminous medical records. I actually flew to the
23 patient's home. I went up there. I saw the patient. I
24 spoke to the patient's mother. I obtained the history
25 from the patient's mother. I did an extensive medical

1 records review. I did a physical evaluation of the
2 patient. I took pictures of the patient to have an
3 accurate photo journal of the patient and his devices.
4 And then I came up with a diagnostic impression, which
5 is contained on page 40 and 41. And then I came up with
6 a plan. And that plan was to define this patient's
7 impairment, disability and costs. So we came up with a
8 vocational position statement, an AMA impairment rating,
9 a functional assessment and a continuation of care plan.

10 Q. And the first section, the comprehensive
11 medical evaluation section, is 43 pages long, correct?

12 A. That's correct.

13 Q. Before we move on to the next section.
14 Anything else that you would like to add about the
15 comprehensive -- comprehensive medical evaluation?

16 A. No. It's just that the history that was
17 provided to me by the mother was corroborated with the
18 facts contained in the medical records, and was
19 consistent with the physical examination of the child.

20 And, again, to further evaluate that and
21 define that, there are photographs in the back of the
22 report that show the patient's external devices, et
23 cetera. Basically, this case has to do with bilateral
24 hearing loss.

25 Q. And in a nutshell, based upon the history that

1 you took from the mother, what was your understanding of
2 the facts leading up to -- just in a nutshell -- the
3 facts leading up to the hearing loss as you understand
4 it?

5 MS. CARULAS: Objection.

6 THE WITNESS: This patient suffered a
7 Vancomycin overdose resulting in red-man syndrome
8 and bilateral deafness. The deafness has been
9 corrected to the best of one's ability in 2009 with
10 external devices and internal devices that have
11 been implanted inside the cranial vault.

12 As a result, this patient does have a
13 vocational deficit. And that is: He will require
14 reasonable accommodations for the hearing impaired
15 in order for him to maintain gainful employment in
16 the competitive open labor market.

17 It's my opinion that he will be able to
18 participate in gainful employment. But he cannot
19 work in a noisy environment, because that noise is
20 amplified by his external/internal devices. And it
21 would be uncomfortable and unreasonable for him to
22 participate in life in that environment.

23 So he can work as long as he's got reasonable
24 accommodations, or he's in a job setting which
25 doesn't require a lot of sensory input or does not

1 have a lot of sensory input around him. And the
2 sensation that we're talking about is sound.

3 So in other words, if he was walking in the
4 fair, and all the -- all the noise was going on, it
5 would be most uncomfortable for him. He'd have to
6 turn his devices off. If he was working in a
7 setting -- in an office setting and there was a lot
8 of talking and TV, radio, telephone, that would be
9 -- not the appropriate environment.

10 However, he could certainly monitor TV
11 cameras. He could monitor security cameras. There
12 is a lot of jobs out there for him. He just has to
13 be reasonably accommodated with his deficits.

14 BY MS. PANTAGES:

15 Q. All right. Turning back to the comprehensive
16 medical evaluation. Did you also have an understanding
17 in addition to the surgery that Ryan had, that he -- he
18 has been in ongoing intensive auditory/verbal therapy?

19 A. Yes. Because realize that hearing is the
20 foundation for language. And even though he is hearing
21 impaired and has these internal/external devices to help
22 correct the hearing deficit, it's not 100 percent
23 correction, and it will greatly affect his language
24 ability and his ability to communicate.

25 So the type of therapies he's been receiving

1 are therapies to help make his internal and external
2 devices efficacious or usable.

3 Q. And based upon your conversations with the
4 mom, and also the review of the record, are you also
5 aware that Ryan does not attend a typical school or a
6 normal school, but goes to a school for hearing-impaired
7 children?

8 A. That's correct.

9 Q. And what significance does that add to your
10 opinions?

11 A. Well, he's going to have to have a specialized
12 environment in order for him to maximize his functional
13 recovery as much as possible. These devices are
14 compensatory techniques and devices. They don't make
15 him normal or whole. It will not fix the problem. It
16 helps manage his deafness.

17 Q. Anything else about the comprehensive medical
18 evaluations that we haven't discussed?

19 A. No.

20 Q. All right. Let's move on to the next section
21 of your report, which is the vocational position
22 statement.

23 What did you do to develop the vocational
24 position statement and what does it mean?

25 A. After obtaining a history from the patient's

1 mother, performing a physical examination on the
2 patient, doing the voluminous medical records review,
3 speaking to some of his treating physicians, it's my
4 opinion that he will be able to maintain gainful
5 employment. However, it has to be in a specialized
6 environment where there is limited noise and limited
7 background noise.

8 Q. Anything else about the vocational position
9 statement?

10 A. No.

11 Q. Okay. Let's move on to the next section of
12 your report, which is the America Medical Association or
13 the AMA impairment rating. Please tell us what that is
14 and what it means.

15 A. This is an attempt by the American Medical
16 Association to assign a number to a loss of a body
17 system. I used the fifth edition. At that time, I did
18 not have the sixth edition. The sixth edition is out
19 now. It's a different edition.

20 And according to the fifth edition, he would
21 have a 35 percent permanent proper -- partial impairment
22 of a whole person. And what that means is, he is 35
23 percent less whole. And that's just a number assigned
24 to the loss of a body system.

25 Q. And what is the -- what's the significance of

1 the 35 percent? What do you use -- how does that impact
2 on your opinion?

3 A. Well, it's -- it just says that he has
4 permanent injury. It's not likely to change. And, in
5 fact, as he ages and suffers the secondary effects of
6 aging, combined with his current impairment, it's my
7 opinion, his disability will actually increase over
8 time. Thirty-five percent is clinically significant. A
9 below-knee amputation is 36 percent. So this is a high
10 impairment rating.

11 Q. Anything else about the AMA impairment rating?

12 A. No.

13 Q. The next section of your report I believe is
14 the functional assessments.

15 A. Yes. And all that states is that as this
16 patient suffers the secondary effects of aging, combined
17 with his current impairment, his disability will
18 actually increase over time.

19 Q. Anything else about the functional assessment?

20 A. No.

21 Q. All right. Moving on. The next section of
22 your report is continuation of care. What does that
23 mean? What did you do to develop the continuation of
24 care?

25 A. Continuation of care is my attempt to describe

1 the costs associated with making this patient as whole
2 as possible. And realize that if we give him everything
3 in this plan, we will fall tragically short of making
4 him whole. I used my knowledge, training, clinical
5 practice experience. And to accuritize the prices, I
6 contacted Dr. Donald Goldberg, the audiologist that
7 worked with this patient; Dr. Nep -- N-E-P-A-R-K-O, the
8 ENT doctor that evaluated and treated this patient; and
9 Dr. Robert Harrison, professor of ENT, director of
10 research, expertise in the science of hearing and
11 hearing loss, in order to accurately define the costs
12 for this patient's future medical care as it relates to
13 his hearing deficits. And then once I contacted all of
14 the people, I put all of this together. I also
15 contacted Dr. Shawn Sullivan, a neuropsychologist.

16 And it's my opinion that this patient needs to
17 see an audiologist one time every two weeks for the next
18 two years, and then four to 12 times per year for the
19 next two years, and that cost will be between 200 and
20 \$300 per outpatient visit. The patient will need to see
21 an ENT specialist one time a year; that cost will be 100
22 to \$150 per outpatient visit. The speech and language
23 pathologist; two hours a week for the next five years,
24 and that cost was pending. The hearing equipment
25 itself; the cochlear external devices would have to be

1 replaced five times per year over a lifetime. Those
2 devices cost \$10,000 a piece. That would be \$100,000
3 over the course of his life. The cochlear internal
4 devices should not, if we are lucky, need to be
5 replaced. If they last a lifetime, there would be no
6 cost. If they have to be replaced, it's \$30,000 per
7 side or per ear. That would be a global fee of \$60,000
8 for internal devices, the right and the left. The
9 batteries for the cochlear implants have to be replaced
10 one time every three days. That's approximately \$100
11 per month. Products for the deaf included, but is not
12 limited to: Access for alarm clock with lamp, telephone
13 ring signaler and bed shaker, one time every seven to
14 ten years, a cost of \$99.95. Clear sounds amplified
15 telephone with caller ID and speakerphone and built-in
16 strobe, one time every seven to ten years, it's \$159.95.
17 Silent call smoke detector transmitter with pillow
18 vibrator receiver, one time every seven to ten years, at
19 \$269.95. A Gentex smoke detector with strobe, one time
20 every seven to ten years, it's \$139.95. Dialogue VCO
21 phone, it's one time every seven to ten years, at
22 \$189.95. VibraLite 3 Vibrating -- no vibrating watch,
23 one time every seven to ten years, that is a cost of
24 \$59.95.

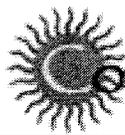
25 Therapies which included: Speech/Cognitive

1 therapy two times a week until age 12. That's 125 to
2 \$200 per outpatient visit. Psychotherapy/Counseling for
3 Behavioral Issues: one time a week for one year at
4 seven, ten and 15, at 125 to \$200 per outpatient visit.
5 Psychotherapy for Patients: One time per week for three
6 months when Ryan reaches ages seven, ten and 15, at 125
7 to \$200 per outpatient visit. Social Skills Training
8 with Speech and Language Therapist or Psychologist: one
9 time a week for one year at ages seven, ten and 15.
10 That's 125 to \$200 per outpatient visit.

11 The Educational Consultation; Interpretive
12 Services and Tutorial Services, will be needed. I can't
13 predict the frequency, the duration and the intensity;
14 therefore, those costs will be dropped out.

15 There is not speculation in this plan.
16 Anything that would be speculative is left out of the
17 plan. It's my opinion that because this patient is
18 walking and talking and has no prior -- or walking and
19 communicating and having no problem with eating orally,
20 he would have a normal life expectancy. According to
21 the Vital Statistics of the United States, the 2007 life
22 tables U.S. Department of Health and Human Services, he
23 should live another 72.2 years.

24 This information was passed off to healthcare
25 economist, who will talk about the present and future



1 value of money. I do not do that.

2 There are five photographs in my report: The
3 first photograph is an identifying picture of the
4 patient. Unfortunately, mine is a back and white. You
5 have the color prints. The next picture, Photograph No.
6 2 shows his left ear and the external device.
7 Photograph No. 3 shows his right ear and the external
8 device. Photograph No. 4 shows that this patient is
9 participatory in his environment. Photograph No. 6
10 demonstrates this patient on a tricycle. Had has no
11 problem with balance or coordination.

