UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SHAREN COPELAND, Individually and as Mother and Legal Guardian of Minor Plaintiff, SYDNEE COPELAND	:	
Plaintiffs,	:	
v.	:	**Civil Action No. 1:02CV01290 TPJ**
HILLCREST WOMEN'S SURGI-CENTER, INC., et al.	:	
Defendants.	:	

PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Plaintiff Sharen Copeland, Individually and as Mother and Legal Guardian of Minor Plaintiff, Sydnee Copeland, by and through undersigned counsel, Regan, Halperin & Long, PLLC, hereby submit this Opposition to the Motion for Summary Judgment filed by Defendants Hillcrest Women's Surgi-Center, Inc. and Linwood Turner, M.D., P.C. In support of their Opposition, the Plaintiffs state as follows:

1. Defendants' Motion for Summary Judgment must be denied since it is procedurally deficient by failing to comply with the requirement of Local Civil Rule 56.1 which requires that a proponent's statement of material facts include specific references to parts of the record relied on to support each statement.

2. Defendants' Motion should also be denied since the facts as pled and as developed during the course of discovery, including the depositions of the fact and lay

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witnesses, clearly establish a cause of action for "traditional medical malpractice." (Duty, breach, causation and damages)

3. Defendants' Motion should be denied since the facts as pled and as developed during the course of discovery, including the depositions of the fact and lay witnesses, clearly establish a cause of action for wrongful birth and/or wrongful pregnancy.

4. Dr. Linwood Turner breached the duty owed to Ms. Copeland by failing to successfully perform the termination procedure and by negligently failing to determine that he had not completed the termination. Dr. Turner further breached his duty to Sharen Copeland on August 1, 2000, when he again failed to realize that she was still pregnant and that he had negligently performed the termination procedure.

5. Hillcrest Women's Surgi-Center, acting through its agents, servants and/or employees, breached the duty owed to Sharen Copeland in October, 2000, when its agents, servants and/or employees told Sharen Copeland that it was normal that her menses had not resumed and did not offer her an appointment or advise her to be seen by a physician when Ms. Copeland telephoned.

6. Hillcrest Women's Surgi-Center, acting through its agents, servants and/or employees, breached the duty owed to Sharen Copeland on October 20, 2000, by failing to advise her that if she continued with her pregnancy, resulting from failed attempted termination procedure, it was likely or foreseeable that any child born of this pregnancy would suffer serious birth defects or injuries.

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7. Dr. Linwood Turner, acting as an agent of Hillcrest Women's Surgi-Center, P.C., negligently performed a termination procedure on Sharen Copeland, causing her to remain pregnant and give birth to Sydnee Copeland, a child with serious birth defects and anomalies.

8. The facts of this case demonstrate traditional tort principles of duty, breach, proximate cause and damages.

9. District of Columbia common law recognizes causes of action for extraordinary medical expenses and damages resulting from the birth of a severely disabled child after a failed termination procedure.

In further support of their Opposition, the Plaintiffs respectfully refer the Court to the attached Memorandum of Points and Authorities.

Respectfully submitted,

REGAN, HALPERIN & LONG, PLLC

By: /s/

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Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the Plaintiffs' Opposition to Defendants' Motion for Summary Judgment Order was electronically filed in the United States District Court for the District of Columbia and mailed, postage prepaid, this 21st day of January, 2004 to:

James M. Heffler, Esquire
Diane M. Uhl, Esquire
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915 Fifteenth Street, N.W., Suite 400
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/s/
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HILLCREST WOMEN'S SURGI-CENTER, INC., et al.	:	
Defendants.	:	

PLAINTIFFS' STATEMENT OF DISPUTED MATERIAL FACTS

Plaintiffs Sharen Copeland, Individually and as Mother and Legal Guardian of Minor Plaintiff, Sydnee Copeland, by and through undersigned counsel, Regan, Halperin & Long, PLLC, hereby submit this Statement of Disputed Material Facts in support of their Opposition to Defendants' Motion for Summary Judgment:

1. On June 26, 2000, Sharen Copeland was seen at Kaiser Permanente where it was confirmed by clinical examination and sonogram that Sharen Copeland had a singleton pregnancy at an estimated gestational age of eight weeks, four days. (See Ex. 1, Kaiser Medical Records, June 26, 2000).

2. On July 18, 2000, Sharen Copeland presented to Defendants Hillcrest Women's Surgi-Center, Inc. and Linwood Turner, M.D., P.C. for an elective termination of pregnancy. At that time, Dr. Linwood Turner, preformed a pelvic examination and an ultrasound. Based on both of these, Dr. Turner determined that

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Ms. Copeland had a singleton pregnancy at an estimated gestational age of ten to eleven weeks. (See Ex. 2, Hillcrest Clinic Records, p. 1; Ex. 3, Depo. of Sharen Copeland, p. 25, lines 3-17).

3. As of July 18, 2000, Sharen Copeland was pregnant with a gestational age of eleven weeks. (See Ex. 4, Depo. of Defense Expert Charlotte Larson, M.D., p. 33, lines 3-21).

4. On July 18, 2000, Sharen Copeland was told, and it was documented by Dr. Linwood Turner, that the pregnancy termination procedure was successful. (See Ex. 2 at pp. 1-2; Ex. 3, pp. 32-3).

5. On August 1, 2000, Sharen Copeland returned to Defendants for a follow-up examination and was informed that the termination of the pregnancy had been successful. (See Ex. 2 at p. 10; Ex. 3, pp. 40-1).

6. Defendants did not perform a pelvic ultrasound to confirm that the July 18, 2000, termination procedure was successful. (See Ex. 2, p. 11).

7. Approximately two months later, Sharen Copeland contacted Defendant Hillcrest Women's Surgi-Center, Inc., inquiring as to the fact that her menses had not returned. She was told that it sometimes takes three months for menses to return. (See Ex. 3, pp. 42-3).

8. Whether Defendants breached the applicable standard of care by not requiring that Ms. Copeland come back to the Surgi-Center for further evaluation when she provided the information set forth in the preceding paragraph. (See Ex. 5, Depo of Plaintiffs' Expert Dr. Michael Ross, pp. 56-58).

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9. On October 16, 2000, Sharen Copeland sought medical attention at Kaiser Permanente for abnormal menses. At that time, a urine test indicated that Sharen Copeland was pregnant. (See Ex. 6, Kaiser Medical Records, October 16, 2000).

10. On October 18, 2000, Sharen Copeland was examined again at Kaiser Permanente and it was determined that she had a viable pregnancy with a gestational age of approximately twenty-three weeks as a result of a probable failed termination. (See Ex. 7, Kaiser Medical Records, October 18, 2000).

11. On October 20, 2000, Sharen Copeland presented to Hillcrest Women's Surgi-Center with reference to the failed termination procedure of July 18, 2000. At that time, Sharen Copeland was told by Dr. Earl Horton, the Medical Director, that the facility did not do late-term terminations, and a referral was given for OB care or termination. Sharen Copeland was concerned as to partial birth terminations at this late juncture. Dr. Horton again stated that the facility did not do these procedures, but provided her with a brochure from Dr. Allen Kline of Philadelphia. (See Ex. 2, p. 11-13; Ex. 8, Depo. of Caridad Wright, pp. 101-06).

12. At the time of the October 20, 2000 visit, neither Dr. Horton, the Medical Director, nor Caridad Wright, the administrator, at Hillcrest Women's Surgi-Center documented any discussion of potential complications or problems associated with carrying the pregnancy to full term. (See Ex. 2 at pp. 11-13; Ex. 8, pp. 101-06).

13. Whether on October 20, 2000, Defendants advised Sharon Copeland that an abortion procedure could still be **safely** performed at other facilities. (See

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Defendants' Statement of Material Facts as to which There is No Material Dispute, ¶ 4; Ex. 2, pp. 11-13).

14. Whether Defendants breached the applicable standard of care on October 20, 2000 by failing to provide Ms. Copeland with information concerning the likelihood that her unborn child had suffered severe damages due to the unsuccessful attempted termination. (Ex. 9, Affidavit of Plaintiffs' Expert Dr. Judith Hall at ¶¶ 5)

15. On November 29, 2000, the minor Plaintiff, Sydnee Copeland, was born at Washington Hospital Center at approximately twenty-nine and ½ weeks gestational age. (See Ex. 10, Washington Hospital Center Medical Records, November 29, 2000).

16. Sydnee Copeland was born with significant birth defects, health problems, and will require lifelong medical care. (See Ex. 11, Life Care Plan of Sharon Reavis, R.N., M.S., C.R.C., C.C.N.)

17. Whether Sydnee Copeland's birth defects and other disabilities were proximately caused by Defendants' failed termination of Sharen Copeland's pregnancy. (See Ex. 9, Aff. of Dr. Hall at ¶¶ 4; Ex. 5, pp. 59-73).

18. Whether Defendants breached the standard of care by failing to successfully complete the termination of Sharon Copeland's pregnancy on July 18, 2000 and recognize it on July 18, 2000 or August 1, 2000. (See Ex. 5, pp. 28-54).

19. Whether Plaintiffs have produced lay and expert testimony supporting a claim for medical malpractice by the Defendants which directly and proximately caused the severe injuries sustained by Sydnee Copeland. (See Ex. 5, pp. 28-54; Ex. 9).

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20. Whether the minor Plaintiff will ever be able to live independently. (Ex. 11, p. 16).

21. Whether the catastrophic damages sustained by Sydnee Copeland were a foreseeable consequence of the Defendants' negligent medical care as alleged.

Respectfully submitted,

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Plaintiffs,	:	
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HILLCREST WOMEN'S SURGI-CENTER, INC., et al.	:	
Defendants.	:	

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

The Plaintiffs, Sharen Copeland, Individually and as Mother and Legal Guardian of Minor Plaintiff, Sydnee Copeland, by and through undersigned counsel, respectfully submit that Defendants Hillcrest Women's Surgi-Center, Inc., and Linwood Turner, M.D., Motion for Summary Judgment must be denied, as Defendants have failed to demonstrate that they are entitled to judgment as a matter of law. As a threshold matter, Defendants' Motion is procedurally deficient and must be denied since it fails to comply with the requirements of Local Rule 56.1 which require that a proponent's statement of material facts include specific references to parts of the record relied on to support each statement. Additionally, Plaintiffs have sufficiently pled, and the record amply supports, that there are disputes concerning material facts regarding Plaintiffs' claims for traditional medical negligence and claims for wrongful birth and/or wrongful pregnancy.

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I. FACTUAL BACKGROUND

On June 26, 2000, Sharen Copeland was seen at Kaiser Permanente where it was confirmed that she had a singleton pregnancy at an estimated gestation age of eight weeks, four days. Plaintiff's Statement of Disputed Material Facts ("Pls. Stmt.") ¶1. On July 18, 2000, Plaintiff presented to Defendants for an elective termination of pregnancy. Dr. Linwood Turner confirmed that Sharen Copeland was pregnant with a singleton pregnancy at a gestation age of 11 weeks. Pls. Stmt. ¶2, 3. Dr. Turner documented and informed Ms. Copeland that the termination procedure was complete and successful. Pls. Stmt. ¶4, 5. On August 1, 2000, Ms. Copeland returned to Defendants for a follow-up examination and was informed that the termination of the pregnancy had been successful. Pls. Stmt. ¶5. Approximately two months following the procedure, Sharen Copeland contact Defendant Hillcrest inquiring as to the fact that her menses had not returned. She was told that this was normal. Hillcrest took no further action with reference to this phone call. Pls. Stmt. ¶7.

On October 16, 2000, Sharen Copeland sought medical attention at Kaiser Permanente for abnormal menses. At that time, a urine test indicated that Sharen Copeland was pregnant. Pls. Stmt. ¶9. On October 18, 2000, a further examination performed at Kaiser Permanente determined that Sharen Copeland had a viable singleton pregnancy at an estimated gestational age of approximately twenty-three weeks as a consequence of a failed termination. Pls. Stmt. ¶10. On October 20, 2000, Sharen Copeland met with Dr. Earl Horton, Medical Director, and Caridad Wright,

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Administrator, of Hillcrest Women's Surgi-Center, Inc., with reference to the failed termination procedure conducted on July 18, 2000. She was told by Dr. Horton that the facility did not perform late-term abortions and a referral was given for prenatal care or a facility that would perform late-term abortions. Pls. Stmt. ¶11.

