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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
Consor & Associates
1655 Palm Beach Lakes Blvd., Suite 500
West Palm Beach, Florida 33401
(561)682-0905

APPEARANCES:

On behalf of the Plaintiffs:

PAMELA PANTAGES, ESQ.
Becker & Mishkind Co., LPA
134 Middle Avenue
Elyria, Ohio 44035
(440) 323-7070

On behalf of the Defendants:

ANNA CARULAS, ESQ.
Roetzel & Andress, LPA
One Cleveland Center
1375 Ninth Street
Cleveland, Ohio 44114
(216) 615-7401

ALSO PRESENT:

VIDEOGRAPHER: EITAN ROSEN

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I N D E X

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E X H I B I T S

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P R O C E E D I N G S

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

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

Will counsel please announce themself to the record.

MS. PANTAGES: Pamela Pantages for Ryan Carpenter.

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

Thereupon,

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

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

THE WITNESS: I do.

DIRECT EXAMINATION

BY MS. PANTAGES:

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

A. My name is Craig Howard Lichtblau.

Q. You are a physician?

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

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

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

MS. CARULAS: Note objection.

BY MS. PANTAGES:

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

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

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

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

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

injury and spinal cord injury.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

A. Yes.

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

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

Q. And did I send you some materials to assist

you in doing that?

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

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

A. Yes.

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

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

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

A. I don't think so.

Q. And are those the materials that -- that

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

MS. CARULAS: Objection.

THE WITNESS: Yes.

BY MS. PANTAGES:

Q. And did you review those materials?

A. Yes.

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

A. That was correct.

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

A. That is correct.

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

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

A. Yes. It's a very large report, because there are some facts in this case that have to be defined. And that was what I tried to do.

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

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

A. That's correct.

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

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

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

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

A. Yes.

Q. -- right?

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

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

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

A. That's correct.

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

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

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

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

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

MS. CARULAS: Objection.

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

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

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

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

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

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

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

BY MS. PANTAGES:

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

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

So the type of therapies he's been receiving

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

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

A. That's correct.

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

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

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

A. No.

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

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

A. After obtaining a history from the patient's

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

Q. Anything else about the vocational position statement?

A. No.

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

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

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

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

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

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

Q. Anything else about the AMA impairment rating?

A. No.

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

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

Q. Anything else about the functional assessment?

A. No.

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

A. Continuation of care is my attempt to describe

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

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

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

Therapies which included: Speech/Cognitive

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

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

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

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

value of money. I do not do that.

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

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

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

BY MS. PANTAGES:

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

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

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

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

A. Yes, I did.

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

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

care.

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

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

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

MS. CARULAS: Objection.

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

BY MS. PANTAGES:

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

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

type of surgery.

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

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

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

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

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

MS. CARULAS: Objection.

THE WITNESS: Psychotherapy. As this child

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

BY MS. PANTAGES:

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

A. Yes. Social skills training.

Q. And what is that for, Doctor?

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

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

A. Yes, we have.

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

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

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

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

MS. CARULAS: Objection.

THE WITNESS: Yes.

BY MS. PANTAGES:

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

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

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

MS. CARULAS: Objection: moved strike.

BY MS. PANTAGES:

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

A. Yes.

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

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

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

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

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

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

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

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

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

A. I have.

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

A. I agree.

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

MS. CARULAS: Objection.

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

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

BY MS. PANTAGES:

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

MS. CARULAS: Objection.

THE WITNESS: Yes.

BY MS. PANTAGES:

Q. And what is your opinion?

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

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

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

BY MS. CARULAS:

Q. Good afternoon, Dr. Lichtblau.

A. Good afternoon.

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

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

A. Yes, I agree.

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

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

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

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

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

Now, it's my understanding that your practice

primarily focuses on physical impairments, correct?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. That's correct.

Q. Are you aware of that?

A. That's exactly why I called him.

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

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

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

A. Yes, I would, that is correct.

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

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

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

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

A. That is correct.

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

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

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

A. I would agree, that is correct.

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

A. That's correct.

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

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

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

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

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

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

Q. But --

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

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

MS. PANTAGES: Objection.

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

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

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

BY MS. CARULAS:

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

MS. PANTAGES: Objection.

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

BY MS. CARULAS:

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

Carpenter's hearing loss, correct?

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

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

A. Yes. That is a correct statement.

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

A. Right.

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

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

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

Q. Okay.

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

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

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

BY MS. CARULAS:

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

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

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

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

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

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

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

A. I agree.

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

A. I agree.

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

A. That's correct.

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

A. No. I believe that they were hired by

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

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

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

BY MS. CARULAS:

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

A. Um --

Q. See if you can find that.

A. Yes, I have that.

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

A. Yes.

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

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

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

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

A. That's correct.

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

A. That's correct.

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

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

But he said, However, this evaluation would

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

A. That's exactly what he wrote.

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

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

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

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

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

BY MS. CARULAS:

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

MS. PANTAGES: Objection: asked and answered.

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

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

MS. PANTAGES: Let him answer it.