12 It's my medical opinion after evaluating this
13 patient and defining his impairment, disability and
14 costs, he does not have a balance problem. He does not
15 have a vestibular problem. He -- this is strictly
16 hearing. And one must realize that hearing is a special
17 sense. Your special senses are your smell, your taste
18 and your hearing. When you loose a special sense, this
19 injury by nature is catastrophic. This in my opinion is
20 a catastrophic injury.

21 MS. CARULAS: Objection. Move to strike that
22 last statement.

23 BY MS. PANTAGES:

24 Q. Thank you, Dr. Lichtblau. I just want to
25 follow up on a couple of things that you mentioned. In

1 formulating the continuation of care plan, it's my
2 understanding that you contacted both people involved in
3 Ryan's care directly and also expert witnesses that were
4 retained by plaintiffs to offer other opinions in this
5 case?

6 A. That is correct. The method -- that is
7 correct. The methodology that I used is to accurately
8 define this patient's impairment, disability and costs.
9 And I have to employ the opinions of other people that
10 have expertise in the costs of internal and external
11 device. This injury, the mechanism of this injury, is
12 very rare. And, therefore, to have accuracy at a
13 premium, I employ all areas of expertise to get these
14 accurate prices.

15 Q. So did you contact Dr. Neparko, Dr. Harris and
16 Dr. Goldberg and Dr. Sullivan to assist you in
17 formulating the continuation of care plan?

18 A. Yes, I did.

19 Q. And did all of those individuals respond to
20 your inquiry and write a report back to you to assist
21 you?

22 A. Yes, they did. I have documented phone
23 conferences in my report, plus I have confirmatory
24 letters from those people to have accuracy at a premium
25 in defining this patient's costs for future medical

1 care.

2 Q. And it's my understanding, is it true, Doctor,
3 that while you through your research assigned
4 individualized costs, it's not part of your role in this
5 case to add up all of those numbers and reduce them to
6 present value?

7 A. That's correct. Because that would be
8 testifying outside my area of expertise. I do not
9 define the present or future costs of money. That would
10 be left up to a healthcare economist. I don't do that.

11 Q. Doctor, in looking at your continuation of
12 care plan, is it fair to say that you've basically
13 divided up Ryan's need into three areas: Medical and
14 surgical care as one, therapy as two, and assisted
15 devices as area three?

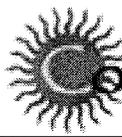
16 MS. CARULAS: Objection.

17 THE WITNESS: Yes, I would agree with that
18 statement. That's an accurate statement.

19 BY MS. PANTAGES:

20 Q. All right. And as far as the surgery and
21 medical care, from what types of care providers would
22 Ryan be needing care in that area of your continuation
23 of care plan?

24 A. He's going to need ENT. For surgical, he'll
25 need an ENT doctor. That's who does -- performs that



1 type of surgery.

2 Q. And did you include in that section frequent
3 assessment by audiologists and people like that?

4 A. Yes, I did. And I spoke to his treating
5 audiologist, ENT doctor, speech language pathologist. I
6 spoke to people that either evaluated him from a
7 forensic standpoint or were taking care of this patient
8 and understood this patient in order to achieve these
9 opinions. These opinions are not pulled out of thin
10 air. They are researched according to this patient's
11 needs.

12 Q. All right. And with respect to the therapy
13 part of the continuation of care plan; did you consider
14 that he was going to need ongoing auditory/verbal speech
15 language therapy from now and definitely into the
16 future?

17 A. Yes. And that is accurately defined in the
18 report. And that has been passed off to the economist
19 to accurately define from a present and future value
20 cost of money.

21 Q. And what other types of therapy did you
22 consider that Ryan might need besides the speech
23 language auditory/verbal therapy?

24 MS. CARULAS: Objection.

25 THE WITNESS: Psychotherapy. As this child

1 goes through the milestones of life; dating,
2 entering college, trying to get married, trying to
3 have a relationship, I've wrote in there for
4 psychotherapy and behavioral issues. Because this
5 patient will not be able to communicate with the
6 outside word in a normal fashion.

7 BY MS. PANTAGES:

8 Q. Any other types of therapy besides the speech
9 language and psychotherapy?

10 A. Yes. Social skills training.

11 Q. And what is that for, Doctor?

12 A. That is to help him reintegrate back into
13 society and in a normal fashion.

14 Q. All right. Any other therapies? Have you
15 discussed all of those?

16 A. Yes, we have.

17 Q. All right. With respect to the assistive
18 devices, in what area of Ryan's life, over the course of
19 his life, do you believe that he would need assistive
20 devices?

21 A. They've been clearly accurately defined in my
22 report. And this is: alarm clocks, telephones, watches.
23 All of these things that we take for granted. His
24 specials sense of hearing has been taken out.

25 Therefore, there is adaptive equipment that is defined

1 in this report that helps to try to simulate him back
2 into society at his highest function level.

3 Q. And is it your opinion that he will require
4 assistive devices in all aspects of his life; activities
5 of daily life, at his job, recreationally, in the car,
6 in every aspect?

7 MS. CARULAS: Objection.

8 THE WITNESS: Yes.

9 BY MS. PANTAGES:

10 Q. Any other areas of the continuation of care
11 plan that we haven't discussed?

12 A. Yes. I've left out all speculation. Realize
13 that possibilities have not been discussed, because
14 you're not supposed to speculate under oath. And
15 realize that this plan assumes the perfect world. It
16 assumes that he never gets infected. It assumes that
17 none of the implants have a malfunction, the internal
18 implants. And, of course, if they have to go back into
19 his head, and they have to do a reimplantation, there is
20 always a risk for cellulitis, osteomyelitis, implant
21 failure, sepsis, deep vein thrombosis, pulmonary
22 embolus, pneumonia. There is always these
23 complications. I've assumed that we live in a perfect
24 world, and the costs for all of these surgical and
25 nonsurgical complications have been totally left out of

1 the plan. And it needs -- one must realize, this is a
2 bare-bones conservative plan.

3 MS. CARULAS: Objection: moved strike.

4 BY MS. PANTAGES:

5 Q. Dr. Lichtblau, with respect to the
6 recommendations that you've made in the continuation of
7 care plan as it relates to medical and surgical
8 treatments, ongoing therapies and the assisted devices,
9 are all of those recommendations offered to a reasonable
10 degree of medical certainty?

11 A. Yes.

12 Q. Any other aspects of the continuation of care
13 plan that we haven't covered?

14 A. No. I think that we've covered it thoroughly.

15 Q. All right. And you mentioned -- you showed
16 our jury the photographs that you took. Why did you
17 take those photographs, and why are they important to
18 your opinion?

19 A. Because you're not allowed to speculate under
20 oath. And that is the objective medical evidence for
21 the foundation of my opinions.

22 Q. All right. Your report also includes
23 documentation, a documentation section. What is the
24 documentation section of your report, and why did you
25 include it?

1 A. We include that to show exactly where we got
2 the prices; who we spoke to, to have accuracy at a
3 premium. If anything wants to be checked, people can
4 call and find out exactly where we got the prices, or
5 call and speak to exactly who I spoke to in order to
6 have this plan as accurate as possible.

7 Q. All right. Any -- any other portion of the --
8 of your report that we haven't discussed?

9 A. No. I think that we've covered it thoroughly.

10 Q. And is it fair to say -- well, Dr. Lichtblau,
11 have you -- you have worked with other children that
12 have cochlear implants?

13 A. I have.

14 Q. And it's true that Ryan's cochlear implants
15 have improved his capacity to function?

16 A. I agree.

17 Q. Does that mean that -- that Ryan is
18 functioning like a normal hearing child?

19 MS. CARULAS: Objection.

20 THE WITNESS: No, he's not functioning like a
21 normal hearing child. And he will never function
22 like a normal hearing individual, because his
23 hearing capacity has been severely reduced. The
24 cochlear implants, the internal devices and the
25 external devices are our compensatory mechanism

1 today to try to increase his ability to participate
2 in his environment. But realize, that falls
3 tragically short of making him normal or whole.

4 BY MS. PANTAGES:

5 Q. And finally, Dr. Lichtblau, do you have an
6 opinion that you hold to a reasonable degree of medical
7 probability or medical certainty as to whether or not
8 all of the recommendations that you've made for Ryan are
9 reasonable and necessary for his future needs?

10 MS. CARULAS: Objection.

11 THE WITNESS: Yes.

12 BY MS. PANTAGES:

13 Q. And what is your opinion?

14 A. I believe that I have accurately defined his
15 impairment and his disability and his costs for future
16 medical care. This is what he needs as a medical
17 necessity.

18 MS. PANTAGES: Thank you, Dr. Lichtblau,
19 that's all I have.

20 CROSS (CRAIG H. LICHTBLAU, M.D., P.A.)

21 BY MS. CARULAS:

22 Q. Good afternoon, Dr. Lichtblau.

23 A. Good afternoon.

24 Q. My name is Anna Carulas and I represent the
25 Cleveland Clinic. I just have a few questions for you.

1 Now, you told us that you are a medical
2 doctor, and your specialty is in physical medicine and
3 rehabilitation, correct?

4 A. Yes, I agree.

5 Q. Now, just so it's absolutely clear with the
6 jury: You are not giving any opinion in this case as to
7 the cause of Ryan's hearing loss, correct?

8 A. Yeah. I was not asked to render causation
9 opinions, that is correct.

10 Q. Okay. And you, I believe, have testified in
11 other matters that you never testify outside of your
12 scope of expertise. And your expertise is in the area
13 of physical medicine and rehabilitation, correct?

14 A. That's correct. But you are narrowing my
15 scope. My scope is defining impairment, disability and
16 costs for future medical care. On occasion, I do give
17 causation opinions for different reason. In this case,
18 I was not asked to give a causation opinion.

19 Q. All right. Now -- so you're here to talk
20 about Ryan's impairment and costs and so forth. I want,
21 just if we can, before we get into your role as a
22 reviewing expert in this case for the medical/legal
23 aspect of this, I want to just briefly talk to you about
24 your practice.

25 Now, it's my understanding that your practice

1 primarily focuses on physical impairments, correct?

2 A. I would disagree with that statement. We take
3 care of traumatic brain injury, spinal cord injury,
4 stroke, progressive neurologic diseases such as: MS,
5 ALS, amputations, multiple orthopedic trauma and chronic
6 pain. So it's not just physical. There are cognitive
7 issues. There are issues that would be outside the
8 scope of just a physical deficit.

9 Q. Okay. But as mentioned, what you deal with,
10 and I do have a copy of your Website, where you state
11 that you -- you deal with issues of, as you mentioned:
12 traumatic brain injury; multiple sclerosis; issues where
13 patients have difficulty walking, dressing, caring for
14 themselves; that sort of thing, correct?