On November 29, 2000, Sharen Copeland gave birth to the Minor Plaintiff, Sydnee Copeland, at Washington Hospital Center at approximately twenty-nine and ½ weeks gestation with significant birth defects, injuries and health problems. Pls. Stmt. ¶15, 16.

Plaintiffs filed their initial Complaint against Defendants on June 26, 2002, and their First Amended Complaint on March 25, 2003. Defendants filed their Answer to First Amended Complaint on April 15, 2003. Defendants filed this Motion for Summary Judgment on September 5, 2003.

II. STANDARD OF REVIEW FOR SUMMARY JUDGMENT

Summary judgment is an "extreme" remedy. It is a "drastic procedural weapon because 'its prophylactic function, when exercised, cuts off a party's right to present his case to the jury.'" Garza v. Marine Trans. Lines, Inc., 861 F.2d 23, 26 (2d Cir. 1988) (citation omitted). Accordingly, the moving party bears the burden of demonstrating the absence of any genuine issue of material fact, and the court must view the evidence in the light most favorable to the non-moving party. See Adickes v. S.H. Kress & Co., 398 U.S. 144, 157 (1970). This standard applies to all evidentiary facts as well as to all inferences to be drawn from them. At all times, the trial court must be aware that "[t]he very nature of a controversy may render summary judgment inadvisable . . . Summary

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procedures are especially salutary where issues are clear cut and simple, but should not be based upon indefinite factual foundations . . .” McWhirter Distrib. Co. v. Texaco Inc., 668 F.2d 511, 519 (Em. App. 1981) (citing Kennedy v. Silas Mason Co., 334 U.S. 249, 256-57 (1948)).

Rule 56(c) of the Federal Rules of Civil Procedure authorizes summary judgment only if “there is no genuine dispute as to any material fact, and . . . the moving party is entitled to judgment as a matter of law.” FED. R. CIV. P. 56(c); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248-49 (1986); Miller v. Federal Deposit Ins. Corp., 906 F.2d 972, 974 (4th Cir. 1990). Plaintiffs’ version of the facts must be accepted as true. See Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587-88 (1986). Plaintiffs, as the non-moving party, are entitled to have the credibility of all of their evidence presumed. See Miller v. Leathers, 913 F.2d 1085, 1087 (4th Cir. 1990), cert. denied, 498 U.S. 1109 (1991). Thus, where the party opposing summary judgment would have the burden of proof at trial, that party is entitled “to have the credibility of his evidence as forecast assumed, his version of all that is in dispute accepted, all internal conflicts in it resolved favorably to him, the most favorable of all possible alternative inferences from it drawn in his behalf; and finally, to be given the benefit of all favorable legal theories invoked by this evidenced so considered.” Charbonnages, 597 F.2d at 414.

The United States Court of Appeals for the Fourth Circuit has admonished that it has long held that summary judgment “should be granted only where it is perfectly clear that no issue of fact is involved and inquiry into the facts is not desirable to clarify the

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application of law." Gill v. Rollins Protective Services Co., 773 F.2d 592 (4th Cir. 1985). It is not appropriate if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party," Anderson, 477 U.S. at 248, nor is it appropriate "even where there is no dispute as to the evidentiary facts but only as to the conclusions of law to be drawn therefrom." Overstreet v. Kentucky Central Life Ins. Co., 950 F.2d 931, 938 (4th Cir. 1991) (quoting Charbonnages de France v. Smith, 597 F.2d 406, 414 (4th Cir. 1979)).

III. LEGAL ANALYSIS

As an initial matter, Defendants' Motion for Summary Judgment should be stricken for failure to comply with the procedural requirements of LCvR 56.1 to "include references to the parts of the record relied on to support the statement so as to isolate the material facts, distinguish disputed from undisputed facts, and identify the pertinent parts of the record." Robertson v. American Airlines, Inc., et al., 239 F.Supp.2d 5, 8 (2002) (internal citations omitted). "[T]he movant's statement must specify the material facts and direct the court and the non-movant to those parts of the record which movant believes support the statement." Id. (internal citations omitted). This Court requires strict compliance with LCvR 56.1. See Jackson v. Finnegan, Henderson, Farabow, Garrett & Dunner, 101 F.3d 145, 150 (D.C. Cir. 1996) (internal citations omitted). Defendants made no specific references to any portion of the record in their Statement of Material Facts Not In Dispute or in the record. As such, Defendants' Motion for Summary Judgment should be stricken on procedural defectiveness alone.

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In the alternative, Defendants' Motion for Summary Judgment should be denied based upon applicable District of Columbia Law that permits recovery for Sharen and Sydnee Copeland under three separate legal theories: traditional medical negligence; wrongful birth; and wrongful pregnancy. Under the factual circumstances of this case, Plaintiffs' establish all of the requisite elements of a negligence action against Dr. Linwood Turner[1] and Hillcrest Women's Surgi-Center, Inc. Additionally, Plaintiff contends that in exercising her right to choose, Sharen Copeland sought medical intervention from Defendants to terminate her pregnancy in July, 2000. Defendants breached their duty to Sharen Copeland through the negligent performance of the termination procedure, and by negligently failing to recognize that the termination procedure was unsuccessful and respond appropriately. As a result of Defendants' negligent termination procedure and follow-up care and counseling, Sharen Copeland remained pregnant and delivered the infant Plaintiff, Sydnee Copeland, who suffered severe injuries and damages as a direct and proximate result of the negligent care and treatment provided by Defendants. Finally, as a result of this negligent termination procedure and follow-up counseling, Sharen Copeland was deprived of the right to an informed decision whether to avoid the birth of a child with serious congenital defects.

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[1] Defendant Linwood Turner, M.D., P.C. is the Professional Corporation that at all relevant times employed Dr. Linwood Turner. It has been stipulated that Dr. Turner was acting within the course and scope of his employment with his Professional Corporation at all times when he rendered medical care and treatment, or failed to render medical care and treatment, to Plaintiff Sharen Copeland.

A. Traditional Medical Negligence

In order to state a claim for traditional medical negligence, a Plaintiff must establish a duty of care owed by Defendant to the Plaintiff, a breach of that duty by the Defendant, and damage to the Plaintiff proximately caused by the breach. See Psychiatric Institute of Washington v. Allen, 509 A.2d 619, 623-24 (D.C. 1986). There can be no reasonable argument that Defendant did not owe a duty to Sharen Copeland. On July 18, 2000, Sharon Copeland presented to Hillcrest Women's Surgi-Center, Inc. for termination of a pregnancy. Pls. Stmt. ¶2. At that time, Hillcrest undertook this responsibility and Dr. Linwood Turner attempted to perform the termination procedure. Ex. 2.

Dr. Michael Ross, a Board Certified Obstetrician and Gynecologist will testify on behalf of Plaintiffs that Dr. Turner breached the standard of care by failing to appreciate that he had not successfully performed the termination procedure, by failing to appreciate that he did not have any products of conception in what he extracted during the termination procedure and by failing to perform any appropriate follow-up that would have demonstrated that the termination procedure was completed. Pls. Stmt. ¶18. Moreover, Dr. Ross will testify that Defendant Hillcrest breached the standard of care by failing to have Sharen Copeland return to the clinic for examination and/or consultation in response to Ms. Copeland's telephone call to the clinic approximately two-months after the scheduled termination when she informed them that she had not resumed her menstrual cycle, but was instead told that this was normal. Pls. Stmt. ¶8. Moreover, Dr. Judith Hall, a world-renowned and published geneticist and pediatrician,

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will testify that Hillcrest breached the standard of care by failing to inform Ms. Copeland in October, 2000, of the potential complications and problems that the unborn fetus may suffer should she decide to proceed with the continued pregnancy. Pls. Stmt. ¶14.

Both Dr. Ross and Dr. Hall will testify that the serious congenital birth defects and injuries sustained by Sydnee Copeland are directly and proximately caused by the negligent attempted termination of Sharen Copeland's pregnancy on July 18, 2000. Pls. Stmt. ¶19. Notably, Dr. Hall will testify both that these defects, anomalies, and injuries were foreseeable **and** proximately caused by the negligent attempted termination. Pls. Stmt. ¶17. Ms. Copeland presented to Defendants for a medical procedure that was negligently performed. Pls. Stmt. ¶18. As a direct and proximate result of that negligence, Ms. Copeland gave birth to a child, Sydnee Copeland, with serious congenital defects and anomalies. Pls. Stmt. ¶16. Plaintiffs have stated a cause of action of traditional medical negligence: duty, breach of that duty, and damages proximately resulting from the breach of duty.

B. Wrongful Birth

In addition to pursuing claims under a traditional medical negligence theory, the District of Columbia recognizes a claim for "wrongful birth". See Haymon v. Wilkerson, 535 A.2d 880-83 (D.C. 1987). In the Haymon case, the Court stated that "[t]he only issue before this court is that which was expressly reserved for future resolution in Flowers v. District of Columbia, 478 A.2d 1073, 1076 n.3 (D.C. 1984), namely, whether a parents claim for extraordinary medical and other expenses resulting

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from the wrongful birth of a child with birth defects presents a claim upon which relief may be granted". Id. at 882. The Haymon Court answered in the affirmative and held that the Plaintiff could recover the "[e]xtraordinary medical and other expenses attributable to the care of her child". Id. at 886.

In defining a "wrongful birth" case, the Virginia Supreme Court has succinctly stated, "[a] wrongful birth action is brought by parents on their own behalf, seeking damages resulting from the birth of a defective child after a failed abortion . . . ." Miller v. Johnson, et al., 231 Va. 177, 181, 343 S.E.2d 301, 303 (1986) citing Naccash v. Burger, 223 Va. 406, 409, 290 S.E.2d 825, 826-27 (1982). While the District of Columbia Court of Appeals has never addressed the precise facts of this case, Plaintiffs submit that in addition to satisfying the elements of a traditional medical malpractice case, this case also embraces all of the elements of a wrongful birth cause of action. In order for a wrongful birth claim to be established, Plaintiff must show a negligent act or omission on the part of the Defendant that led to the Plaintiff giving birth to a child with birth defects, and had the Plaintiff been aware that she was carrying a child with birth defects, she would have chosen to terminate the pregnancy. Haymon at 883.

In this case, Dr. Turner's negligence in failing to perform the termination procedure within the standard of care, and in subsequently negligently failing to recognize that the termination procedure was complete, directly led to Sharen Copeland giving birth to a child with serious birth defects. Pls. Stmt. ¶17. Although it was foreseeable that the failed termination procedure likely would lead to delivery of a child with serious birth defects, neither Dr. Turner nor anyone on behalf of Hillcrest advised

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Ms. Copeland of this. Pls. Stmt. ¶14. Ms. Copeland was never told that carrying her pregnancy to term would likely lead to delivery of a child with congenital birth defects. Pls. Stmt. ¶12. Thus, Defendants deprived Ms. Copeland of her right to make an informed decision about whether to carry her child to term.

Although Dr. Earl Horton, the Medical Director of Hillcrest, provided Sharen Copeland with the names of other facilities that would perform late-term abortion procedures, Sharen Copeland ultimately was deprived of the right to choose to terminate the pregnancy. The effect of the negligent failed termination procedure was that Sharen Copeland had no knowledge that she was still pregnant until October, 2000, when she was twenty-three to twenty-four weeks pregnant. At that point in time, Sharen Copeland felt that she did not have a choice based on safety, medical, philosophical and financial reasons. Defendants' negligent failed termination procedure constructively operated to deprive Sharen Copeland of the right to choose to terminate the pregnancy. As a consequence, Sharen Copeland delivered a child with serious birth defects that will require around the clock and life long medical care and expenses. Pls. Stmt. ¶16. Plaintiffs seek recovery for Sydnee Copeland's emotional and physical pain, serious neurological, psychological and emotional injuries, as well as the multitude of birth defects. In addition, Plaintiffs seek recovery for the substantial medical expenses in connection with the treatment of Sydnee's injuries, and her loss of wage earning capacity. Pls. First Amended Complaint ("Pls. Am. Cmplt.") ¶23. Finally, Plaintiffs seek recovery of Sharen Copeland's emotional distress and mental anguish suffered as a consequence of Defendants' negligence. Pls. Am. Cmplt. ¶27, 29. District of Columbia

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Law permits recovery for extraordinary child rearing expenses, finding that "[t]here is by now quite general agreement that parents should be permitted to recover at least their pecuniary losses". Haymon, 535 A.2d 885; See also Dyson v. Winfield, 129 F.Supp.2d. 22, 23 (D.D.C. 2001).