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

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

loss as it relates it an overdose of Vancomycin.

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

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

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

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

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

(Discussion off the record.)

(Discussion on the record without videographer.)

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

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

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

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

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

THE COURT REPORTER: Okay.

THE VIDEOGRAPHER: Okay.

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

(Back on the video record.)

THE VIDEOGRAPHER: Thank you. We are now back

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

BY MS. CARULAS:

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

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

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

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

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

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

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

unable to read my deposition before this deposition today.

BY MS. CARULAS:

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

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

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

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

A. Well, that's because --

Q. Listen. Let me finish.

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

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

Was that your testimony, sir?

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

Q. Thank you, sir.

A. I'm not done with my answer.

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

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

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

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

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

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

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

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

MS. CARULAS: Objection: move to strike.

BY MS. CARULAS:

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

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

questions about mechanism of action.

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

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

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

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

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

this is allowed in. Sir --

MS. PANTAGES: Objection to --

BY MS. CARULAS:

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

MS. PANTAGES: Objection.

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

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

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

BY MS. CARULAS:

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

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

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

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

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

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

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

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

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

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

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

A. Yes, I did.

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

A. Yes. And --

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

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

Is that in your report, sir?

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

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

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

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

BY MS. CARULAS:

Q. All right, sir. Have you --

MS. PANTAGES: Objection as to statements by counsel.

BY MS. CARULAS:

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

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

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

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

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

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

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

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

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

A. That's correct.

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

A. That's correct.

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

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

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

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

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

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

A. I think so.

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

A. That's correct.

Q. And he has had intensive therapy both with

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

A. That's correct.

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

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

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

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

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

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

A. No. I --

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

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

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

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

BY MS. CARULAS:

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

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

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

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

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

A. I disagree with that statement. Worker's

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

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

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

A. That's correct.

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

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

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

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

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

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

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

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

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

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

The videographer here has to change tapes.

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

(A brief recess was taken.)

(Back on the record.)

THE VIDEOGRAPHER: We are now back on video

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

BY MS. CARULAS:

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

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

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

of his life.

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

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

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

MS. CARULAS: Objection: move to strike.

BY MS. CARULAS:

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

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

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

Q. Have you read, sir --

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

MS. CARULAS: All right. Move to strike.

BY MS. CARULAS:

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

A. I did --

Q. -- as far as -- let me finish my question. Sir, did you read the deposition of Mrs. Carpenter as far as her testimony regarding the functioning of Ryan, yes or no?

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

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

A. No.

Q. -- true?

A. I did not.

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

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

MS. CARULAS: Objection: Move to strike.

BY MS. CARULAS:

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

BY MS. PANTAGES:

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

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

frequency, duration and costs.

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

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

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

MS. CARULAS: Objection.

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

BY MS. PANTAGES:

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

MS. CARULAS: Objection.

THE WITNESS: That is correct.

BY MS. PANTAGES:

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

Dr. Goldberg?

A. That is correct.

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

MS. CARULAS: Objection.

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

BY MS. PANTAGES:

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

A. Yes.

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

A. Yes.

Q. Tell us about that, please.

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

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

MS. CARULAS: Objection: Move to strike.

BY MS. PANTAGES:

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

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

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

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

MS. CARULAS: Objection: move to strike.

BY MS. PANTAGES:

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

MS. CARULAS: Objection.

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

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

MS. CARULAS: Objection: move to strike.

BY MS. PANTAGES:

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

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

MS. CARULAS: Objection.

BY MS. PANTAGES:

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

A. Yes.

Q. First -- first full paragraph of your

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

MS. CARULAS: Objection.

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

BY MS. PANTAGES:

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

MS. CARULAS: Objection.

THE WITNESS: I agree.

BY MS. PANTAGES:

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

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

MS. CARULAS: Objection.

THE WITNESS: Yes.

BY MS. PANTAGES:

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

MS. CARULAS: Objection.

THE WITNESS: Yes.

BY MS. PANTAGES:

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

A. That's correct.

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

MS. CARULAS: Objection.

THE WITNESS: That's correct.

BY MS. PANTAGES:

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

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

MS. CARULAS: Objection.

THE WITNESS: Yes.

BY MS. PANTAGES:

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

MS. CARULAS: Objection.

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

BY MS. PANTAGES:

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

MS. CARULAS: Objection.

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

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

MS. CARULAS: Objection: move to strike.

BY MS. PANTAGES:

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

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

MS. CARULAS: Objection.

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

MS. CARULAS: Objection: move to strike.

BY MS. PANTAGES:

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

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

A. I do.

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

A. That's correct.

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

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

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

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

MS. CARULAS: Objection.

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

BY MS. PANTAGES:

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

A. That's correct.

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

familiar speaker and an unfamiliar speaker?

MS. CARULAS: Objection.

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

BY MS. PANTAGES:

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

MS. CARULAS: Objection.

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

BY MS. PANTAGES:

Q. And just so the record is clear,

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

MS. CARULAS: Objection.

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

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

MS. CARULAS: I have nothing further.

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

(Witness excused.)

(Deposition was concluded.)