15 A. Yeah, the way you've asked that question. But
16 there is a huge cognitive component to MS in the brain
17 and a stroke in the brain. I mean, I'm not just -- it's
18 just not a physical aspect. Many times I have to deal
19 with cognitive deficits when you are dealing with a
20 penetrating wound to the brain, a non-penetrating wound
21 to the brain, a subdural hematoma, an epidural hematoma,
22 an intraventricular bleed. I mean, I can go on and on
23 and on. And certainly cognitive issues are an integral
24 aspect of physical medicine rehabilitation when you are
25 trying to reintegrate someone back into society.

1 Q. Okay. And I didn't mean to necessarily
2 mischaracterize that. I guess what my question is, is
3 this case deals with therapy that was provided by a
4 Dr. Donald Goldberg specifically in audiologic
5 rehabilitation. You're aware of that, correct?

6 A. Yeah, I agree. This comes under the special
7 senses. And, of course, I deal with special senses,
8 because what happens in traumatic brain injury,
9 non-traumatic brain injury, stroke. What's the largest
10 deficit? It's usually special senses.

11 Realize that if somebody loses their eyesight,
12 it's a disaster. That's a catastrophic case. If
13 somebody loses their hearing, it's a special sense.
14 It's a catastrophic case. If somebody loses their
15 taste, their sense of smell, which is a special sense,
16 they've lost 75 percent of their taste. That's a
17 catastrophic injury.

18 Anytime you deal with the special senses, it's
19 a catastrophic injury. I deal with the loss of special
20 senses, maybe for a different reason. The mechanism of
21 action of why this patient has lost a special sense is
22 highly unlikely and very, very rare. I deal with the
23 loss of special senses for a different reason. But it's
24 still the loss of a special sense, which in my opinion
25 comes under the category of catastrophic injury.

1 Q. All right, sir. And you know we are doing
2 this -- just so the jury understands -- we are doing
3 this across a video conferencing. You're down in
4 Florida, and Ms. Pantages and I are up here in
5 Cleveland.

6 What I would like to do, just if we can try to
7 move this along, is if you try to answer my questions
8 and we'll get there a lot quicker. I have a copy of
9 your Website and you say, for instance, that you
10 describe what a physiatrist is. And then you say that
11 your treatment may involve: medication, therapeutic
12 exercise, injections, assistive devices, such as:
13 braces, artificial limbs, heat, cold and traction
14 therapies, massage and electrotherapies. Is that in
15 your Website?

16 A. That's in my Website. But, of course --

17 Q. Thank you, sir. Now, let me ask you --

18 A. I didn't finish. I did not finish my answer.
19 That is in my Website. However, that is just a very
20 minimal cursory definition of what we do. We take care
21 of traumatic brain injury, spinal cord injury, stroke,
22 progressive neurologic diseases, multiple orthopedic
23 trauma. So, of course, that Website is wholly
24 incomplete.

25 Q. Okay. Now, we know in this particular case,

1 again, that Ryan -- actually Mrs. Carpenter sought out
2 the services of Dr. Donald Goldberg. You're aware of
3 that?

4 A. Yes.

5 Q. And you are aware that Dr. Goldberg has
6 special qualifications, and, in fact, a PH.D.
7 specifically in audiologic rehabilitation?

8 A. That's correct.

9 Q. Are you aware of that?

10 A. That's exactly why I called him.

11 Q. Okay. And you, sir, do not have that type of
12 specialty qualifications?

13 A. I agree with you. I agree with you. That's
14 why -- that's why I called him.

15 Q. Great. And if -- just hypothetically -- if a
16 patient such as Ryan Carpenter was sent to you, you
17 would involve someone like a Dr. Goldberg to get
18 involved for the therapy, correct?

19 A. Yes, I would, that is correct.

20 Q. All right. Now, we know that in this
21 particular case, you were not asked to get involved in
22 any way to help Ryan with therapy, true?

23 A. That's correct. I'm not a treating physician.
24 I'm a disability evaluating physician, that is my role.

25 Q. Okay. And you saw Ryan only the one time at

1 the request of Ms. Pantages, and that was back in April
2 of 2007, correct?

3 A. That is correct.

4 Q. And I know you touched on this briefly, but
5 it's my understanding that you do review and testify in
6 medical/legal matters such as this frequently, true?

7 A. Yeah. I would say it's frequently, that is
8 correct.

9 Q. And I know you began doing this back in 1991
10 or 1992, correct?

11 A. I would agree, that is correct.

12 Q. And -- all right. And you were kind enough,
13 at the time that we took your deposition, to provide a
14 booklet of how often you're involved in medical/legal
15 matters. And it's a booklet, I'm just going to show it
16 to the jury, because -- since you're not in the
17 courtroom testifying live. But it's a booklet of -- of
18 your testimony from January 2005 to the present. And
19 it's a listing of deposition and trial testimony,
20 correct?

21 A. That's correct.

22 Q. And as I counted it up, I think from just 2005
23 to the present, you have given about 572 depositions and
24 more than 100 trial testimony; is that fair?

25 A. Yeah. I think I've been in trial about 150

1 times. And almost 600 depositions to count today. But
2 realize that at least 50 percent, if not more, of that
3 forensic experience, deposition and trial is on my own
4 patient population. As I say, I've had over 6,200
5 admissions to the trauma hospital. I have over 30,000
6 outpatients. So I testify with frequency.

7 But really, only 10 percent of what I do is
8 expert witness. Most of the -- I think the greater
9 majority of what I do is on my own patient population.
10 The greater majority of the forensic experience is on my
11 own patients where I'm a treating physician. I work at
12 least 100 hours a week. And 80 percent of that time is
13 on patient care.

14 Q. And I think what you -- you did testify to is
15 that while only 10 percent of your time is involved in
16 doing medical/legal matters, that about 25 to 30 percent
17 of your gross income is actually from the forensic work;
18 isn't that correct?

19 A. That's correct. That's because the
20 reimbursement for medical care is dropping through the
21 floor, as we all know. So if -- if the billing for
22 forensic work stays the same, and the collection rate
23 for medical care is dropping, then it's going to be a
24 greater percent. And that's what -- that's what's
25 happening.

1 Q. But --

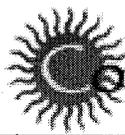
2 A. I'm not increasing -- I'm not going to
3 increase the amount of legal work that I do. I will
4 keep it at 20 percent.

5 Q. But what you are essentially saying is that it
6 is more lucrative from an economic standpoint to be
7 involved in the medical/legal matters than it is the
8 medical practice, correct?

9 MS. PANTAGES: Objection.

10 THE WITNESS: Of course it is, because I don't
11 turn away people. So if I have people that I have
12 to take care of and they have no money, I'm going
13 to take care of them. And my reimbursement for
14 that type of stuff is zero.

15 And the reimbursement for forensic work is
16 usually there. Not always. But usually you get
17 paid when you're an expert witness or you're doing
18 forensic work. In the care and practice and
19 treatment of medical care in society, you're not
20 always going to get paid. And when you do get
21 paid, it's very low. And I've often said that the
22 social construction of medicine in the United
23 States is a failure. That's why this legal
24 proceeding for this child is critically important.
25 Because his future needs to be secured. With his



1 loss of a special sense, he will need the internal
2 device and the external device and all of the
3 therapies that go with it, and all of the medical
4 care and evaluations that go with it for the rest
5 of his life as a medical necessity. And we cannot
6 rely on the social construction of medicine to
7 provide that.

8 BY MS. CARULAS:

9 Q. Sir, how much have you made as far as your --
10 in the medical/legal and review of this case? What has
11 your charge been?

12 MS. PANTAGES: Objection.

13 THE WITNESS: If Madam Court Reporter could
14 hand me that. The total cost for flying and seeing
15 the patient, four hours of medical records review,
16 the 30 8-by-10 photographs, airfare, lodging,
17 parking, everything for the report was \$10,216. I
18 believe that we had a two-hour deposition at \$750
19 an hour. There would be another \$1,500 charge.
20 Today, I don't know if you booked out one hour or
21 two hours, but it's \$750 an hour.

22 BY MS. CARULAS:

23 Q. All right, sir. Now, let's move to the task
24 that you were asked to do in this case. The only issue
25 you were asked to look at by Ms. Pantages was Ryan

1 Carpenter's hearing loss, correct?

2 A. No, that's incorrect. I was asked to define
3 his impairment, his disability and his costs for future
4 medical care using a medical model. That's what I did
5 with this big voluminous report with all of the 8-by-10
6 photographs. It was not just his costs for future
7 medical care. But it's how his ability or inability to
8 reintegrate back into society.

9 Q. Okay. But the medical issue that you were
10 asked to look at and come up with this formulation was
11 regarding Ryan's hearing loss, correct?

12 A. Yes. That is a correct statement.

13 Q. Okay. Now, you did do, as we know, and
14 extensive evaluation and wrote long reports and so
15 forth, correct?

16 A. Right.

17 Q. And as you went through the medical records,
18 you actually listed -- and I have in one of them your
19 AMA impairment rating based on your evaluation of
20 April 14th, 2007 -- and you listed 36 different
21 diagnoses; is that correct?

22 A. That's correct. But that has nothing to do
23 with the AMA impairment rating. It's -- I carry over
24 the same diagnosis impression through each -- through
25 each section. The only part of the AMA impairment

1 rating that I utilized was his loss of special sense.
2 That's why we're here today. And that's the only thing
3 that he gets as far as an AMA impairment rating.

4 Q. Okay.

5 A. I don't give him any impairment rating for
6 anything else.

7 Q. All right. I know actually on page 3 and page
8 4 of one of your charts -- and I'm going to just mark
9 this as Exhibit A for purposes of showing the jury.

10 (Defendants' Exhibit Letter A was marked for
11 identification.)

12 BY MS. CARULAS:

13 Q. You have a list of 36 different diagnoses, and
14 you've put that same list of 36 conditions on the AMA
15 impairment rating; is that correct?

16 A. That's correct. But it's just a carryover
17 through each section. That has -- the AMA impairment
18 rating only focuses on his bilateral hearing loss.
19 That's it. I don't assign a number or a loss of a body
20 system to anything else because that would be
21 inappropriate.

22 Q. Okay. But my point is: You did go through
23 the medical records, and you've said, It was my opinion,
24 at the time, that the patient was suffering from -- and
25 you listed 36 different issues. You started with:

1 History of pre-term birth at 34 weeks' gestation, number
2 one. Number two, history of mild ventriculomegaly with
3 intraventricular hemorrhage bilaterally, diagnosed by
4 ultrasound. Number three, history of chronic lung
5 disease. Number four, history of hypertension. And on
6 and on, correct?