The policy considerations underlying the Haymon decision are all present in this case. Plaintiffs are not claiming the ordinary expenses of raising a normal, healthy child. Plaintiffs seek "only to recover the wholly unanticipated extraordinary medical expenses which she . . . will incur in raising [her] mentally and physically handicapped child." Haymon at 884. Additionally, these damages are not speculative in the least. Not only are the extraordinary medical costs Plaintiffs seek "related solely to the mental and physical defects with which her daughter was born, and are well within the methods of proof available in personal injury cases", but unlike the Haymon case where there was no allegation that the Down's Syndrome that the child suffered at birth actually was caused by the defendant's negligence, Sydnee Copeland's birth defects are proximately caused by the Defendants' negligent attempted termination. Pls. Stmt. ¶17. "Permitting the recovery of extraordinary medical expenses avoids the speculative damages issue of concern to the court in *Flowers*. Furthermore, allowing recovery for the negligent deprivation of a woman's right to decide whether to terminate her pregnancy is consistent with the District of Columbia's public policy that physicians should be liable for losses proximately caused by their negligence." Haymon at 886. Plaintiffs' case is consistent with the principles and policy considerations of the wrongful birth cause of action permitted in Haymon.

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C. Wrongful Pregnancy

District of Columbia law also recognizes claims for "wrongful pregnancy." The leading case is Flowers v. District of Columbia, 478 A.2d 1073 (D.C. 1984). In the Flowers case, the plaintiff brought suit claiming that a tubal cauterization was negligently performed and as a result, she had become pregnant and gave birth to a **healthy** child. The plaintiff claimed the medical expenses, pain and suffering, lost wages incurred during her pregnancy, wages she lost after the birth until she could return to work, and all costs of raising the healthy child until the age of eighteen. The court allowed all of plaintiffs' claims for damages to go forward except for the cost of raising her healthy child. The court specifically stated that it was "not here concerned with the foreseeability of the possible birth of a child with defects and we do not consider the measure of damages in such a case." Flowers at 1076 n.3, citing Fassoulas v. Ramez, 450 So.2d 822 (Fla. 1984). Thus, although the District has not expressly resolved the issue of whether the extraordinary expenses of raising a disabled child are available in a wrongful pregnancy action, the D.C. Court of Appeals' reference to the Fassoulas case clearly indicates that the Court is inclined to award these expenses.

Most cases from other jurisdictions around the country pertaining to wrongful pregnancy involve unsuccessful sterilization procedures. See e.g. Emerson v. Magendantz, M.D., et al., 689 A.2d 409 (1997). In sterilization procedures, there can be no argument that any birth defects or complications are the result of the failed sterilization procedure. Thus, these cases are readily distinguishable from the present

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Washington, D.C. 20036

202-463-3030

case where Ms. Copeland underwent an invasive procedure to terminate a pregnancy that was the proximate cause of the birth defects of the child, Sydnee Copeland.

IV. CONCLUSION

For these reasons, Plaintiffs respectfully request that the Court enter the attached Order denying Defendants' Motion for Summary Judgment.

Respectfully submitted,

REGAN, HALPERIN & LONG, PLLC

By: /s/

Patrick M. Regan #336107
Lisa D. Barnett #480535
1919 M Street, N.W.
Suite 350
Washington, D.C. 20036
PH: (202) 463-3030
Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SHAREN COPELAND, Individually and as Mother and Legal Guardian of Minor Plaintiff, SYDNEE COPELAND	:	
Plaintiffs,	:	
v.	:	**Civil Action No. 1:02CV01290 TPJ**
HILLCREST WOMEN'S SURGI-CENTER, INC., et al.	:	
Defendants.	:	

ORDER

Upon consideration of the Motion for Summary Judgment filed by Defendants Hillcrest Women's Surgi-Center, Inc. and Linwood Turner, M.D., P.C., Plaintiffs' Opposition thereto, and it appearing to this Court that Defendants have failed to comply with the procedural requirements of Local Rule 56.1 and have not provided citations to specific parts of the record in their Statements of Material Facts, it is this _____ day of _____, 2004;

ORDERED that Defendants' Motion be, and the same hereby is, DENIED.

_____
Thomas Penfield Jackson
U.S. District Judge

cc: Patrick M. Regan, Esquire
1919 M Street, NW, Suite 350
Washington, D.C. 20036

James M. Heffler, Esquire
915 Fifteenth Street, N.W., Suite 400
Washington, D.C. 20005

VISIT/ PROB. # E

WRITE ON THIS SIDE FIRST

NP

Dr. Moss-7358

Copeland, Sharen

631063767

1/26/00

AGE: 36 WEIGHT: 278

BP: 130/70 LMP: 12/18/99 allergies: NKA DOB: 3/8/64

G 2 P 1 AB

c/o: ? Miscarried 6/25/00 + Last pap: 3/00

Pt c/o heavy bleeding last night — passed something large into the toilet — then the bleeding slowed way down. Ø pain but still crampy.

Exam: nl ext ♀

vagina clear Ø blood

ex's lesion

uterus difficult to evaluate 2° obesity

ad NTs masses appreciated

Sono → 8w4day IUP ⊕ FCA

Imp: Threatened Ab

Plan: ABO/Rh/ABS, CBC

RV later this week.

Precautions

Ø pervaginia.

Addendum: 13) 12/38

Has appt 6/30/00

PLAINTIFF'S EXHIBIT 1

tabbies

HILLCREST SURGI - CENTER **PROCEDURE: TAB LOCAL ☑ GEN ☐ D & C**

Name Copeland, SHaren A.
Address 37 Barberry Ct. City Upper Marlboro
State Md. Zip Code 20774 County PG
Home Phone # (301) 499-5010 Work Phone # (202 482-1996
Place of Employment Occupation
Age 36 D.O.B. 3-8-64 SS # 579-98-4450
☑ B ☐ W ☐ H ☐ O / ☐ S ☐ M ☐ Div ☐ Sep ☐ Widowed Insurance or Terms of Payment Cash/280
Nearest Relative Gwen Reese Relationship mother
Address Phone # ( )
LNMP 4-24 Calculated Weeks 12 Pos. P.T. ☑ Yes (☐ Urine ☐ Blood) ☐ No
Where ☐ Home (EPT

Date/ Signature 7/18/a Carolette Winnigham

MEDICAL HISTORY

1. Previous operations or surgical procedures: TAB 15 years ago
2. Previous general anesthesia ☐ Yes ☑ No Any problems? ☐ Yes ☑ No
3. Current Medications: Celan 20mg 2 T.I.D HCTZ Daily for HTN
4. Allergies to drug, adhesive tape or iodine solutions: Penicillin
5. Smoking history: Denies Alcohol history: Denies
6. Any of the following: Dentures ☐ Yes ☑ No Plates ☑ Yes ☐ No Caps ☐ Yes ☐ No Glasses ☐ Yes ☑ No Contact Lenses ☐ Yes ☑ No

REVIEW OF SYSTEMS

Heart:
Hypertension ☐ Yes ☑ No
Heart Attack ☐ Yes ☑ No
Heart Murmur ☐ Yes ☑ No
Arrhythmias ☐ Yes ☑ No
SOB ☐ Yes ☑ No
Rheumatic fever ☐ Yes ☑ No
Orthopnea ☐ Yes ☑ No
Skipped beats ☐ Yes ☑ No
History of congestive Heart failure ☐ Yes ☑ No
Other

Circulatory:
Thrombophlebitis ☐ Yes ☑ No
Problems with oral contraceptives ☐ Yes ☑ No
GI:
Hepatitis ☐ Yes ☑ No
Ulcer ☐ Yes ☑ No
Hiatal hernia ☐ Yes ☑ No

Lungs:
Asthma ☐ Yes ☑ No
Bronchitis ☐ Yes ☑ No
Emphysema ☐ Yes ☑ No
Tuberculosis ☐ Yes ☑ No
Renal:
Kidney stones ☐ Yes ☑ No
UTI ☐ Yes ☑ No

Metab:
Diabetes ☐ Yes ☑ N
Anemia ☐ Yes ☑ N
Thyroid ☐ Yes ☑ N
Sickle Cell ☐ Yes ☑ N
Bleeding problems ☐ Yes ☑ N
Neuro:
Seizures ☐ Yes ☑ N
Strokes ☐ Yes ☑ N
Psych Tx ☐ Yes ☑ N
Substance Abuse ☐ Yes ☑ N
STD ☐ Yes ☑ N
Breast Feeding ☐ Yes ☐ N

OB/GYN HISTORY: G 3 P 1 AB 1 (SP 0 Ind 1)
Contraceptive Hx None

Date/ Signature 7/18/a Carolette Winnigham

PHYSICAL FINDINGS

Blood Pressure 110/72 Pulse 80 Temp 99 Height 5'3" Weight 200 lbs
Heart: ☑ Normal ☐ Abnormal Lungs: ☑ Normal ☐ Abnormal
Pelvic: Weeks 16+4 Position of Uterus: ☑ Anterior ☐ Posterior ☐ Mid-Position ☐ Adnexa: Normal ☐ Abnormal
Comments:

Date: 7/18/a Signature: LINWOOD TURNER, M.D. M.D

Date/ Signature

REEVALUATION

Blood Pressure Pulse Temp Weeks Pregnant
Comments:

Date: Signature: M.D

Date/ Signature 7/18/a R. Hampton L.T.

LABORATORY

Time In: 940/a Time Out: 945/a
Hct Hgb Rh Neg Immune Globulin ☐ Yes ☐ No
Urinalysis: Sug Protein Pregnancy Test positive
Other:
RH NEGATIVE

This patient has been seen, the chart reviewed, and the type and choice of anesthesia discussed with the patient.
Date: 7/18/a Signature: LINWOOD TURNER, M.D. M.D

Form 200
9/94

NAME: Copeland Sharon

Date/ Signature

PRE-OPERATIVE CHECKLIST

- ☐ 1. NPO since midnight
- ☐ 2. Responsible adult to accompany patient
- ☐ 3. Signs or symptoms of recent URI
- ☐ 4. OR Permit and Consent signed and witnessed
- ☐ 5. Pre-op screen completed
- ☐ 6. ID band on and correct
- ☐ 7. Dentures removed and secured
- ☐ 8. Contact lenses or glasses removed and secured
- ☐ 9. Jewelry removed and secured
- ☐ 10. Hairpins, makeup, nail polish removed
- ☐ 11. Clothing removed and labeled
- ☐ 12. Patient has voided
- ☐ 13. Lab data completed and recorded on chart
- ☐ 14. Counseling notes completed and on chart with Anesthesia Instructions signed and witnessed
- ☐ 15. Other: _____

Pre-Op Vital Signs: BP _____ P _____ T _____

Date/ Signature

OPERATING ROOM

Pre-Op DX _____ Post-Op DX _____

Proposed Operation _____ Operation Performed _____

Anesthesiologist _____ Surgeon _____

Type of Anesthesia _____ OR Room No. _____ Position of Patient _____

Bovie Pad Location _____

Anesthesia began _____ Operation began _____ Operation ended _____

Monitors indicate sterile packs used in this operation ☐ Yes ☐ No Equipment Used _____

Blade, sponge and instrument counts correct ☐ Yes ☐ No

Circulating nurse _____ Instrument Nurse _____

55289-187-14 DOXYCYCLINE 100 mg 14 CAPSULES

Date/ Signature 7/18/00

OPERATIVE FINDINGS

Operation Start 12:25 Operation End 12:20 pm

Dilation to 8 mm Cannula 10 mm Embryonic Tissue and/or Fetal Parts Identified ☒ Yes ☐ No

Tissue Volume ☐ Small ☐ Medium ☐ Large 1% Xylocaine Paracervical 10 cc's Comments _____

Blood Loss 20 cc's Patient's Tolerance ☒ Good ☐ Fair ☐ Poor Tissue to Pathology: ☐ Yes ☐ No

Complications: None

Drugs Given: _____

Drugs Prescribed: ☒ Doxycycline 100mg #14 1 po Bid x 7 days ☒ Methergine 0.2 mg po Tabs # 10

☐ Other: _____

Physician's Signature LINWOOD TURNER, M.D. M.D.

Date/ 7/18/00

POST ANESTHESIA CARE UNIT

Discharge Criteria: Time in 12:25 B/P 120/70 P 80 Time out 12:55 B/P 100/60 P 80

☒ Pre-Op Mobility ☒ Stable Vital Signs ☒ Pad Check Ectopic Precautions Instructions Yes ☐ No ☐

☒ Voided ☒ Minimal Nausea & Vomiting ☒ Alert & Oriented Escort Home Yes ☐ No ☒

☒ Prescriptions ☒ Discharge Instructions ☒ Oral Intake

Drugs Administered:		Time:	Initial:
	☒ Ibuprofen 800mg po	12:25	
	☐ Acetaminophen 325mg Tabs 1 1 po		
	☒ Ergotrate 0.2 mg po	12:45	
	☒ Mini-Gamulin Rh'IM'	12:45	
	☐ Rhogam 'IM'		
	☐ Other: _____		

Comments: _____ Time: _____ Initial: _____

Post Operative Contraceptive: _____ Post Operative Follow-Up: _____

☒ Discharge Evaluation Performed ☐ Discharge Home _____

Nurses's Signature: _____ M.D. Date/Time: 12:55

CANCELLATION NOTE:

PROGRESS NOTE:

Physician's Signature _____ M.D.

REGISTRATION SHEET

Please answer ALL questions COMPLETELY FRONT AND BACK. PRINT CLEARLY and do not abbreviate
All information is CONFIDENTIAL. Please be as specific as possible.

Name: (LAST) (FIRST) (MIDDLE)

Address: City:

State: Zip Code: County:

Home Phone#: Work Phone#:

Place of Employment:
(If not employed, write "n/a") Occupation:

If student, list name of school:

Your Age: Date of Birth: Social Security#:

Race: Black White Hispanic Other

Marital Status: S M Div Sep Widowed

Name of friend or relative to contact in an emergency:

Name: Owen Reese Relationship: Mother

Their complete address:

Their complete phone#:

How are you paying today? CASH MONEY ORDER MASTERCARD VISA AM EX

DISCOVER Other (please explain)

____HMO/INSURANCE - Name of Plan (Have authorization slip insurance card, & I.D. ready - ALL INSURANCE MUST BE PREAUTHORIZED)

What amount were you asked to bring in? $ 280 + 40

First day of your last normal period? April 24, 2000

Did you have a POSITIVE pregnancy test? YES NO

Where: HOME HMO

What kind of test did you have? URINE BLOOD

OVER PLEASE -> -> OVER PLEASE -> -> OVER PLEASE -> -> OVER PLEASE - > ->

DO NOT WRITE BELOW THIS LINE

LG:_____ NPA:_____ DOS:_____

REPRODUCTIVE HEALTH COUNSELOR'S NOTES

Patient's Name: _____ Date: 7/16

DECISION MAKING: Patient's decision regarding unplanned and/or problem pregnancy was discussed and the following apply:

✓ Patient chooses TAB and is confident about her decision.

✓ The alternatives to the procedure including, but not limited to carrying the pregnancy to full term and adoption have been fully discussed with the patient.

INFORMED CONSENT: The following were explained to the patient and the patient stated understanding of the following:

✓ The abortion procedure and its risks and complications

✓ P/O instructions for local anesthesia

___ P/O instructions for twilight anesthesia or general anesthesia

✓ F/U instructions

BIRTH CONTROL: Birth control options were discussed and patient decided on the following method:

___ Oral Contraceptives (Type: _____)
___ Depo Provera
___ Norplant
___ Diaphragm
✓ IUD
___ Spermicide and Condom
___ Tubal Ligation
___ Vasectomy
___ Other: _____

COMMENTS: _____

COUNSELOR'S SIGNATURE: _____

PROGRESS NOTES: _____

Date: _____ _____ M.D.
Signature of Physician

COUNSDC.DOC6/15/95

4

CONSENT TO ABORTION

I, _____, age 26, marital status Sep, hereby give my consent to, and request and authorize _____, or a physician designated by him/her, together with any necessary assistants, to perform upon me, an ABORTION by suction curettage (aspirate and scrape out the contents of the womb), and if any unforeseen condition arises in the course of the abortion calling for procedures in addition to or different from those now contemplated, I further consent to and request and authorize said physician and his/her assistants to do whatever they deem to be medically advisable.

I further consent to the disposal by my attending physician or his/her assistants of any tissue or other parts which may be removed from my body pursuant to the procedures consented to above.

The nature of pregnancy, the nature and purpose of an abortion, the probability of success of such an operation, the possible physical and psychological effects which might be unforeseeable, the risks involved, and the possibility of complications including but not limited to **pain and suffering, emotional upset, retained products of conception, bleeding and infection of varying degrees, perforation of the uterus, internal injuries, hysterectomy, sterility, missed pregnancy, ectopic pregnancy, adverse reaction to anesthetics and other medications have been fully and reasonably explained to me.** I am aware that although my pregnancy test is positive and physical examination is suggestive of pregnancy, there are rare instances where an intrauterine pregnancy is not confirmed after the procedure. I understand that I can wait to have more elaborate tests to confirm the pregnancy but I decline to do so. Furthermore, I fully understand that although products of conception may be removed and identified during this surgical procedure there is no guarantee I do not continue to have another (combined) pregnancy outside the uterus. I have been advised that there are alternatives to abortion, such as childbirth and adoption. The medical and surgical procedures to be used have been fully explained and all questions answered to my satisfaction. I acknowledge that no guarantee or assurance has been made to me concerning the results that may be obtained.

I consent to the administration of anesthesia to be applied by my attending physician or whomever he/she may designate and the use of such anesthetics as may be deemed medically advisable. I have discussed and agreed to the administration of _____ anesthesia to me for the purpose of the performance of an abortion, and I have had the use of such anesthesia, and any risks that may be presented, fully explained to me. Should hospitalization for any reason be necessary, I understand neither the physician, employees, clinic nor corporation will be responsible for any cost so incurred.

I certify that I have read (or had read to me) and fully understand the above consent to abortion and that the nature of the procedure, risks, benefits and alternatives therein referred were fully explained to me and that all my questions (if any) have been answered to my satisfaction. I have as a result, been able to make an informed and intelligent choice about whether to undergo an abortion, that (if such information is known to me) my pregnancy commenced on 4/24/00 (date of last normal menstrual period), and all above blanks or statements requiring insertion or completion were filled in. I further certify that this consent was made without coercion, duress or haste and while I was of sound mind and under no sedation whatsoever.

Patient's written statement: "I have read the above consent form. The possible risks, alternatives and complications have been explained to me and all of my questions have been answered to my satisfaction."

DATE: _____

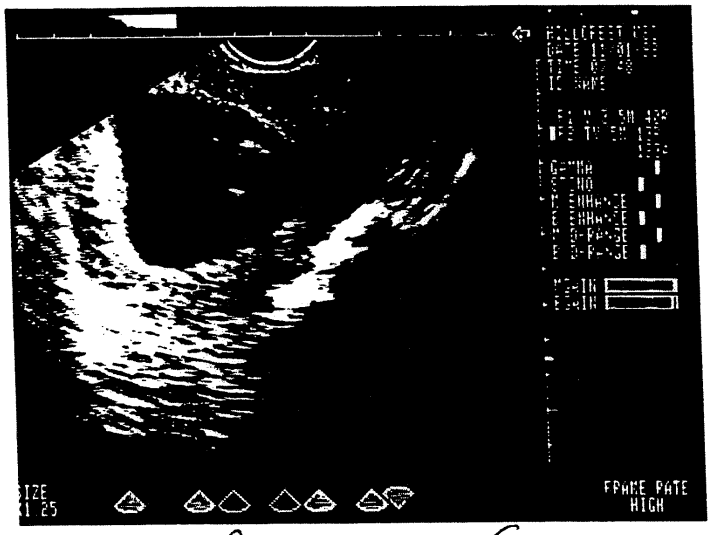
WITNESS: _____ SIGNATURE OF PATIENT

Foregoing Consented To By:

SIGNATURE OF PARENT OR OTHER PERSON AUTHORIZED TO CONSENT FOR PATIENT

FORM 107&109B-C
Adult & Minor
Rev. 11/89

(over)



Copeland Stowers
7-18-2000

MICRhoGAM® Rh_0(D) Immune Globulin (Human) Ultra-Filtered
Micro-Dose for use *only* after spontaneous or induced abortion or termination of ectopic pregnancy up to and including 12 weeks' gestation.

CONTROL FORM Hospital/Clinic ______________________

ATTENTION LABORATORY	ATTENTION OBSTETRICAL SERVICE
Patient's Name ______	IMPORTANT [illegible]
Patient is Rh negative ______ Date	1. Establish patient [illegible] dose of MICRhoGAM [illegible]
LOT NO. OF MICRhoGAM ISSUED ______ DATE ______	2. Verify the lot number [illegible] of MICRhoGAM recorded on this form with the lot number and expiration date printed on the [illegible] of MICRhoGAM.
Tech. ______	3. Retain this form for verification of administration of MICRhoGAM.
	Date MICRhoGAM injected ______
	Pregnancy termination date ______
	Attending physician ______

620-20-215-1

Hillcrest
WOMEN'S SURGI-CENTER, INC.
3233 PENNSYLVANIA AVENUE • WASHINGTON, D.C. 20020 • TEL: (202) 584-6500 • FAX: (202) 581-4234

POST SURGICAL INSTRUCTIONS

PLEASE REVIEW THIS SHEET CAREFULLY.

1. For the next 14 days you should not have intercourse, take tub baths, douche or swim. Showers may be taken. Avoid strenuous physical activities.

2. You may bleed or spot off and on for up to 2 weeks. Bleeding no heavier than your menstrual period is normal. Use only sanitary pads, no tampons for the next 2 weeks. You can expect your period in three to six weeks. If you are going to use Birth Control pills, take your first pill as instructed. Should your period not occur within a few days after completion of the first pack of pills, call your physician or clinic.

3. Should you experience mild cramping, take your usual pain medication or 2 Tylenol tablets every 4 hours.

4. Take your temperature each morning and evening for the next five days. If it is above 100.4 twice in a row, call the clinic anytime, day or night.

5. Call the clinic for a follow-up appointment. Give your "FOLLOW-UP FORM" to the doctor.

6. Take all prescribed medications as directed by your physician.

7. If you experience any of the symptoms below you should contact the clinic immediately, 24 hours a day at (202) 584-6500 or call (301) 839-8777.

   a. temperature above 100.4 twice in any 24 hour period.
   b. allergic reaction to antibiotic. (itching, rash, hives).
   c. heavy bright red bleeding and passing of large clots. Prolonged bleeding over two weeks.
   d. severe pain.

POST-OPERATIVE ANESTHESIA INSTRUCTIONS

For your health and safety, the following instructions should be observed:

1. DO NOT drive a motor vehicle, operate machinery or appliances for 24 hours following your surgery.

2. DO NOT engage in activity that requires mental alertness for 24 hours.

3. Dizziness may last for several hours. It is not uncommon for you to feel drowsy. It is suggested that you lie down and relax for the remainder of the day and limit yourself to essential activities.

4. You may eat light meals including liquids for the next 24 hours. If you do not feel hungry, there is no need to force yourself to eat. Warm liquids such as soups and teas are usually well tolerated. Jello is also good.

5. Slight nausea is not uncommon. If you have severe nausea and vomiting, please call the clinic.

6. If you are taking medications daily, resume your normal schedule.

7. Take medications prescribed by the clinic as instructed.

PLEASE CALL THE CLINIC AT (202) 584-6500 if you have questions.

DATE: 7/16/02

PATIENT'S NAME: [signature]

WITNESS: [signature]

Hillcrest

INSTRUCTIONS REGARDING COMPLICATIONS

In the event you experience unusual symptoms related to post-operative bleeding, abdominal pains, fever, and other symptoms which may cause concern, the following guidelines should be observed. For medical advice, call the telephone numbers listed at at the end of these instructions.

BLEEDING

Heavy bleeding would constitute soaking a regular size sanitary pad every hour, accompanied by passing large clots the size of a fifty cents coin, (50¢). Sometimes the bleeding will stop once the uterus contracts strongly. However, if the bleeding persists, DO NOT WAIT, call the clinic. If the clinic is closed, an emergency number will be provided. Call this number and ask to speak to the doctor on-call. The answering service will notify the doctor and get help. These instructions should be followed carefully, to do otherwise could endanger your health.

FEVER

If you develop a fever above 100 degrees, take two tablets of Tylenol or Aspirin immediately. Repeat the process after four hours. If the fever persists, call the clinic. If the clinic is closed, an emergency number will be provided. Call this number and ask to speak to the doctor on-call. It is important to follow these instructions carefully. To do otherwise could be detrimental to your health.