7 A. Excuse me. You have to slow down. The court
8 reporter is developing carpal tunnel syndrome.

9 Q. Okay. We don't want that, or she'll have
10 another job for you there.

11 But my point is, you did list that in your
12 report; is that correct?

13 A. I agree.

14 Q. Okay. Now, you mentioned that you spoke with
15 a number of different doctors who were caring for Ryan
16 Carpenter. You mentioned a Dr. Goldberg, who we have
17 discussed, who was his treating therapist, true?

18 A. I agree.

19 Q. You mentioned a Dr. Harrison, a Dr. Neparko
20 and a Dr. Sullivan, correct?

21 A. That's correct.

22 Q. Was it your understanding that those
23 individuals; doctors; Neparko, Harrison, and Sullivan
24 were involved in Ryan's care and treatment?

25 A. No. I believe that they were hired by

1 plaintiff's side to evaluate the patient, render an
2 opinion, and that's why I was allowed to call them.

3 Q. Okay. Now, in one of your discussions with
4 Dr. Sullivan, who was a neuropsychologist, I have a note
5 here -- and I'm just going to mark it as Exhibit C.

6 (Defendants' Exhibit Letter C was marked for
7 identification.)

8 BY MS. CARULAS:

9 Q. This is a memo that you did on April 18th,
10 2007.

11 A. Um --

12 Q. See if you can find that.

13 A. Yes, I have that.

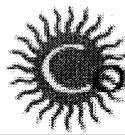
14 Q. Okay. And it mentions here that you had a
15 lengthy discussion with Dr. Sullivan?

16 A. Yes.

17 Q. And it's my understanding that you talked with
18 these individuals, and your practice is you actually
19 dictate this memo while they're on the phone, so that
20 this is an accurate statement; is that correct?

21 A. That's correct. I don't -- I'm 53 years of
22 age, I couldn't hang the phone up, then dictate. I have
23 to contemporary, at the same time.

24 Q. Okay. And in this particular case, in
25 paragraph 2 of that memo there, you say it was



1 Dr. Sullivan's opinion that this patient did demonstrate
2 some attention deficits?

3 A. That's correct.

4 Q. Which he did not -- let me say it again. It
5 was Dr. Sullivan's opinion that this patient did
6 demonstrate some attention deficits, which he did not
7 feel would be secondary to the Vancomycin and would --
8 and it would be more secondary to the other events
9 during his birth. Did I read that correctly?

10 A. That's correct.

11 Q. All right. And then he further said -- that
12 it was Dr. Sullivan's opinion, that when this child
13 turns eight years of age, he should have another
14 psychometric battery to determine any deficits as it
15 relates to his brain -- I'm sorry -- as it relates to
16 his birth injury. And I'm going to hand this up to the
17 jury so they can follow along.

18 So let me read it again. It was
19 Dr. Sullivan's opinion, that when this child turns eight
20 years of age, he should have another psychometric
21 battery to determine any deficits as it relates to his
22 birth injury, not necessarily van (phonetic) -- not
23 necessarily Vancomycin. And then he goes on about some
24 costs.

25 But he said, However, this evaluation would

1 not be related to Vancomycin. This would be related to
2 any type of anoxic event that he suffered during birth.
3 Did I read that correctly?

4 A. That's exactly what he wrote.

5 Q. Okay. All right. So you did not take into
6 account in your evaluation any issues that may be going
7 on with Ryan that were unrelated to the hearing loss
8 that has been alleged to be secondary to Vancomycin; is
9 that correct?

10 A. No, I didn't. Because I run a CP clinic, and
11 it's my opinion that this patient does not have an
12 anoxic brain injury at birth. This is not a brain
13 damage injury, a birth injury case at all. This is
14 hearing loss secondary to an overdose of Vancomycin.

15 The Cleveland Clinic has already admitted
16 liability. There is no issue on the table as far as I'm
17 concerned as to the mechanism of action or what
18 happened. It's all in the records. It's already been
19 stated. It's been agreed upon. It's my opinion that
20 there is no other issue. The issue in this case is an
21 overdose of Vancomycin as already agreed to by the
22 Cleveland Clinic. And this patient has bilateral
23 hearing loss, which is a loss of special sense. The
24 loss of special sense, in my opinion, is a catastrophic
25 injury, and there will be a sequela to that for the

1 remainder of this patient's life. And this patient will
2 need ongoing close supervision and monitoring for the
3 rest of his life.

4 MS. CARULAS: Objection: move to strike that
5 statement.

6 BY MS. CARULAS:

7 Q. Sir, my question to you is: You did not, as
8 you evaluated this case for purpose of your report and
9 so forth, did not involve an analysis in this case
10 regarding what Dr. Sullivan said here about attention
11 deficit, true?

12 MS. PANTAGES: Objection: asked and answered.

13 THE WITNESS: Yeah, that's true. That is
14 true. In my opinion --

15 MS. CARULAS: Thank you, sir. Sir, thank you.

16 MS. PANTAGES: Let him answer it.

17 THE WITNESS: No. I'm allowed. I know --
18 I've done enough litigation to know that I'm
19 allowed to answer the question. And you are
20 cutting me off, which is unfair.

21 The answer to the question is, that is
22 correct. This has nothing to do with attention
23 deficit disorder. This has nothing to do with a
24 brain injury at birth. This is not a brachial
25 plexus injury at birth. This is bilateral hearing

1 loss as it relates it an overdose of Vancomycin.

2 And the only thing I've addressed in this
3 report is bilateral hearing loss as it relates to
4 an overdose in Vancomycin. I am not interested in
5 any other opinion, because that's not my opinion.
6 My opinion is consistent with the medical record,
7 consistent that was provided to me, the history
8 that was provided to me by the mother, and has
9 already been agreed upon by the Cleveland Clinic.
10 This is an overdose of Vancomycin knocking out this
11 child's hearing.

12 And as a result, I was asked by plaintiff's
13 counsel to define his impairment, disability and
14 costs for future medical care as it relates to his
15 bilateral loss of hearing, which is a special
16 sense, in my opinion, is catastrophic in nature.

17 MS. CARULAS: I'm going object: move to
18 strike.

19 Now -- go off of the record for a moment,
20 please.

21 THE VIDEOGRAPHER: Okay. We are now going off
22 of video record. The time on the monitor 1:77
23 (sic) p.m.

24 (Discussion off the record.)

25 (Discussion on the record without videographer.)

1 MS. CARULAS: I would like to put this on the
2 record as far as the court reporter is concerned.
3 Are we all set?

4 THE COURT REPORTER: Yes, ma'am, I am.

5 MS. CARULAS: Okay. What I'd like to do --
6 I'm obviously going to strike any of the recent
7 testimony that Dr. Lichtblau gave on the causation
8 issue in this case regarding the Vancomycin and so
9 forth.

10 What I'm going to do now is, I'm going to ask
11 a series of questions that is only conditioned on
12 whether the judge would allow this type of
13 questioning at the time of trial. Which I will
14 argue, obviously, should not come into testimony.

15 So what I would like to do is go back on
16 record. And we'll go back on the video. And I'll
17 ask a series of questions, just in the event that
18 the court would allow that previous testimony to
19 come in. Okay?

20 THE COURT REPORTER: Okay.

21 THE VIDEOGRAPHER: Okay.

22 MS. CARULAS: Okay, sir, we can go back on the
23 record.

24 (Back on the video record.)

25 THE VIDEOGRAPHER: Thank you. We are now back

1 on video record. The time on the monitor is
2 1:42 p.m.

3 BY MS. CARULAS:

4 Q. All right. Dr. Lichtblau, just a moment ago
5 you gave some testimony in this case on the subject of
6 causation. And your statement that you believe that the
7 Vancomycin caused this patient's bilateral hearing loss;
8 is that correct?

9 A. Yeah. The way you've asked that question,
10 that is correct.

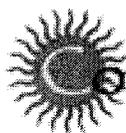
11 Q. Okay. Let me, if I can, refer you to your
12 discovery deposition. Do you have that with you, sir?

13 A. No. I was never provided -- I was never
14 provided a copy of my deposition.

15 Q. Okay. Well, we -- you know that that
16 deposition was taken on July 28th, 2009. Ms. Pantages
17 was there. And one of my partners took your deposition.
18 And you've stated that you have not been provided a copy
19 of that by Ms. Pantages; is that correct?

20 MS. PANTAGES: Objection: or by the court
21 reporter.

22 THE WITNESS: I don't think I have a copy of
23 it. I don't know why I don't have it. But I
24 don't -- I don't know the technical problem. But I
25 do not have a copy of my deposition. And I was



1 unable to read my deposition before this deposition
2 today.

3 BY MS. CARULAS:

4 Q. Okay. So, but, let me ask you -- I'm going to
5 read some of the deposition. And we're at a little bit
6 of a disadvantage since I can't walk around the table
7 and show it to you. But Ms. Pantages will follow along.
8 I'm looking at page 7. And I want you to tell me
9 whether or not this was indeed your testimony. I'm
10 looking on page 7, line 11.

11 Question: You know what -- before we get into
12 it, let me ask you briefly: Does the comprehensive
13 medical report basically summarize all the opinion --
14 all the opinions that you hold in this case?

15 Your answer: Yes. Because realize, I'm not
16 going to offer any opinions about causation.

17 So, again, you said, I'm not going to offer
18 any opinions about causation --

19 A. Well, that's because --

20 Q. Listen. Let me finish.

21 -- medical malpractice, standard of care,
22 falling below the standard of care. I'm simply going to
23 define this patient's impairment, disability and costs
24 as it relates to subject incidents. But I'm not the
25 expert on the subject incident. I'm not going to sit

1 here and talk about Vancomycin toxicity. I'm going to
2 talk about what this child -- what his impairment is.
3 What his disability is. What his cost of future medical
4 care is. Because that's in my scope as a physical
5 medicine and rehabilitation physician. I never testify
6 outside my scope.

7 Was that your testimony, sir?

8 A. It is my testimony and it's very accurate.

9 Q. Thank you, sir.

10 A. I'm not done with my answer.

11 Q. Thank you, sir. I'm done with my question.

12 MS. PANTAGES: No. I would like to ask you to
13 stop interrupting him. He is allowed to complete
14 his answer. And it doesn't change things when you
15 interrupt him. Go ahead, Doctor.