ABDOMINAL PAINS

If you experience pain which may be related to the surgical procedure, take your medication for pain immediately. Any medication with Ibuprofen such as IB Motrin, Advil, Nuprin, Medipren, or Tylenol can be used to alleviate abdominal pains. Follow the recommended directions. Call the clinic at the earliest possible time and ask to speak with one of the nurses. If you develop pain at night, take your medication for pain. Call the clinic immediately if the pain persists inspite of taking the medications to relieve the spasms. If the clinic is closed, an emergency number will be provided.Call this number and ask to speak to the doctor on-call. It is very important that you follow these instructions. To do otherwise could have serious health consequences.

Hillcrest
HILLCREST WOMEN'S SURGI-CENTER, INC.
3233 PENNSYLVANIA AVENUE • WASHINGTON, D.C. 20020 • TEL: (202) 584-6500 • FAX: (202) 581-4234

D. Md. 8/11/00
10:00 - 10:30

FOLLOW-UP FORM

PATIENT: [redacted] SURGICAL DATE: 7/18/00

PATIENTS - PLEASE COMPLETE SECTION 2 AND ASK YOUR FOLLOW UP PHYSICIAN TO COMPLETE SECTION 3 AND RETURN TO Hillcrest

SECTION 1 - DATA FROM HILLCREST

1. THE FOLLOWING LABORATORY PROCEDURES WERE PERFORMED ON THIS DATE: 7/18/00
   HCT ____ HGB ____ Rh ____ IMMUNE GLOBULIN YES ____ NO ____
   URINALYSIS: SUGAR ____ PROTEIN ____ POSITIVE PREGNANCY TEST YES ____ NO ____
   MISC. ____
2. DRUGS PRESCRIBED: ____ DOXYCYCLINE 100 mg #14, 1 PO BID x 7 days
   ____ METHERGINE 0.2 mg # ____
   ____ OTHER ____
3. PATIENT WAS COUNSELED ON CONTRACEPTIVE TECHNIQUES AND HER CHOICE ____
   WAS/WAS NOT PROVIDED.
4. A ONE OR TWO WEEK POST-ABORTION EXAMINATION SHOULD BE PERFORMED WITH SPECIAL ATTENTION TO:
   BLEEDING ____ ANEMIA ____ INFECTION ____ VAGINITIS ____
   ADNEXAL MASS ____ CONTRACEPTIVE CHOICE ____ OTHER ____
   NUMBER OF WEEKS POST-CONCEPTION 10-11

SECTION 2 - QUESTIONS FOR PATIENT

1. Did you take your temperature? YES NO Highest reading noted ____
2. How many days did you bleed? ____ (circle the type of bleeding below)
   (A) more than normal period (C) less than normal period
   (B) same amount as usual period (D) only spotting or staining
3. Did you have cramps, backache or other discomforts? YES NO
   IF YES, EXPLAIN ____
4. If given birth control pills, were they taken as directed? YES NO
   IF NO, EXPLAIN ____
5. Did you take your antibiotics as directed? YES NO
   IF NO, EXPLAIN ____

SECTION 3 - QUESTIONS FOR PHYSICIAN

1. Evidence of:
   (A) Hemorrhage (over 500 cc) YES NO (note Hct____ Hgb____)
   (B) Endometritis YES NO
   (C) Adnexitis YES NO
   (D) Retained products YES NO
   (E) Still pregnant YES NO
   (F) Psychological sequelae YES NO
2. Complications requiring hospitalization? YES NO
   Type of complication ____
   Hospital: ____ Date: ____
3. DRUGS PRESCRIBED: ____
   COMMENTS: ____
5. Circle one: PRIVATE PHYSICIAN CLINIC
   Name: ____ Address: ____
   Agency: ____
   DATE: 8/11/00 SIGNATURE: LINWOOD TURNER, M.D.

fu6/94

FOLLOW-UP EXAM: $50.00 AFTER TWO WEEKS

COUNSELOR'S REMARKS

PATIENT'S NAME: Copeland, Sharon DOS: 2/18/00

10/19/00 10:30 AM Ms. Copeland called me today to inform me that she was seen @ Kaiser Permanente yesterday and she was informed that she is carrying a late pregnancy, approximately 7 months gestational age. I referred the case to Dr. Earl Horton and he decided not to bring ~~patient~~ in to the clinic for counseling. I talked to Ms. Copeland @ 11:30 AM and advised her to come in to the clinic @ 10:30 AM on October 20, 2000. Patient stated she will come in. Candice Wright

10/20/00 10:30 AM Patient and significant other were counselled by Dr. Earl Horton regarding their options available to them, carrying the pregnancy to full term as opposed to having an abortion. The patient inquired from Dr. Horton how the procedure could have been missed and Dr. Horton replied that there are the risks involved in performing this type of procedure. Dr. Horton informed patient and male companion that there are medicines performed in the late midtrimester such as the D+E and Saline AB. Patient inquired as to partial birth and Dr. Horton replied that this procedure is performed when pregnancy reaches term. The male companion had several questions about late midtrim procedures and a brochure from Dr. Allen Klein @ Wichita was given to them. Dr. Horton stated that this could happen (miscarriage) and that the patients sign the consent informing that the clinic will not be held responsible for costs. Patient and male companion left seemingly satisfied with Dr. Horton's counselling.

Signature of Counselor

PROGRESS NOTES:

Candice Wright, for
10/20/00

_______________ M.D.
Signature of Physician

FORM 216
REV. 3/87

COUNSELOR'S REMARKS

'ATIENT'S NAME : Copeland, Steven DOS: 10/20/00

10/20/00 Patient did not enroll Hillcrest with [illegible] [illegible] [illegible] [illegible]

Signature of Counselor

ROGRESS NOTES:

': ______________

Signature of Physician M.D.

FORM 216
REV. 3/87

FACILITY
C-U.W. ___
C-S.E. ✓
WC ___
G. ___
K ___

CLINIC COMPLICATIONS
(Please attach a copy of patient's medical record)

DATE 10/20/00

NAME OF PATIENT Copeland, Sharon REFERRED BY Self

ADDRESS 37 Bailberry Court, Upper Marlboro TELEPHONE # 301-499-8010

AGE 36 LNMP 4/24 G 3 P 1 AB 1 INSURANCE Cash

DATE OF SURGERY 7/18/00 SURGEON Dr. Ernest Turner SIZE OF GESTATION 10-11 weeks Cash

NATURE OF COMPLAINT Patient came in today accompanied by male significant other for counselling with Dr. Earl Horton. AB was missed on 7/18/00; patient's gestation was diagnosed at Kaiser on 10/18/00.

PHYSICAL FINDINGS: BP ___ P ___ TEMP ___ , Candice Wright [illegible]

TREATMENT Rev. c pt + boyfriend [illegible] of pregnancy pt. c missed AB + continuing preg. Options

RX discussed at length. Pt. advised that I [illegible]

FINAL DIAGNOSIS(ES) not be able to do termination but referral given to pt for OB care / or termination

ATTENDING PHYSICIANS'S SIGNATURE [signature] Earl L. Horton, M.

HOSPITALIZED COMPLICATIONS

WAS PATIENT TRANSPORTED TO HOSPITAL BY HILLCREST? ___ METHOD OF TRANSPORTATION ___

NAME & ADDRESS OF HOSPITAL ___

DATE OF ADMISSION ___ DATE OF DISCHARGE ___
(attach discharge summary)

DIAGNOSIS ___

TREATMENT ___

SURGICAL PROCEDURE ___

(attach pathology report)

COMMENTS ___

ATTENDING PHYSICIAN'S SIGNATURE ___ M.D.

FORM 104
Revised 5/19/75

Q. Between that visit to Kaiser on June 26th and July 18th, when you went to Hillcrest.
A. I don't recall. I don't recall.
Q. Do you --
A. I don't believe I did, but I don't recall.
Q. When did you make the definite decision that you wanted to terminate that pregnancy?
A. I believe it was during that time the father and I were discussing it and we felt a baby wouldn't fit into our lives, so we decided to terminate it.
Q. When did you first contact Hillcrest?
A. It had to be sometime prior to the 18th. I'm not sure of the date.
Q. And did you just call them up and say you wanted to make an appointment for a termination?
A. Yes.
Q. And do you remember at that time what, if anything, you were told, or were you just given a date for the termination?
A. I believe they asked me how long do I

believe I am, and told me what the cost would be.
Q. Anything else?
A. I can't recall.
Q. Was this covered by your insurance?
A. No, it wasn't.
Q. Did you ask for Dr. Turner or any other particular doctor?
A. No, I didn't.
Q. Had you ever heard of Dr. Turner, as you recall, before July 18th?
A. No, I don't recall ever hearing that name.
Q. Now, I want to turn your attention to July 18, 2000, when you visited, when you went to the Hillcrest Center. Did anyone go there with you?
A. No.
Q. How did you get there?
A. I drove.
Q. If you would, tell me what the procedure was when you first went in. Who did you first talk to, what was done to you up until the time you actually met the doctor?

A. You go in and check in with the receptionist, she takes your name, and I believe I filled out a small form, I can't recall. And then you sit back down and you wait and they call you in to speak to, I think it's the nurse, or maybe when you go in for blood work, something like that, and then you go out again, a lot of in and out the door.
Q. Do you remember having blood work done and having urine taken?
A. Yes.
Q. And then after that you waited again?
A. Yes.
You speak to a counselor who takes down your information and tells you what's going to happen.
Q. Do you remember any kind of exam?
A. I remember Dr. Turner examining me because he was -- I told him I was eleven weeks, but there was something came up about the fee, and I believe he did an ultrasound to determine if I was further along because the fee was different. I don't remember how it came about.

Q. Were you through?
A. And then you're put in the room.
Q. Do you remember Dr. Turner doing an ultrasound?
A. Yes, I do.
Q. And that was to see if you were past 11 weeks?
A. Yes.
Q. He told you that was because the fee is higher at that point?
A. I don't know if he said that, but it kind of came about where I believe the ultrasound was done for that reason.
Q. And then what did he tell you after he did the exam?
A. He said I was eleven weeks, as I had told him.
Q. After having the blood and urine and filling out the form, et cetera, you said you did see a counselor, correct?
A. Yes.

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A. Medically speaking?
Q. As it's used on this form were you told there's a possibility when you have an abortion that there could be a missed pregnancy. Do you have an understanding of what that means?
MS. BARNETT: Objection to the form.
THE WITNESS: Not really.
BY MR. HEFFLER:
Q. Do you remember if there was anything else that you didn't understand on this form that you didn't ask about?
A. I can't recall.
Q. After the procedure was done on July 18, do you remember speaking with the nurse, I think her name was Ms. Wright, where she gave you a list of follow-up instructions and things like that?
A. I did speak with a nurse. I don't recall her name.
Q. I just want to show you what's been marked as Exhibit No. 2, Deposition Exhibit No. 2, which is entitled "Post Surgical Instructions, and, again, is

that your name and your signature in the lower, right-hand corner?
A. Yes.
Q. If you look at Paragraph 7 it says, "If you experience any of the symptoms below you should contact the clinic immediately 24 hours a day," and gives a phone number.
Did you develop any of those symptoms?
A. Those mentioned here?
Q. A, B, C and D, temperature above 100.4, allergic reaction, heavy, bright red bleeding and passing of large clots, and severe pain?
A. No, I did not.
Q. And, finally, I'm going to show you what's been marked as Deposition Exhibit No. 3, which is a two-page document, and the second page has a signature on the left. Is that your signature?
A. Yes.
Q. And above that it says, "If you experience unusual symptoms which you feel may be related to the procedure you had, call the clinic and ask to speak to

one of the nurses."
Did you understand that if at any time after July 18 you developed any symptoms that concerned you, that you thought were related to the abortion, that you should call the clinic right away?
A. Yes, I did.
Q. As we sit here today, do you recall any discussion at all on July 18th, either before the procedure, itself, or during the procedure or after the procedure, on that day, where anyone told you that it's possible that you could still be pregnant when you leave here, that the pregnancy can be missed? Do you remember any discussion like that?
A. I don't recall anyone focusing on the missed pregnancy as a possibility. I don't recall that.
Q. All right, when you say focusing, when you left the clinic did you understand that it was possible, even though you had the procedure done, that it was possible you still could be pregnant?
MS. BARNETT: Objection to form.

THE WITNESS: When I left the clinic I thought the procedure was done.
BY MR. HEFFLER:
Q. So you did not feel it was possible to still be pregnant?
A. No.
Q. And, again, you used the term, focusing; I just want to make sure I understand, do you have any recollection of anyone mentioning to you on July 18 that -- anything along the lines that, "It is possible you could still be pregnant and you should watch for any signs of that," do you remember anything like that?
A. No, no one said that to me.
Q. Now, after your discussions with the counselor you then went in to see Dr. Turner, is that right?
A. Yes, I did.
Q. Do you remember him?
A. Remember his appearance?
Q. Yes. Do you think if he walked in the room

minutes. That's a guess.
Q. Now, did Dr. Turner say anything to you before he started the actual termination procedure?
A. Just to relax.
Q. Did he explain what he was going to be doing?
A. Yes, I believe he did.
Q. And was it the same type of termination procedure you had had back in 1996?
MS. BARNETT: Objection to the question.
BY MR. HEFFLER:
Q. Or was it 1994?
A. Yes, it was 1994.
Yes, I believe it was the same procedure.
Q. And then during the procedure when he did the procedure did it seem -- did it strike you as being any different than the last one in terms of how it felt to you or in terms of what he did?
A. It didn't appear -- I don't recall it being different.
Q. That's fine.

Did Dr. Turner appear to be in any great hurry?
A. I believe he -- I don't recall. I believe he was there to do whatever time it required to do the job, do the procedure.
Q. And then after you finished the procedure, did he say anything to you? Did he say it went fine or anything of that sort?
A. I believe he did say it. I don't recall, but --
Q. If you don't recall, that's fine. You don't have to guess.
A. I don't recall.
Q. Then after that is when you went for -- you got your discharge instructions from the nurse?
A. You go to another room to lie down for a period until the cramping goes.
Q. Then you spoke with the nurse when you left?
A. Yes. She gives you instructions, and gave me a shot of something.

Q. And was an appointment made, then, for your follow-up visit?
A. Yes.
Q. And that was on August 1, 2000?
A. Yes.
Q. Now, in between then and August 1, 2000, in between the July 18th procedure and your follow-up visit of August 1st, did you have any significant problems or any concerns that there was anything wrong?
A. No, I didn't.
Q. Did it seem as it had the last time you had this done?
A. Yes, it did.
Q. And you returned on August 1st, 2000, and you saw Dr. Turner again, is that right?
A. Yes, I did.
Q. And just tell me what happened then.
A. Well, I was waiting in the clinic a long time because it was very busy, and I went up to the receptionist again to tell her I had to get back to

work, when might Dr. Turner be able to see me, and the nurse finally called me. She set me in this little waiting area, they have this little waiting area before you go into the room. She told me that she was trying to get me into a room so Dr. Turner could examine me.
That took a few minutes. She told me to come into this room real quick because he had a second to look at me. So I went in this room and he came in. He told me to pull down my panties and stuff and get on the table. I did that. He put his hand in my vagina for a second and pressed down on my stomach and said I was fine, and, you know, I could get dressed.
Q. He just said you were fine?
A. Yes, said everything was fine.
Q. At that point did you have any question in your mind as to whether the pregnancy had been terminated? In other words, did you have any physical feelings that made you question it?
A. No, I didn't.
Q. Now, in the records that we've seen the

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next time that you saw any doctor or other health care provider was when you went to Kaiser on October 16 of 2000. Was there any time in between August 1st and October 16 when you saw or spoke to any health care provider?

A. The only person I spoke to was someone at the clinic when I called because my period hadn't returned after, a little after two months it hadn't returned.

Q. So that would have been, you say, a little after two months. Was that early October?

A. I don't recall the date I called. It was either late September or -- I believe it was early October. I don't recall the date.

Q. When you say two months, do you mean a little over two months after your follow-up visit?

A. Yes. My period hadn't returned and I called.

Q. So this would have been, you said, probably early October?

A. No. It had to be, like, towards the end --

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I believe, towards the end of September or early October when I called.

Q. Did you say -- your voice went down -- did you say end of September, early October?

A. Yes. I called them and I was informed it sometimes takes three months for the periods to return. I don't recall who I spoke to.

Q. Okay. At that point, aside from the fact that your period had not returned for two months, did you feel like you were pregnant?

A. I didn't feel like I was pregnant. I felt there was something abnormal happening with my body. I couldn't pinpoint what it was.

MS. BARNETT: Do you need to take a break?

THE WITNESS: I have a headache.

MR. HEFFLER: Sure.

(A short recess was taken.)

BY MR. HEFFLER:

Q. When you called the clinic in late September or early October, along with telling them that your period hadn't come yet, did you tell them

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you felt something abnormal happening?

A. No, I don't recall telling them that.

Q. At any rate, you then went to Kaiser on October 16th. What prompted you to go to Kaiser on October 16th?

A. Because I was feeling movement in my stomach, what I thought was flutters.

Q. When did you first feel that?

A. I think I felt it in October, the beginning-middle, I mean October was when I felt this.

Q. After you had called the clinic?

A. It was after that, yes.

Q. At that point -- I'm sorry?

A. I don't know how long after, but it was after.

Q. And at that point, between not having your period and feeling the movement in your stomach, did you now feel that you might be pregnant?

A. I felt something was wrong. I don't know if I was certain or thinking that I was pregnant. I mean, yes, I guess I did, yes.

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Q. And from August 1st on -- August 1st is when you had the follow-up appointment -- from then on did you resume sexual activities?

A. Yes, I believe we had relations after the initial, you know, period, you know.

Q. When you felt that movement in October and thought you might be pregnant, did it occur to you that this might be the same pregnancy that you thought was terminated, or did you feel it was more than likely a new pregnancy?

A. I didn't feel that I was pregnant, because we were using condoms. I mean, I had gotten pregnant. I'm sorry.

Q. At any rate, you went to Kaiser on October 16, did they do a test and tell you that you were pregnant?

A. Yes, they did.

Q. And were you surprised?

A. Yes, I was, because I had informed them about the termination three months ago.

Q. Did they say anything -- did anyone there

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consistent with a 10-week gestational period or an 11-week gestational period?
A. Again, I'd have to wheel it out. It's probably closer to an 11-week.
Q. Well, you would agree with me that when you're performing a termination procedure, the difference between a 10-week and an 11-week gestation is somewhat significant?
A. It's fairly significant. In this case it's not -- I don't think that it's greatly significant, honestly.
Q. Okay. Well, can we agree, now that you've had a chance to look at the Kaiser record again, you've looked at the last menstrual period date again, that the gestational age of the pregnancy is more likely 11 weeks than 10 weeks?
A. It could be.
Q. Well, do you have anything to suggest that it's more consistent with the 10 weeks than it is the 11 weeks?
A. No.

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Q. Okay. What does the standard of care require for a termination procedure at 11 weeks?
A. Standard of care? Could you be more specific? In regards to what?
Q. For the termination procedure.
MR. HEFFLER: Do you mean how it should be done or what it is that she did?
MS. BARNETT: Correct. Correct.
A. Do you want me to go through it step by step?
Q. Right.
A. Well, after appropriate anesthesia has been given, obviously, cervix is going to be dilated up to the cannula size that would be appropriate. And in this case, I would probably say a 31 -- I'm sorry. Not cannula size.
Up to the Pratt dilator size that would be appropriate, which would be a 31. That's what I would do.
If I could get her dilated to that point. Keep in mind, individual cervices sometime

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don't want to stretch beyond a certain point. So if you can get her to 31, you try to get them to 31.
And then you would introduce a size cannula that would be appropriate. In this case you could do 10. A size 10 cannula would be fine.
And then you apply suction and remove the products of conception.
Q. How long do you apply suction?
A. Until it's gone.
Q. And how do you determine that?
A. When you no longer see products of conception coming through. And also I always follow that up with a sharp curettage afterwards to make sure that I can feel that there are no products of conception remaining.
Q. At 11 weeks gestational age, what products of conception would you expect to see?
A. You -- can you be -- what do you mean by what products of conception?
You would expect to see products of

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conception.
Q. What would you expect to see?
A. Tissue.
Q. Anything else?
A. Blood, tissue.
Q. Anything else?
A. Not necessarily, no.
Q. And when you say tissue, are you including placenta in that as well?
A. Yes.
Q. Anything else?
A. No.
Q. Decidua?
A. Well, it all comes through the tube. So you're looking at a cannula. All you see is the white tissue mixed with blood.
Q. Any fetal parts?
A. No.
Q. Why not?
A. It's not standard of care to count fetal parts at this gestational age.

learning curve; in other words for almost all medical procedures you start to get good at ten and you frequently don't get a whole lot better than you get after 50, and people with the cardiac procedures and other things, this seems to be the general rule, so one would expect if you have done 50 or so terminations at this particular point of pregnancy you should have a pretty good idea about what to expect, certainly by ten a good idea and you should be considered probably an expert by 50.

Q. So Dr. Turner, when he entered the amniotic cavity, should have seen a gush of fluid?

A. That's correct.

MS. BARNETT: Object to the form.

BY MR. HEFFLER:

Q. Correct?

A. Yes.

Q. And, obviously, if you're correct that he didn't enter the amniotic cavity he didn't see the gush of fluid, correct?

A. Correct. Or he saw something that wasn't

amniotic fluid.

Q. I may have asked you this, but to your knowledge, have you ever done a termination procedure that you thought was successful where the woman went on to actually deliver that baby?

A. Have I ever done, no. You asked it in a different way, but the answer is, no. No both times.

Q. Do you know whether any of your associates have ever had that happen either in this office or any other place?

A. The only pregnancies that I am aware of that continued in that situation have been uterine anomalies where they have been double uteri, where one side of the uterus was evacuated and where the other side was never touched. I'm aware of a pregnancy that did continue at that point.

Q. Now, again, you read the expert disclosure today?

A. I did.

Q. The part dealing with you?

A. Yes.

Q. It says you're going to talk about breaches of standard of care and causation and damages, is that correct?

A. That's what it said there.

Q. Are you going to talk about all that?

A. I believe so.

Q. It starts saying on Page 3 that you're going to say that defendants breached the standard of care when Dr. Turner failed to terminate Sharen Copeland's pregnancy. Are you saying that the failure to have a successful termination in itself means there was negligence?

A. I don't want to rephrase your question specifically, but I'm saying that the failure to recognize that the pregnancy was not terminated was the failure. In other words, there are certainly -- if it turned out that Ms. Copeland had a uterine anomaly and she had a complete bicornuate uterus and he never knew that, he had the tissue, looked at the tissue and said, "Gosh, she's eleven weeks, we don't have a sonogram here, I'm going to send the tissue out

to look at," that's not a violation of the standard of care. He didn't get the pregnancy, but it's not a violation.

You know, if he had the sonogram available and he got less tissue, looked at it and said, "I didn't get the pregnancy," the actual act of not getting it is not the violation. The violation is the act of not recognizing that you didn't get it. That's the violation.

Q. Okay.

A. So it's semantic, but it's important. If you do enough of them you're going to miss occasionally or you're going to run into that uterus. In fact, one of my patients here I had for 15 years, I met her when I worked in the clinic I talked about, and she came in because she had pregnancy symptoms after she had a termination a week before. She had a blind horn of her uterus. She had a pregnancy that is totally isolated. They never got it, and we took that out and she had twins in her remaining horn.

Q. The breach on July 18 was not to recognize

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immediately that there had been a termination?

A. Not recognize that the type of tissue and parts that were removed were inconsistent with her dates, and required further action. The action could have been sending that tissue out to pathology, the action could have been to sonogram her at that point, and we know from the depositions that there was a sonogram available in the clinic, and so it would have been relatively easy to put a scanner on, or if you were uncomfortable doing that or felt your skill level was too low, there is nothing wrong with saying I want you to go out and get a sonogram today or tomorrow. I don't know what time of the day the termination was done. Just to make sure we got it all, we're going to send the tissue out. There are numerous ways to confirm that you've gotten the tissue.

Q. Incidentally, are you going to be testifying there was any independent negligence of the Hillcrest Clinic apart from what Dr. Turner did or didn't do?

A. That's a difficult question for me to

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answer, sir, not being a lawyer, because if it turns out that Ms. Copeland called the clinic following the termination and said, "I haven't had my period," or said, "I still feel pregnant," and there was no advice either to come in or to see your doctor or to get a pregnancy test or some follow up, then the clinic would have a violation, but, you know, I haven't read her deposition. These things were not discussed, at least in any detail, in the three depositions that I did read.