16 THE WITNESS: Okay. That is correct. I'm not
17 the causation expert. But all through my report,
18 and I stated in that deposition, in that discovery
19 deposition, my opinions were either in the report
20 or in the discovery deposition, and Diagnosis No.
21 32, all through my report, in all six sections:
22 History of Vancomycin overdose resulting in red-man
23 syndrome and bilateral deafness.

24 So, I'm not the causation expert. However,
25 mechanism of injury is critically important. And

1 the last question that I was asked, or two
2 questions ago, about another evaluating physician
3 regarding attention deficit disorder, the mechanism
4 of injury is critically important to my opinions.
5 I'm not going to offer opinions regarding the
6 amount of Vancomycin, the magnitude of the
7 toxicity. That's -- that's clearly a matter of
8 fact. The child has bilateral hearing loss. The
9 Cleveland Clinic has already admitted liability.

10 All I'm trying to say, that is the truth, the
11 whole truth, nothing but the truth. This is not
12 attention deficit disorder. This is not a
13 traumatic brain injury. The is not a brachial
14 plexus injury. This is all about bilateral hearing
15 loss, secondary to Vancomycin poisoning or
16 toxicity, and that has been through every section
17 of my report, Diagnosis No. 32. I'm not adding
18 anything new. I'm not changing my opinions. I'm
19 merely stating that this is all about bilateral
20 hearing loss, secondary to toxicity.

21 If another doctor has another opinion
22 regarding why this patient is in the condition this
23 patient is, it would be different from my opinion.
24 My opinion is, this is one hundred percent; this
25 impairment, disability and costs for future medical

1 care is one hundred percent secondary to bilateral
2 hearing loss as is described in Diagnosis No. 32
3 through each section of my report, Vancomycin
4 toxicity, which the Cleveland Clinic has already
5 admitted to.

6 MS. CARULAS: Objection: move to strike.

7 BY MS. CARULAS:

8 Q. Sir, as you looked at the medical records in
9 this case, that you have in front of you, where in the
10 records from the Cleveland Clinic did they state that
11 Ryan Carpenter's hearing loss was proximately caused by
12 the Vancomycin?

13 A. Well, number one, I don't have the records in
14 front of me, because I needed a truck to bring them
15 over. And number two, it's a known fact -- I mean, we
16 can play smoking mirrors all day long. They have
17 already admitted to the -- they have already admitted to
18 this liability of Vancomycin toxicity. They -- I don't
19 know that they have admitted in the record, but we know
20 that's what it is. We know this child suffered red-man
21 syndrome. We know this patient has bilateral hearing
22 loss, secondary to Vancomycin toxicity. That is the
23 facts of this case. That's Diagnosis No. 32, throughout
24 six sections of my report. There has been no change in
25 my testimony. You're the one that keeps asking me

1 questions about mechanism of action.

2 Q. Sir, I'm doing this -- I'm doing this at this
3 point in time, because you are the one that raised it.

4 Did you see -- even looking at your report, is
5 there anything specifically where you quote the medical
6 records, where the medical records say that the
7 Vancomycin was the direct and proximate cause of the
8 patient's hearing loss?

9 A. No. Very seldom do you see that written in a
10 medical record, in a medical malpractice case, where
11 they admit in the medical record that this is secondary
12 to Vancomycin poisoning for some mistake that the
13 hospital or nursing staff did.

14 This is -- my opinion is that this is one plus
15 one equals two. The Cleveland Clinic has already
16 admitted the liability. They've already admitted to
17 their mistake. I don't even know why you're doing this
18 line of questioning. There is no issue on the table as
19 to whether the Vancomycin poisoning is the proximate
20 cause. They've admitted to it.

21 Q. Sir, do you understand -- and we are now
22 getting so far a stream of what should be the
23 appropriate questioning here. So, again, I'm saying
24 this for purposes of the record and Judge McCormick.
25 But I'm asking this further in the event that any of

1 this is allowed in. Sir --

2 MS. PANTAGES: Objection to --

3 BY MS. CARULAS:

4 Q. Do you understand the difference between the
5 issue of, number one, an alleged deviation from standard
6 of care, and number two, the issue of causation?

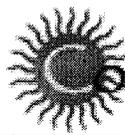
7 MS. PANTAGES: Objection.

8 THE WITNESS: I do. But that is not my issue.
9 The answer in the previous line of questioning was,
10 I was discussing mechanism of action, because you
11 brought up how another healthcare provider had
12 diagnosed him with AD -- attention deficit
13 disorder. That is not the issue in this case.

14 The issue in this case is bilateral hearing
15 loss, secondary to Vancomycin toxicity. That is my
16 Diagnosis No. 32. I have not changed my opinions.
17 You've asked different questions than you asked in
18 the discovery deposition; that's why you're getting
19 different answers. I am not the causation expert.

20 However, it is documented throughout my whole
21 report why this patient has bilateral hearing loss.
22 And the Cleveland Clinic has admitted to it. So I
23 don't know why you're asking these set of
24 questions.

25



1 BY MS. CARULAS:

2 Q. Sir, again, this is all for purposes of the
3 record and the judge. Number one, you are aware that
4 the Cleveland Clinic has acknowledged, and did so from
5 day one, that there was a mistake in this case as far as
6 the Vancomycin, correct?

7 A. I agree with that statement. That's a correct
8 and true statement.

9 Q. Okay. As I know that you put in your
10 Diagnostic Item No. 32, you put down that you -- the
11 issue of the Vancomycin and the hearing loss.

12 My question to you: In your detailed report
13 that you set forth, was there anywhere where you quoted
14 something in the medical record, where it did link up or
15 show that the causation was there between the Vancomycin
16 and the hearing loss, yes or no?

17 A. No, I did not do that. That's not my role.
18 My role is to define impairment, disability and costs.
19 This is trial video. You're asking me a specific set of
20 questions that you did not ask me in the discovery depo.

21 The answer to my questions lies in Diagnosis
22 32 that is in my report in five, six, different
23 sections. There is no change in my opinions. My
24 answers are a little different, because you're asking
25 the questions different.

1 Q. Sir, the issue of causation, as you said, it's
2 not your issue because that would be outside of your
3 scope of expertise, correct?

4 A. Correct. I'm not going to sit here and talk
5 about whether it's ten times too much or 12 times too
6 much, or is it six times too much to cause bilateral
7 hearing loss. We know this child is a normal child
8 except for bilateral deafness. That's what we know. We
9 know that the child suffered ototoxicity, secondary to
10 Vancomycin overdose. That's all on the table. There is
11 no hocus pocus about that. And I don't really need to
12 get into that. That is just the mechanism of action.

13 That's why in your previous line of
14 questioning, when you asked me about attention deficit
15 disorder or other disorders, I disagreed. That's not
16 true. This case is one hundred percent about
17 ototoxicity, secondary to an overdose of Vancomycin. I
18 don't agree with anybody else, if they want to say, this
19 is a traumatic brain injury, an anoxic brain injury at
20 birth, a brachial plexus injury, that's all smoking
21 mirrors. That has nothing to do with the facts of this
22 case.

23 The facts of this case are well defined,
24 number one. And number two, the mechanism of injury has
25 already been admitted to by the Cleveland Clinic.

1 Q. Sir, on page 28 of your report. Did you
2 summarize the note from Dr. Hirose?

3 A. Yes, I did.

4 Q. And did you document there a note of
5 9/11/2003: To summarize, I feel that it is unlikely
6 that Vancomycin caused his hearing loss.

7 A. Yes. And --

8 Q. Let me read that for the jury. And just tell
9 me if this is in your note.

10 To summarize, I feel that it is unlikely that
11 Vancomycin caused his hearing loss. Immuno glycosides
12 are ototoxin, and Vancomycin, although it sounds like
13 one, is not an Immuno glycoside. Vancomycin can be
14 synergistic with Gentamycin, which he did receive.
15 However, should this be a hearing loss due to
16 ototoxicity, there should be outer hair cell dysfunction
17 and loss of the cochlear microphonic and loss of
18 otoacoustic emissions. The auditory neuropathy pattern
19 is not consistent with ototoxicity.

20 Is that in your report, sir?

21 A. Yes. I put that in my report to eliminate all
22 controversy. And, obviously, the Cleveland Clinic
23 doesn't agree with that note. They have already
24 admitted liability. There are other experts that talk
25 about liability. Everybody knows in the medical

1 profession that Vancomycin, Gentamycin, any mycin,
2 whether it's Immuno glycoside or not is dangerous.

3 And when you receive such a large dose as this
4 child did, you know, if it looks like a duck, quacks
5 like a duck, walks like a duck, quacks like a duck, and
6 ends up on a Chinese restaurant and is moo goo gai duck,
7 chances are, it's a duck.

8 MS. CARULAS: I'll move to strike. This is
9 all part of my voir dire for the judge anyway.

10 BY MS. CARULAS:

11 Q. All right, sir. Have you --

12 MS. PANTAGES: Objection as to statements by
13 counsel.

14 BY MS. CARULAS:

15 Q. Have you, sir -- do you have any expertise in
16 the area of otolaryngology?

17 A. No, ma'am, I don't.

18 Q. Do you, sir -- have you ever conducted any
19 research specifically on the issues of ototoxicity of
20 antibiotics or any medications?

21 A. No, ma'am, I have not conducted research.
22 However, I have privileges at five hospitals. I write
23 for antibiotics. And I'm licensed to practice medicine
24 in the state of Florida. And that is Medical School
25 101. If you're writing for Immuno glycosides, you've

1 got to be very careful, because everybody knows they're
2 ototoxic.

3 So Gentamycin, Vancomycin, all of them,
4 they're an area of concern. And it's irrelevant.
5 Because when you receive ten times the allotted dose,
6 you are going to have a sequela. That's what happened
7 in this case.

8 And early in my direct testimony, I said that
9 cases like this are very rare and far between, because
10 this is obviously a mistake. This never should have
11 happened. The Cleveland Clinic has already admitted
12 liability. I don't know what the controversy is, and I
13 don't know why you're asking these questions.

14 Q. All right, sir. Now, I'm going to move now at
15 this point in time to my voir dire portion -- end that.
16 And then let's go forward with your questioning.

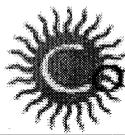
17 Sir, you have said and made a statement that
18 under the AMA determination, you put the number of 35
19 percent as to Ryan Carpenter's impairment, correct?

20 A. That's correct.

21 Q. Okay. And it's my understanding that you --
22 you said that you used the fifth edition as opposed to
23 the current sixth edition, correct?

24 A. That's correct.

25 Q. Now, it's my understanding that as far as



1 hearing loss and the determination of this impairment,
2 that 35 percent is the far extreme, that's the farthest
3 as far as one with hearing loss on the graft; is that
4 correct?