If that is shown to be a fact, a real fact, that would be a violation of the Hillcrest Clinic.

Q. Have you been told by anyone that that happened?

A. I think I talked about it at the beginning of the deposition that there is certainly an issue about her calling, and I don't have the details about that, so I would just volunteer so we don't have to do the deposition again if that is proven to be a real event I would consider that to be a violation.

Q. Any other possible violations that you are

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aware of by the clinic apart from Dr. Turner?

A. No.

Q. Now, again, this states at Page 3 that "Dr. Turner breached the care on July 1 when he failed to appreciate that there were no fetal parts contained in the extraction," correct?

A. Yes.

Q. First of all, what do you mean by fetal parts, what fetal parts are you talking about?

A. Arms, legs, chest cavity, head. At that point in a pregnancy the fetus is very recognizable. The eyes are very pigmented. You can see the feet. You can see fetal parts. The absence of fetal parts certainly is a warning sign that either you had the dates wrong, you didn't get the pregnancy, conceivably that it was a missed abortion, that this was a pregnancy that didn't continue normally, but these all require confirmation.

At eleven weeks the volume of tissue that you get out doing a termination in the sac, the bag that catches the material is the size of a baseball.

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It's a significant amount of tissue. The doctor has the duty to examine that tissue to see if the fetal parts are there, and if there are no fetal parts why there are no fetal parts there.

Q. Now, you're saying at eleven weeks the doctor should visibly see arms, legs, chest cavity, head, what else?

A. Not all of those, necessarily, but some fetal parts that tell you at eleven weeks. I don't think you have to reconstruct a baby like you need to at 13 or 14 weeks. That's not what I'm getting at. You asked what fetal parts and I described all the fetal parts you could see. You should see some of those.

Q. Are you saying that you wouldn't necessarily see all of them?

A. I don't think it's required by the standard of care at eleven weeks to, you know, reconfirm to make sure that you have all of the fetal parts. You'll get them. They'll be there at that point, but to see that there are fetal parts because it's a way

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at that point that the doctor confirms that you're in the sac and you got the pregnancy.

Q. I understand.

Are any of those parts that you specifically mentioned, arms, legs, chest cavity, head, are any of them present earlier than others?

A. Well, certain parts are going to be more identifiable easier. For instance, a whole thorax is going to be easier to look at than a little foot. The lower parts of the baby's body develop slower so, for instance, the arms are going to be more developed than the feet because of the way things happen. The head is going to be bigger than the rest of the whole body. The eyes are very prominent and pigmented. So certainly there are parts that are easier to pick out. Any of them being seen would tell you you're in the sac.

Q. At eleven weeks give me an idea how big these parts would be. How big would the head be?

A. A baby at eleven weeks, you're talking about 40-50 millimeters, almost two inches. I'll give you an exact number if I can. Let me see, at eleven weeks, it's about 5 to 6.5 centimeters crown-rump length. That's between the rump and the top of the head, that's about two to two-and-a-half inches. So half of that would be head. So the head could be almost an inch in size at that point. These are recognizable structures.

Q. And how long would an arm be, for example?

A. You know, you're getting -- I can't answer, exactly. I don't want to be inaccurate. It's large enough so that it would be recognizable.

Q. Do this for me. I'm going to give you a piece of paper here.

A. I'm not a good artist.

Q. Just draw, I realize this is not exact.

A. Why don't we get out a textbook and do it accurately.

MS. BARNETT: You can go ahead, Doctor, and do it, but I'm going to object because the Doctor has testified he doesn't want to guess, he doesn't want to be inaccurate, and he testified as completely as he can.

MR. HEFFLER: Actually, he didn't say that, but your testimony is on the record now.

BY MR. HEFFLER:

Q. All I want you to do is, you used a measuring instrument a minute ago, you can do that again if you want to. First, draw the approximate size of the head at eleven weeks. Draw the approximate size of an arm, a leg and a chest cavity.

A. I'm going to volunteer for the record that I'm not a great artist and this is not going to be an accurate assessment. So let's say two inches, approximately, let's say the whole baby is about two inches. That's about two inches. This is not quite to scale. The arm is going to be larger, that would be an approximation.

Q. Of the whole baby?

A. Umbilical cord, yes, the eyes and ears, like that.

Q. Is that two-inches? That is pretty close to two inches.

A. Give or take.

Q. Draw a line and label that whole baby.

A. (Witness complying.)

Q. What does that say?

A. Guesstimate.

Q. Write at the top of this, eleven weeks.

A. (Witness complying.)

Q. Now, similarly, if you would, just draw the approximate size of the head at eleven weeks.

A. Excuse me?

Q. The approximate size of the head.

A. This is it.

Q. Basically, the top half?

A. This is eye, this is head, and the rest of this is body.

MR. HEFFLER: Now, let's label this Exhibit No. 3.

(Deposition Exhibit 3 was marked for identification.)

MS. BARNETT: Same objection.

MR. HEFFLER: You don't like my labeling

it?

MS. BARNETT: I object to you making it an exhibit to the deposition.

BY MR. HEFFLER:

Q. Now, the procedure that was done by Dr. Turner, this was a suction termination?

A. Suction curettage, yes.

Q. Is that the type you used to do, too?

A. That would be the standard of care, yes.

Q. When that is done do the products of conception, including the fetal parts, come out as distinct parts, or do they generally get sort of all mishmashed and crushed together?

A. It depends. Sometimes the fetal parts we're talking about will come out as a single unit depending on the size of the suction curette they use and whether the baby was healthy or whatever. They can come out as separate parts.

Q. Can they also just come out as part of this whole mishmash of products of termination?

A. When you do a suction termination all the

parts will end up in the suction bag. Occasionally, you may do the suction and parts will be extruded through the cervix which you tease out and put them as a separate part of the specimen, but the majority of the tissue ends up in a collection bag.

Q. I understand that. The majority of the collection is in the bag. It's been sucked out by this cannula, correct?

A. Yes.

Q. What I want to know is, you said sometimes you can actually see in that tissue that there are distinct, clear fetal parts, correct?

A. You need to look at the tissue. You have to take the bag out and look. You can't see it without taking the bag out.

Q. Assuming one looks. I'm not going to assume one sees it without looking, okay. As I understand it, when it's all in the bag if someone looks there are times when you will clearly see fetal parts, correct?

A. Yes.

Q. Are there, also, times when as a result of the procedure, itself, those fetal parts are crushed as part of this entire sort of mishmash of stuff?

A. Is it possible? It's possible, but if that happens the likelihood that it was a normal pregnancy is small. The likelihood that the pregnancy was of normal size or that the pregnancy tissue had been dead for some time is small. If you took a healthy, viable pregnancy at that point you're going to see fetal parts. It is obvious.

If the baby was smaller, it died two weeks ago and becomes easily fragmented because the tissue is not healthy or if it was just a completely missed abortion where there was no tissue there at all you wouldn't see any.

Q. If you do a complete abortion, are you saying at eleven weeks, are you saying there can't be an instance when the fetal parts, the bone structure you're talking about are just crushed up with everything else and it's not distinct?

A. The technique is not a crushing technique,

it's a suction technique. You don't crush at this point of pregnancy. It all bases on, A, what was there before you started, was it a healthy pregnancy, were the dates right, that's the big premise. If your dates are right and it was a healthy pregnancy, with a reasonable medical certainty you're going to see fetal parts. I am not saying absolutely, positively all the time, there are compensations, but it would be very unusual not to see fetal parts.

Q. Now, since the procedure, you said, is not a crushing technique that would crush up these bones --

A. Let me correct things. There are no bones there. There's cartilage.

Q. That would crush up the fetal parts material --

A. Okay.

Q. -- why wouldn't you see all the fetal parts?

A. Because there is a lot of tissue there. There is a lot of placenta there at that point. There

is a lot of decidua. As I volunteered to you, they may be in different places and at that point of the pregnancy all you're looking for is to confirm that you got the pregnancy, that you got it. You're not looking to reconstruct it.

Later in pregnancy, as I volunteered to you, it is extremely important to reconstruct it because the fetal parts, A, contain bone; and, B, they are large enough to cause bleeding and problems with infection later.

Q. Apart from the fetal parts, is there any other appearance of the products of conception that the doctor should see or be able to see at eleven weeks that would confirm a successful procedure?

A. There is certainly an issue of volume of tissue, relative volume, and experience would tell you approximately how much volume you would expect to see during a particular time of pregnancy, but one of the things that's sort of interesting, depending on whose stuff you read over the years, doctors are amazingly inaccurate in their ability to predict whether or not

there's pregnancy tissue there by pure visualization without the use of a dissecting microscope or having tissue sent out. So using your eye to identify fetal tissues is not the best thing in the world. The literature will suggest it is somewhat inaccurate.

Q. You're saying other fetal parts?

A. Yes, that is correct.

Q. I realize there is a certain expected volume at a certain gestational age, but is there a certain amount from experience that you would expect at eleven weeks?

A. There are certain times at eleven weeks where you may get a reasonably complete looking placenta that you may be able to identify, something that looks like placental tissue and occasionally you can actually tease them out where you actually pull out a miniature placenta with chorion and decidual membranes outside it. That's reasonably reliable. You can look at it, if you are lucky enough to get it out intact, which at this point you frequently don't do.

Once again, no matter whose literature you read, in the absence of seeing fetal parts the doctor's ability to judge that they've, actually, gotten the pregnancy is not that great. We make errors doing that.

Q. Is there a certain color that you would expect the products of conception to be?

A. A color?

Q. Yes.

A. Of course, they are bloody at that point. I mean, the decidual tissue looks about the same color as placental tissue, maybe placental tissue has a little more color white; and we look for villous structure in there. We think we know what we're looking at. As I said several times before, it's not the easiest thing to do and it varies depending on where in pregnancy you are and knowing for sure that you're dealing with the right dates. A high level of suspicion is very helpful in doing termination.

Q. Can a competent doctor reasonably feel that he is seeing the appropriate volume and appearance of

products of conception at eleven weeks and still be wrong?

A. I don't think I can answer that question the way you phrased it. If you're asking me as a reasonably prudent physician I could answer that. I don't know what competent means. I don't know what it means relative to what we're doing here. I don't think it is a fair question. If you are asking me about a reasonably prudent physician --

Q. You're bothered with the word, competent?

A. Yes. You and I here are because this involves a legal indication. I don't know what the word, competent, has to do in a legal term. I know what a reasonably prudent physician has to do in a legal term. A lay person's idea of what competent is would equate with probably reasonably prudent, but I think we're here to be accurate.

Q. Let me ask you strictly as a physician, not as a legal medical expert, but strictly as a physician do you think that if a doctor believes that he is seeing the appropriate volume and appearance of

Page 46

products of conception, apart from fetal parts, and he turns out to be wrong --

A. What term of pregnancy?

Q. -- at eleven weeks.

A. Okay.

Q. -- in your opinion would that indicate that this is not a competent physician?

MS. BARNETT: Objection to form.

THE WITNESS: I can't answer that question.

BY MR. HEFFLER:

Q. Would it indicate to you that the physician has not acted reasonably, that he's violated the standard of care?

A. Yes. I think that at eleven weeks if you don't see fetal parts there, even if the volume of tissue is approximately normal, that you have a duty to find out what's going on, to make sure that you've gotten what you're after.

Q. What's the latest gestation where you perform abortions now?

A. Now?

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Q. Yes.

A. For a true abortion I don't like to do them further than about eight to ten weeks. We occasionally do missed abortions that will be with residents that are 12 to 13 weeks in the hospital when I'm covering the residents.

Q. You're talking missed as opposed to incomplete?

A. I'm talking about patients who have non-viable pregnancies that haven't passed it that need to have the pregnancies evacuated.

Q. Why are they non-viable pregnancies? I don't understand.

A. The baby died.

Q. Because an abortion --

A. No.

Q. Where was the missed abortion?

A. That means that the mother wanted to be pregnant, and the baby died, and the uterus has to be evacuated because she hasn't passed the pregnancy.

Q. But when there was a missed abortion?

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A. No. Missed is a medical term for someone who has a pregnancy that hasn't been successful, not a termination that hasn't been successful. In other words --

Q. A missed abortion?

A. Let's just say that Mrs. Smith came to the office, she's very excited she is pregnant, been trying for six months, and we do a pregnancy test that's positive and she comes in here at eight or ten weeks and has a little spotting, and I sonogram her and I see a sac with a baby that's not ten weeks' size, but five-and-a-half weeks' size and there is no fetal heart. That's a missed abortion. That's the medical term for missed abortion. That's what we call it.