5 A. I don't have the fifth edition with me. It
6 would be Table 11-3. I can't remember. I think that
7 that's correct, but I'm not sure.

8 Q. So hearing loss could be anywhere from the
9 range of one percent to 35 percent on that graft,
10 correct?

11 A. That's correct. But, obviously, he has
12 bilateral internal devices and bilateral external
13 devices, so that's an assistive device. But without
14 those assistive devices, he's for all intents purposes
15 deaf.

16 Q. I understand that. But if someone who was
17 born deaf -- someone who was born deaf, never heard,
18 never spoken, that person would be given the 35 percent
19 AMA disability impairment, correct?

20 A. I think so.

21 Q. Okay. We've talked about how Ryan Carpenter,
22 on the other hand, did have the cochlear implants placed
23 at a very young age, correct?

24 A. That's correct.

25 Q. And he has had intensive therapy both with

1 Dr. Goldberg, as well as at his schooling, the Middle
2 Ridge Academy, correct?

3 A. That's correct.

4 Q. And as you put together the numbers and came
5 up with a 35 percents -- percent, you did not take into
6 account his current functioning with the cochlear
7 implants and the therapy, true?

8 A. No, I did not. You're not supposed to do
9 that, because that's like comparing a quad. If a
10 quadriplegic is in a wheelchair it - the kid has no
11 mobility, they have an impairment for no mobility. If
12 you put them in a wheelchair, and they have mobility due
13 to the wheelchair, you don't lower their impairment
14 rating because they have an assistive device.

15 This patient has sophisticated assistive
16 devices. And what if those assistive devices can no
17 longer be used because he develops an infection, or has
18 a problem, or there is a malfunction? It's my opinion,
19 based on the facts of this case, he has 35 percent.

20 Now, is it corrected somewhat with the
21 cochlear ear implants? Yes, it is. But I can't
22 guarantee that will be always like that for the rest of
23 his life. And the impairment, according to the guide,
24 would be 35 percent.

25 Q. All right. But my question to you is: You

1 did not take into any account his current functioning
2 with the cochlear implants?

3 A. No. I --

4 Q. And where he is at for your number in the
5 impairment assessment?

6 A. That's exactly right. And just like, if I had
7 a quadriplegic that is never going to walk again, and
8 they get an impairment for loss of gait, if you put them
9 in a wheelchair, and wheelchair (sic) them down the hall
10 to give them mobility, that would not change their
11 impairment rating. They still have a loss of
12 ambulation. So it would be unfair to do that.

13 This case is bilateral hearing loss. We have
14 a compensatory mechanical device that we're depending
15 upon. And we're going to assume for the record, that
16 it's a perfect world and it will work for the next 72
17 years. And we all know, as we're sitting here, it's not
18 a perfect world. And, in fact, it's far from a perfect
19 world.

20 MS. CARULAS: I'm going to object and move to
21 strike.

22 BY MS. CARULAS:

23 Q. Now, sir, did you talk with Dr. Goldberg, his
24 treating therapist, as to his opinion as to Ryan, his
25 functioning and his impairment?

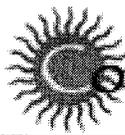
1 A. No, I didn't, because -- there may be
2 something about that, but I wouldn't talk to a therapist
3 regarding impairment ratings, because therapists can't
4 give impairment ratings. Only MDs can give impairment
5 ratings. I might have talked to him about his
6 abilities. But I wouldn't discuss an impairment rating
7 with the therapist, because therapists have no insight
8 and that's not what they do.

9 Q. Okay. Therapists obviously are able to tell a
10 patient's functioning, true?

11 A. Yeah, I agree with that statement. However,
12 you're trying to compare strawberries and tricycles. My
13 opinion regarding this patient's impairment does not
14 have anything to do with his functioning; it's straight
15 out of the book. He's got bilateral hearing loss that
16 requires internal and external devices. His --
17 regardless what his functional capacity is, in this
18 particular case, with this set of facts, he is
19 bilaterally deaf without those devices, and that comes
20 with a certain number in the books, in the fifth
21 edition, and that's what I did.

22 Q. Okay. Now, if this were a worker's comp case,
23 you are supposed to use the most current addition when
24 you come up with an impairment analysis, correct?

25 A. I disagree with that statement. Worker's



1 compensation in the state of Florida has its own guide.
2 In other states if litigation is requiring impairment
3 ratings, you're supposed to use the most current
4 edition, that is correct.

5 But at the time that I did this, the sixth
6 edition was not out yet.

7 Q. Okay. The sixth edition, however, it is
8 currently out. And it came out some time ago, correct?

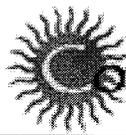
9 A. That's correct.

10 Q. All right. And there have been some
11 significant changes between the fifth and the sixth
12 edition, correct?

13 A. Yeah. Very significant changes. However, I
14 would not be able to give a sixth edition evaluation,
15 because you have to have a certain amount of objective
16 information at 100 hertz, 200 hertz, 600 hertz, and I
17 don't have that information. So I could not plug it
18 into the new formula.

19 Q. Okay. You couldn't use the sixth edition
20 because you haven't evaluated Ryan over the past two
21 years, two-plus years, correct?

22 A. Not only that, but I don't have the
23 information that it would take to use the sixth edition.
24 You have to use a certain amount of decibels at 100
25 hertz, 200 hertz, 600 hertz. I don't have that



1 information. So to use the sixth edition would be
2 speculative. And if you're going to speculate, then
3 you're not allowed to do that in a court of law. So I
4 stuck with the fifth edition.

5 Q. All right. And the significant changes
6 between the fifth and the sixth edition, one of which --
7 and I have the sixth edition here with me --
8 specifically said that part of the problem with the
9 prior additions was that impairment ratings did not
10 adequately or accurately reflect loss of function; is
11 that correct?

12 A. Well, that's correct. However, the new
13 edition is using grade modifiers and all kinds of --
14 there are all kinds of changes in the edition. And it's
15 my opinion that the sixth edition is actually more
16 inaccurate than the fifth edition. And there is a big
17 uproar right now. And there is a lot of physicians that
18 have written into the AMA. And I think they're going to
19 come out with a revised sixth edition. Because the
20 modifiers and the new grade modifiers that have come out
21 do not accurately reflect the problem.

22 If you have a fusion in your neck, it comes
23 out to, like, 8 percent impairment. Where the old
24 guide, the fifth edition, it would be 12 or 13 percent.
25 It's far too conservative and it's inaccurate.

1 Q. What the sixth edition specifically said is
2 that the prior editions, like the fifth edition that you
3 used, the numerical ratings were more of a
4 representation of legal fiction than medical reality; is
5 that correct?

6 A. Yeah, that's in there. And realize in a lot
7 of this, AMA impairment rating, is not evidence based;
8 it's consensus based. And the problem is, the consensus
9 of all of my colleagues and everybody I know, even
10 authors of the book, such as Anthony Dorto, state the
11 new sixth edition is very inaccurate and it's fumbling.
12 And we are very unhappy with the sixth edition. It is
13 not evidence based. It tries to be. It is consensus
14 based. And it is not the consensus of the medical
15 profession. And that's why I think they're coming out
16 either with a revised sixth edition or a seventh
17 edition. There will be corrections to this book.

18 The videographer here has to change tapes.

19 THE VIDEOGRAPHER: We are now going off video
20 record on Tape No. 1. We will be back on Tape No.
21 2. The time on the monitor 2:06 p.m. It will only
22 take me a second.

23 (A brief recess was taken.)

24 (Back on the record.)

25 THE VIDEOGRAPHER: We are now back on video

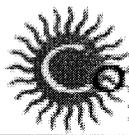
1 record. This is Tape No. 2. The time on the
2 monitor is 2:08 p.m.

3 BY MS. CARULAS:

4 Q. All right. Sir, we were talking about the
5 current sixth edition. And you would agree that under
6 the sixth edition, it specifically says, If an
7 individual must regularly use a prosthesis or orthosis
8 or other assistive device, the physician should test and
9 evaluate the organ system with the device. You're aware
10 of that?

11 A. I agree. But it could not be done in this
12 case, because I didn't know the number of decibels and
13 the different hertzes. And I couldn't plug it in. Even
14 if I had that -- even if I had the sixth edition back
15 then, I didn't have that information. So the most
16 accurate way I could do it -- because the sixth edition
17 wasn't even out -- was use the fifth edition. That's
18 what I did.

19 If you're trying to say the sixth edition
20 would be different, yes, the sixth would be different.
21 Would the impairment rating be less? Yes, it would be
22 less. It's 30 percent, 29 percent, what's the
23 difference? It's a catastrophic injury. He has lost
24 his special senses. He's requiring mechanical devices
25 to have some functional aspect of hearing for the rest



1 of his life.

2 Q. All right, sir. The bottom line is, you did
3 not in your determination of his disability, put him --
4 you put him in the range of one who would be completely
5 deaf without any assistive devices or with any therapy,
6 correct?

7 A. That's correct. That's what you're supposed
8 to do with the fifth edition. I followed the fifth
9 edition exactly how you're supposed to use it to the
10 best of my ability. I think the number is irrelevant.

11 What's relevant is this is a catastrophic
12 injury. He's relying on these mechanical devices for
13 the rest of his life, the next 72 years. We're going to
14 assume there is no mechanical deterioration, or no type
15 of complication, and we're going to assume it's the
16 perfect world. And we both know as we sit here, it's
17 not a perfect world. And it's my opinion, as a loss of
18 a special sense, eyesight, hearing, smell, are special
19 senses, that is a catastrophic injury. It's not likely
20 to change. And as this patient suffers the secondary
21 effects of aging, combined with his current impairment,
22 his disability will actually become greater.

23 MS. CARULAS: Objection: move to strike.

24 BY MS. CARULAS:

25 Q. Now, sir, as you are evaluating his function,

1 his impairment, we know you mentioned you didn't ask
2 that question of Dr. Goldberg. Did you read
3 Dr. Goldberg's deposition?

4 A. I did not. Dr. Goldberg is not --

5 Q. Have you read, sir --

6 A. I'm not done with my answer. Dr. Goldberg is
7 not a disability evaluation -- evaluating physician.

8 MS. CARULAS: All right. Move to strike.

9 BY MS. CARULAS:

10 Q. Sir, did you read the deposition of
11 Mrs. Carpenter --

12 A. I did --

13 Q. -- as far as -- let me finish my question.

14 Sir, did you read the deposition of Mrs. Carpenter as
15 far as her testimony regarding the functioning of Ryan,
16 yes or no?

17 A. I did not. I spoke to Mrs. Carpenter in the
18 comfort of her own home, and I got her opinions exactly
19 what she told me this child can do.

20 Q. Okay. And that was two years ago. But my
21 question -- my simple question to you is: You did not
22 read her deposition that was taken about a month ago --

23 A. No.

24 Q. -- true?

25 A. I did not.

1 Q. All right. And you went through a long list
2 of different devices and costs of different therapies
3 and so forth. It's my understanding that your opinions
4 as to the need for these therapies is relying on your
5 discussions with other folks; is that correct?

6 A. No. I would totally disagree with that
7 statement. That's not a true statement. It's partly.
8 I want to know the frequency and the costs from the
9 other folks. It's my opinion as a disability evaluating
10 physician, one that takes care of patients that have
11 deficits in the special senses, that this patient has
12 suffered a catastrophic injury, and the spirit and the
13 intent of the continuation of care plan, which is
14 authored by myself, is to make this patient as whole as
15 normal. So I'm not relying on other people for my own
16 opinions. The other people help me get prices and
17 frequencies. But my opinions are based on my own
18 knowledge, training, clinical practice experience in
19 taking care of patients that have deficits in special
20 senses. This case is unique, because the way this
21 patient acquired his deficit in special sense is already
22 been admitted to by the Cleveland Clinic.

23 MS. CARULAS: Objection: Move to strike.

24 BY MS. CARULAS:

25 Q. Now, sir, I think you mentioned that your

1 experience with patients with cochlear implants is
2 rather limited. Maybe a couple of patients, you said?

3 A. Yeah. I think -- I would say between two and
4 four patients. It's very rare for a situation like
5 this. Very, very highly uncommon.

6 Q. All right. And I think you mentioned that you
7 did have experience with one cochlear implant patient,
8 correct?

9 A. Yes.

10 Q. And I believe your testimony was that we asked
11 in the deposition what your experience was, and you said
12 that you did know one patient in Vero Beach. And your
13 testimony was, quote, Who is probably the best looking
14 child that I've ever seen in my life. And he is
15 reintegrating back into society very well. He
16 definitely is set up just like this patient. And he is
17 doing rather well. He is in a special school and he is
18 in a school for the deaf. And you know they have
19 accommodated them to the best of their ability, which is
20 outstanding.

21 A. I agree with that statement. That's correct.

22 Q. Okay. And your testimony was that he has done
23 very well, correct?

24 A. Yes. And my testimony is this child is doing
25 very well. Look at Photograph No. 5, he riding on a

1 tricycle. I think he's doing very, very well. But
2 realize, you know, don't let it fool you, he does have a
3 significant problem.

4 MS. CARULAS: Okay. Thank you, sir. That's
5 all I have.

6 MS. PANTAGES: I just have a couple questions
7 on redirect.

8 REDIRECT (CRAIG H. LICHTBLAU, M.D., P.A.)

9 BY MS. PANTAGES:

10 Q. Just a couple follow-up questions,
11 Dr. Lichtblau. You were asked on cross-examination by
12 defense counsel about whether you were as qualified as
13 Dr. Goldberg to talk about Ryan's future needs. First
14 of all, do you have an understanding as to whether
15 Dr. Goldberg is a physician?

16 A. No. My understanding is Dr. Goldberg is a --
17 hold on a second. I want to say this accurately. I
18 believe he's an audiologist. Let me see here. Yeah.
19 He's a certified speech therapist, audiologist. And my
20 conversation with Dr. Goldberg is one paragraph. It's
21 very, very short. It's within his scope. I'm not
22 looking to Dr. Goldberg to define impairment, disability
23 and costs for future medical care in regards to this
24 patient. I just want to know from his perspective, in
25 his scope of providing therapy services, what the

1 frequency, duration and costs.

2 Q. All right. Is it your understanding that as a
3 non-physician Dr. Goldberg is limited in his practice to
4 giving therapy to his patients?

5 A. Right. He is not allowed to do AMA impairment
6 ratings. I wouldn't talk to a therapist about an AMA
7 impairment rating.

8 Q. In fact, you as a physician, you make
9 diagnoses, you order tests, you prescribe medications.
10 All of that is well outside of the scope of
11 Dr. Goldberg's professional duties, correct?

12 MS. CARULAS: Objection.

13 THE WITNESS: That's correct. I also admit
14 patients to hospitals. I write narcotic pain
15 medications. There is a lot of things I do based
16 on my licensure that a speech therapist cannot do.

17 BY MS. PANTAGES:

18 Q. And is it true, Doctor, that most speech
19 therapists provide therapy on an order from a physician
20 like you?

21 MS. CARULAS: Objection.

22 THE WITNESS: That is correct.

23 BY MS. PANTAGES:

24 Q. Do you order or do you write orders for your
25 patients so that they can get therapy from people like

1 Dr. Goldberg?

2 A. That is correct.

3 Q. And do you manage patient care which includes
4 speech language therapists like Dr. Goldberg?

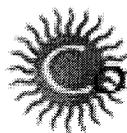
5 A. That's correct. And not only do I do it in
6 the general sense, but I also do it in the sense where
7 patients loose special senses, such as this patient.
8 Anytime somebody loses a special sense, that is a
9 catastrophic injury, and that's why we employ speech
10 therapists. For instance, vision, taste, hearing,
11 smell, those are your special senses. And I would write
12 speech therapy orders in order to maximize a patient's
13 functional recovery. And I'm the physician that would
14 do that.

15 Q. And do you supervise the care provided by
16 non-physicians like Dr. Goldberg to your patients?

17 A. Yes.

18 Q. Also on cross-examination, defense counsel
19 asked you about your area of specialty of physical
20 medicine. And I'm not -- I'm not sure what the
21 implication was. But from the standpoint of a physical
22 medicine physician, do you manage the care of
23 catastrophically injured people who require additional
24 care after their initial injury?

25 A. The answer to that question is yes. And I



1 think there is a little bit of a problem because we keep
2 talking about physical medicine. The actual name of my
3 specialty is physical medicine and rehabilitation, also
4 known as PM and R, or a physiatrist. And we take care
5 of catastrophically injured patients, which include but
6 is not limited to, traumatic brain injury, spinal cord
7 injury, stroke, amputation, multiple orthopedic trauma,
8 musculoskeletal pain and discomfort.

9 And the goal of a physiatrist is to integrate
10 those people back in society at their highest
11 functioning level. And realize, that's an ongoing
12 condition throughout the scope of their life. So
13 anytime somebody has a deficit in a special sense, this
14 is a catastrophic injury, and it will require close
15 medical surgical surveillance for the rest of that
16 patient's life.

17 Q. And when you do that, Dr. Lichtblau, do you
18 have to treat the whole person, both the physical --
19 physically injured person and the emotionally, or
20 psychologically, or cognitively injured person?

21 A. Yes. Because when patients suffer from
22 chronic pain, realize pain is -- there are three
23 components to pain: physical, emotional and
24 psychological. This patient is not suffering from
25 chronic pain. But this patient has a deficit in a

1 special sense, which is a catastrophic injury. And he
2 will require the management for the loss of his hearing
3 and the psychological, psychiatric issues for the
4 remainder of his life.

5 Q. And is that unusual in the patients that you
6 see that are catastrophically injured, that they have a
7 psychological or emotional component to their injury?

8 MS. CARULAS: Objection.

9 THE WITNESS: No. Because most patients that
10 are catastrophically injured always have a
11 psychiatric/psychological component to their
12 injury.

13 BY MS. PANTAGES:

14 Q. And is that part of your expertise in managing
15 those patients; to provide them appropriate
16 psychological care for that component of their injury?

17 A. Yes.

18 Q. And in treating the whole patient, Dr.
19 Lichtblau, are you also involved with that patient's
20 family?

21 A. Yes.

22 Q. Tell us about that, please.

23 A. Well, many times, especially with a pediatric
24 patient, of course, they're minors. So this affects the
25 mother, the father, the sister, the brother. And, in

1 fact, when I sat down in the patient's home and spoke to
2 the mother, she become very emotional and she cried her
3 eyes out. Because she's got a beautiful child who is
4 physically capable; however, because of the hearing, she
5 understands being an RN, being a nurse, what this means
6 for this patient and her family for the rest of his
7 life. And she knows how avoidable this whole issue was,
8 and she understands that a mistake was made that should
9 have never happened.

10 MS. CARULAS: Objection: Move to strike.

11 BY MS. PANTAGES:

12 Q. And is that -- is that, again, part of your
13 expertise as a physical medical rehabilitation
14 specialist to not only deal with the patient but also
15 routinely deal with patient's families in these
16 settings?

17 A. That is correct. Because realize, many times
18 my patients are so catastrophically injured, that I'm
19 not treating the patient anymore; I'm really treating
20 the family. What happens if somebody's loved one is in
21 a comma? They have no consciousness. They have no
22 awareness. They don't have a pain experience. I mean,
23 we brace them and we use orthotic devices so they don't
24 end up contracted. We make sure they get nutrition. We
25 make sure that they don't have breakdown bedsores. But

1 we're not really doing a whole lot for that person.
2 We're actually treating the mother, the father, the
3 sister, the brother; the family.

4 So in this particular case, there is a family
5 dynamic, because the mother, being an educated nurse,
6 understands the magnitude of the deficit. And
7 understands that there was a mistake made. And as a
8 result of the mistake, this child will suffer for the
9 rest of his life.

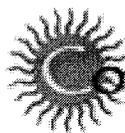
10 MS. CARULAS: Objection: move to strike.

11 BY MS. PANTAGES:

12 Q. All right. You had -- you had made a comment
13 referencing your Diagnosis No. 32: history of Vancomycin
14 overdose, resulting in red-man -- red-man syndrome and
15 bilateral deafness. Did you note in your review of
16 these records, of Ryan's medical records, repeated
17 references to risk factors for hearing loss due to the
18 Vancomycin overdose?

19 MS. CARULAS: Objection.

20 THE WITNESS: Yes. But, again, the Cleveland
21 Clinic has already admitted to the liability.
22 They've already admitted to the mistake. And
23 everybody knows in the medical profession, anytime
24 that you use Vancomycin, Gentamycin, any of the
25 mycins, it's very, very dangerous. You have to



1 really worry about kidney -- knocking out
2 somebody's kidneys, knocking out their hearing.
3 Kidney function and hearing loss are the two big
4 things that you worry about. And, of course, if
5 you give an overdose of Vancomycin, you know, five,
6 ten times of what it's supposed to be, then you
7 really have an area of concern. And the facts of
8 the case speak for themselves. This child was
9 given a dose way too much for what he could handle
10 and what he could clear, and it's amazing that they
11 didn't knock out his kidneys.

12 MS. CARULAS: Objection: move to strike.

13 BY MS. PANTAGES:

14 Q. But my question, Dr. Lichtblau, was: Did you
15 see references in the Cleveland Clinic records to this
16 child's risk factors for hearing loss as a consequence
17 of the known Vancomycin overdose?

18 A. Yes. That was definitely documented in the
19 record.

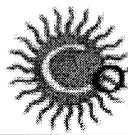
20 MS. CARULAS: Objection.

21 BY MS. PANTAGES:

22 Q. And I'd like to direct your attention to page
23 2 of your report. Are you with me?

24 A. Yes.

25 Q. First -- first full paragraph of your



1 comprehensive medical evaluation, you're summarizing
2 your conversations with Mrs. Carpenter, who you noted
3 was a registered nurse, that prior to him receiving the
4 Vancomycin, he had passed his hearing test and had been
5 qualified as having normal hearing. Is that a history
6 that Mrs. Carpenter gave you when you met with her?

7 MS. CARULAS: Objection.

8 THE WITNESS: Yes. And that's corroborated in
9 the medical record. That is the facts of this
10 case.

11 BY MS. PANTAGES:

12 Q. All right. And then she goes on to describe
13 the Vancomycin and that he had a typical red-man
14 syndrome. Again, that's an increased respiration and
15 increased heart rate. Again, that's a history that you
16 obtained firsthand from Mrs. Carpenter, correct?

17 MS. CARULAS: Objection.

18 THE WITNESS: I agree.

19 BY MS. PANTAGES:

20 Q. According to your report -- your report says
21 at the time that Christina saw her child in the
22 neonatal -- neonatal intensive care unit, she knew that
23 he had classic -- classic red-man syndrome. And she
24 questioned at that time whether he had received the
25 Vancomycin too fast or whether he had received too much

1 of a dose. Is that information that you obtained
2 directly from Mr. Carpenter?

3 MS. CARULAS: Objection.

4 THE WITNESS: Yes.

5 BY MS. PANTAGES:

6 Q. Your report goes on to say, It took
7 approximately two hours for the patient to receive any
8 type of relief from Benadryl, secondary to such a severe
9 reaction to the Vancomycin. Again, is that information
10 that you obtained directly from Mrs. Carpenter?

11 MS. CARULAS: Objection.

12 THE WITNESS: Yes.

13 BY MS. PANTAGES:

14 Q. Your report goes on to state, Later on, the
15 patient's mother states that she learned he was given a
16 dose ten times the amount that he should have been
17 given.

18 A. That's correct.

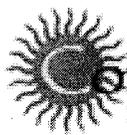
19 Q. Is that information that you obtained directly
20 from Mrs. Carpenter?

21 MS. CARULAS: Objection.

22 THE WITNESS: That's correct.

23 BY MS. PANTAGES:

24 Q. Your report goes on to say, The patient's
25 mother states that her son stabilized from all the



1 respiratory problems and neurologic problems and had
2 absolutely no deficits from that; however, as a direct
3 result of the overdose of Vancomycin, she states he had
4 a severe compromise of his hearing in both ears. Again,
5 is that information that you received directly from your
6 interview with Mrs. Carpenter, a registered nurse?

7 MS. CARULAS: Objection.

8 THE WITNESS: Yes.

9 BY MS. PANTAGES:

10 Q. If you could turn to page 28 of your report.

11 A. Okay.

12 Q. And, again, the first full paragraph starting
13 with 09/11/2003. On cross-examination defense counsel
14 read a portion of your report, so that the jury could
15 hear.

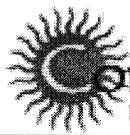
16 A. Yes.

17 Q. But she didn't read the entire -- the entirety
18 of that paragraph. I believe that she stopped with the
19 sentence, The auditory neuropathy pattern is not
20 consistent with ototoxicity. Do you see where I'm
21 referring?

22 A. Yes.

23 Q. Defense counsel only went halfway through that
24 paragraph, correct?

25 A. Yes.



1 Q. Could you please, slowly, Dr. Lichtblau, read
2 the remainder of the notes that you took from Dr.
3 Hirose's note, so that the jury can hear that whole
4 paragraph?

5 MS. CARULAS: Objection.

6 THE WITNESS: The prognosis for these children
7 can be very mixed. I did reiterate the auditory
8 neuropathy is to some degree a descriptive term
9 that does not point to any specific etiology.
10 Various different sources of high hearing loss can
11 result in abnormal ABR wave form with preserved
12 cochlear function. What specifically caused Ryan's
13 hearing loss is at this point speculation.

14 BY MS. PANTAGES:

15 Q. Thank you, Dr. Lichtblau. So did you -- can
16 you tell us in lay terms what that means when she says
17 it's a descriptive term that doesn't point to any
18 specific etiology. What does that mean?

19 MS. CARULAS: Objection.

20 THE WITNESS: At that point in time, in the
21 report it's documented, they weren't sure why this
22 child had bilateral hearing loss. Later on in the
23 record, it becomes wholly obvious as to why there
24 was bilateral hearing loss. It was to an overdose
25 of Vancomycin. The amount that was overdosed was

1 ridiculous. The Cleveland Clinic has already
2 admitted the liability. They've already admitted
3 to the mistake.

4 MS. CARULAS: Objection: move to strike.

5 BY MS. PANTAGES:

6 Q. And what we can take from the note that
7 defense counsel partially read on your cross-examination
8 is that Dr. Hirose -- well, let me restate the question.

9 Is it true from Dr. Hirose's note, that
10 defense counsel partially read during your
11 cross-examination, that Dr. Hirose didn't know at the
12 time that she wrote that note what was causing Ryan's
13 hearing loss?

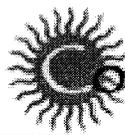
14 MS. CARULAS: Objection.

15 THE WITNESS: Well, that's exactly what she
16 wrote. She wrote it was an unclear etiology.
17 However, it's irrelevant. Because as time goes on,
18 they do figure it out. They figure it out to the
19 point that the Cleveland Clinic has already
20 admitted to the liability. They have admitted
21 their mistake. This is a Vancomycin overdose,
22 already admitted to by that party.

23 MS. CARULAS: Objection: move to strike.

24 BY MS. PANTAGES:

25 Q. And then finally, Dr. Lichtblau, you were



1 asked on cross-examination about the 35 percent
2 impairment disability. Do you recall that line of
3 questioning?

4 A. I do.

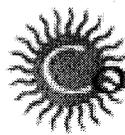
5 Q. And you were asked if you had -- had a
6 conversation with Dr. Goldberg about Ryan's current
7 function. Do you recall that line of questioning?

8 A. That's correct.

9 Q. In your experience with speech therapy, how
10 does a speech therapist typically do speech therapy with
11 -- for auditory/verbal therapy with a child like Ryan;
12 what is that setting like?

13 A. Well, that's a one-on-one setting. And they
14 have special computers, special techniques, that they
15 use to try to get the patient to understand moving of
16 lips, sounds, and understand that there are sounds
17 associated with functional things in the environment and
18 in society. And it's a very slow process. It's very
19 complicated. And it doesn't matter how much therapy you
20 give this child, there will always be a deficit. This
21 child will never be normal.

22 Q. And is it your experience -- in your
23 experience in working with -- with people with hearing
24 impairments, whether they have cochlear implants or
25 whether they have hearing aids, does their functioning



1 level change from the time that they're on -- in a
2 one-on-one quiet setting to a different type of setting?

3 MS. CARULAS: Objection.

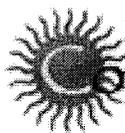
4 THE WITNESS: That's correct. And realize
5 that there are limitations with these devices. If
6 there is a lot of sensory input, like he's walking
7 around in a fair, walking around in a mall, any
8 type of noisy environment, even an office setting
9 where there is a lot of typing, or people using
10 keyboards, answering telephones; the device doesn't
11 know how to filter those sounds out, and it can be
12 very confusing and almost annoying. So that device
13 is very good in a quiet setting with one on one.
14 In a public setting with a lot of noise, that
15 device is not that efficacious. And, in fact,
16 that's when this patient will realize the
17 functional deficits he has, secondary to his
18 bilateral hearing loss.

19 BY MS. PANTAGES:

20 Q. Are you aware also from your review of these
21 materials that Dr. Goldberg has been treating Ryan for a
22 couple of years now?

23 A. That's correct.

24 Q. And does a hearing-impaired -- a
25 hearing-impaired person's function change between a



1 familiar speaker and an unfamiliar speaker?

2 MS. CARULAS: Objection.

3 THE WITNESS: Yes, it does. And the external
4 devices have to be reprogrammed all of the time.
5 And you have to be very careful. If you slide down
6 a slide it can erase them. They can't get wet. I
7 mean, this is not a panacea. These devices are an
8 aid. They do not make this child normal or whole.
9 And, in fact, these devices fall tragically short
10 of making this child whole or normal.

11 BY MS. PANTAGES:

12 Q. Is it fair to say then, Dr. Lichtblau, that
13 Ryan's functioning level is going to fluctuate depending
14 on different factors, like the familiarity of the
15 speaker, or the quietness of environment, incoming
16 noise. Does his functioning level depend on all of
17 those very factors?

18 MS. CARULAS: Objection.

19 THE WITNESS: Yeah. It's called enviromental
20 factors. The environmental factors play a role,
21 and that's why I said earlier in my testimony that
22 these devices help. They do not make him normal.
23 And, in fact, at times, they can be quite annoying.

24 BY MS. PANTAGES:

25 Q. And just so the record is clear,

1 Dr. Lichtblau, how do environmental factors impact on a
2 hearing-impairment person's function?

3 MS. CARULAS: Objection.

4 THE WITNESS: Well, they wouldn't be able to
5 discern the sounds. It's like being deaf. Because
6 if he's walking through a noisy environment, he
7 might as well turn the device off. Because the
8 device will not be functioning at a level that will
9 actually be helpful to him. It could actually be
10 obnoxious. So basically it's an amplifier. And if
11 you're amplifying a bunch of background noise, it
12 will not be a functional device.

13 MS. PANTAGES: That's all I have, Doctor,
14 thank you.

15 MS. CARULAS: I have nothing further.

16 THE VIDEOGRAPHER: This is the conclusion of
17 the videotaped deposition of Dr. Lichtblau. We are
18 know going off video record. The time on the
19 monitor is 2:35 p.m.

20 (Witness excused.)

21 (Deposition was concluded.)

22

23

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25