Q. If there hasn't been an abortion, how can it be a missed abortion?

A. Abortion is the medical term for loss of a pregnancy. We're talking about what one would call a therapeutic abortion which is terminating a pregnancy that would otherwise continue on its own.

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Q. Abortion doesn't necessarily mean removal?

A. That's correct.

Q. It just means the pregnancy has terminated?

A. Yes.

Q. With miscarriage there is usually an expulsion of the tissue, isn't there?

A. No, no.

Q. Let me go back. Why do you prefer not to do abortions beyond eight to ten weeks?

A. I don't do enough of them to be skilled enough at that point. I think, as I explained to you, the further you go the greater the risks are and I much prefer to have patients going to people who do a lot of later terminations because I think their complication rate is lower.

Q. Do you always have your tissue examined pathologically after you do an abortion?

A. Do I always, no.

Q. And in what instances do you do that?

A. In the situation where, say, we're eight or ten weeks, there was fetal tissue there, I may not

choose to get it examined, but most of the other times I do.

Q. What percentage of the time would you --

A. Certainly, if I may volunteer, all of the terminations I do in the hospital are all examined, 100 percent of those.

Q. Where do you do your procedures now?

A. Mostly in the hospital.

Q. Do you do some in the office?

A. Very rarely.

Q. When you worked at the clinic about what percentage of the time did you send the material for pathology?

A. I couldn't even volunteer what percentage of the time I sent them at that time.

Q. And in your office now, what percentage do you send?

A. Most of the tissue goes out. Almost all of the tissue goes out. I prefer to have the tissue examined.

Q. And I think you may have answered this. Do

you believe that Dr. Turner did get some products of conception in this case?

A. I believe it's possible he may have gotten some small pieces of placenta, certainly not significant amounts of placenta, and he probably got some decidua, but not a whole lot of pregnancy tissue at all, he couldn't, or the pregnancy wouldn't have continued.

Q. Now, again, those questions were referring to the Page 3 where you indicated the standard of care was breached when Dr. Turner failed to confirm that there were fetal parts, and I gather you're also saying that when he didn't confirm that, that he failed to send it to pathology, correct?

A. That's correct.

Q. Does that cover all of your criticisms on that day, July 18, 2000?

A. I think it does. My criticisms are sort of a ying-yang method. That is if the abortion was done properly he should have recognized that there wasn't enough tissue there and sonogramed it or sent the

tissue out.

And, on the other hand, if the abortion wasn't done properly, then it wasn't done properly and it was a violation of the standard of care, so my personal feeling is that there is no way, whichever of those events happened, that what happened was consistent with the standard of care.

Q. Now, the statement goes on to talk about the follow-up visit of August 1, 2000 and --

A. We're on Page 4, correct?

Q. It starts the bottom of Page 3. It indicates you're going to testify that Dr. Turner's examination on August 1, 2000, was inadequate, incomplete, cursory, et cetera?

A. That's correct.

Q. Is that correct?

A. Yes.

Q. How do you know that? How do you know it was an inadequate exam?

A. I hate to use the ying-yang example, but one of two things had to happen. Someone with Dr.

Turner's vast experience in examining uteri two weeks after abortion, which could have put her at 13 weeks, should certainly have been able to appreciate a 13-week size uterus.

Now, that being said, and if he could not see, that would be a violation.

The other side of the coin is as we've talked about of Ms. Copeland was not svelte, she was overweight.

Q. What was her height and weight?

A. She was very heavy. I don't remember. I can tell you what her weight was.

Q. Somewhere around 300 pounds?

A. Her weight was 200 pounds and her height was 160 centimeters.

Q. 200 pounds?

A. 200 pounds, that's what the note says. That's what I'm looking at here. Unless I can't read it. Are you saying it's 280?

Q. I think it's 280.

A. Their handwriting is as bad as mine. If

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she's 280 she is significantly overweight. To get back to what I said before, one could appreciate at that point it could not have been as easy to examine her and gauge the size of the uterus. If she came in at seven months and she was pregnant and they didn't appreciate that she was pregnant right off the bat, if they couldn't tell at seven months one could appreciate it was still pretty difficult at 11 to 13 weeks. If you couldn't feel the uterus adequately, he had to do a sonogram to make sure the uterus was of normal size.

Either it was a difficult exam, and we all have difficult exams and we are fortunate in that we have ways of complimenting our examinations. Once again, a sonogram was available in the clinic. If Dr. Turner didn't feel comfortable using the sonogram he could have referred her out or had someone else in the clinic to do it who was more competent.

If he felt the uterus adequately at 13 weeks there is no way he wouldn't have been able to tell that this was not normal at that point after a

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termination.

Q. So you're saying it is more difficult to perform the examination in a woman this size, correct?

A. Yes.

Q. It is hard to assess the size of the uterus?

A. Yes.

Q. You're saying if he didn't feel comfortable that he was able to assess it he should have done what?

A. A sonogram or a pregnancy test or something to confirm. If you can't feel the uterus and the patient is there to make sure everything is normal, that the uterus is back to normal size and that the termination has been successfully completed and if you couldn't do that you have a duty to do something else to compliment your difficult examination.

Q. The statement goes on,, this is at Page 4.

A. Okay.

Q. Where it says you will address issues with reference to discharge instructions once you have the

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opportunity to review the deposition transcripts.

Do you have any idea what that means?

A. I have an idea what it means, but I'm not going to have any comments about that at all. I have reviewed the deposition transcripts and I'm certainly satisfied that the instruction sheets that are given to the patients at the end at Hillcrest Clinic are consistent with the standard of care.

Q. Now, it then goes on, and I think this is what you referred to before, to say that "Hillcrest violated the standard of care in failing to have Ms. Copeland return to the clinic following a telephone call approximately two to three months after the scheduled termination"?

A. I would say that statement doesn't completely and accurately reflect my opinions. My opinions are that if she did call two to three months following the termination and she hadn't resumed her menstrual cycle they had a duty to either refer her to see her doctor, or to see her, or to tell her this was not normal and she needed some follow up. They didn't

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have to see her, I don't know that Ms. Copeland would have even gone in to see them, but they had a duty to refer her. That's the only thing.

Q. And two to three months after the -- three months after the termination would have been the middle of September?

A. 7/18, 8, 9, 10/18 would be three months and that was when she became aware of the pregnancy, was it not?

Q. That was my next question. So do you have any reason to believe that anything would have changed if she had been referred to a physician because she hadn't resumed her menstrual cycle, say, two months after in September?

MS. BARNETT: Objection to the form.

THE WITNESS: I certainly think it would have been changed, she would have been a month less pregnant at that point, and a month less pregnant may have given her more options. It certainly would have given her an opportunity to examine the pregnancy, look for normalcy, have a Level II sonogram, and there

are certainly places in this country that would do terminations at that point.

BY MR. HEFFLER:

Q. How many weeks was she when she did discover she was still pregnant?

A. She was seven months, was the term they gave, but I think she was 23 weeks by cursory sonogram, which I believe is the way Kaiser described it.

Q. Okay.

A. And I'm 99 percent sure that's an accurate statement, but I'll try to make sure, right now. She was seen on 10/18 at the Kaiser clinic by Elizabeth M-O-S-O-K-E, I can't read it, but her doctor number is 7399 or 89 and it says, "IUP 23 weeks, consistent with probable failed VIP. OB sonogram as soon as possible. And the note at that point says, "Limited office sono IUP 23 weeks, positive fetal heart rate."

Q. At that point, I believe it was the next day, October 19th, when she went back to the clinic. Are there places where she still could have had a safe abortion procedure?

A. Yes.

Q. Now, this statement goes on to say that the child suffered injuries and damages. As I understand it, it's saying that at the time of the attempt to terminate in July there were things done to the fetus that resulted in the disabilities and problems that the baby has today, correct?

A. Yes.

Q. And what this says is that at the time of the termination there was a temporary disruption of the blood flow to the fetus and that led to placental and vascular damage which caused the various injuries, correct?

A. Yes.

Q. Explain to me just how that happens. I mean, first explain how the blood flow is disrupted, and then explain how that wound up causing the kinds of problems and damages that this baby has.

A. Okay, it's, actually, pretty easy to do. Let me start off with the premise that at this point in the pregnancy this is what can be called the period of organogenesis, when the organs are forming. The baby grows extremely rapidly. The baby grows a millimeter a day. The baby is growing like crazy. The stress on placenta and after birth is significant enough to supply nutrients and food for this structure to keep growing.

We have very good data. You may remember, you're around my age, back in the '80s when we started doing chorionic villa sampling there was a moratorium on doing violence to the fetus because the National Institutes of Health said it became apparent there was a fourfold increase in the incidence of limb bud abnormalities in babies who had chorionic villa sampling.

Chorionic villa sampling is a rather delicate procedure to try to get a piece of the placenta to do chromosomes on, and it became clear when that study was done that if you do the procedure earlier in pregnancy, even with a small catheter, there is enough temporary disruption of blood flow to the baby that the parts of the baby which are the end of the food chain, which the end of the food chain is the extremities, and in particular the lower extremities are the end of the food chain, these are the parts that get the last dribs of oxygen and food from the blood supply. That's why they grow slower, that's why the baby's legs are smaller than the baby's arms, and that's why the baby's head is the largest structure, because it gets preferential blood flow. We found if you disrupt it even for a short period of time it had consequences in development.

Fortunately, most of the stuff which was delivered was defects in legs, but it did lead to not doing chorionic villa sampling under ten weeks because we knew if you disrupted the placenta it would cause abnormalities.

It is not very farfetched, then, to say if you're not doing a delicate in and out, one procedure to just grab off a little bit of placenta, but if you take a big old suction curette and wave it around and damage the placenta you're going to, in all

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likelihood, cause hypoxia, loss of food and oxygenation. And those organs like the feet, legs, that are most distal in the food chain, wind up with injury, it's very easy to understand that.

Q. Have you ever seen this happen before to this extent?

A. Have I seen what?

Q. A disruption of the fetal blood flow causing the kind of injuries that this baby has.

A. No. I think I volunteered to you I haven't seen an unsuccessful termination that wasn't in a separate, totally separate horn where the pregnancy was never touched at all. I hadn't seen a case like that.

And we had some cases at the hospital during this time period of limb bud reductions that were recorded after chorionic villa sampling.

Q. You said the placenta was never touched at all. There had to be some removal of placental tissue?

A. No. That was where the pregnancy was

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totally separate, they never could have gotten near it with the curette. They never came near it. There is no way they could have gotten near it.

Q. In this case in order to disrupt the blood supply there had to be some removal of placental tissue?

A. No. You don't have to remove the placental tissue. You could negotiate your curette up around the placenta without removing a significant amount of placental tissue, but all you have to do is disrupt the blood supply to the placenta. You don't have to remove placental tissue.

You know, it would be sort of like, you know, getting to Lance Armstrong and saying he's competing in the Tour De France and you're going to go ahead and you're going to remove his right, upper lobe it is going to make a difference to him because he's at peak performance there. Any small decrease in oxygenation is going to make Lance fall off the field.

That's what's happening here, you have an organism running at peak performance here, inferring

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if you disrupt some of the food and oxygen supply there will be hell to pay.

Q. What was the injury that you said you saw occurring or has been documented to occur with chorionic villa sampling?

A. They called it limb bud reduction, they are abnormalities of the feet and lower extremities; occasionally, the upper extremities. That's what they were called, they are referred to as limb bud abnormalities, malformations of the lower extremities.

Q. So, again, you've blamed, I think, the disruption causing the club feet in the manner you described --

A. It's not going to be only club feet. The classic disruption of chorionic villa sampling is what I said earlier.

Q. I'm not talking about chorionic villa sampling. I'm talking about this case, how did it cause the club feet?

A. It caused disruption in the blood supply to the baby which could have caused structural

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developmental problems in the feet. It could have caused neurologic damage to the baby which led to the formation of the club feet and so, you know, there are a number of mechanisms. I can't say -- I'm not an embryologist -- which specific ones, but I'm sure if we had one to talk about it they could tell you the most likely mechanisms, depending on the exact days of the pregnancy that the disruption occurred.

Q. How did it cause the GERD?

A. I don't think I could tell you specifically, but once again GERD certainly can be a neurologic disorder. It doesn't have to be a direct disorder of the formation of the stomach and esophagus, but those things are not tubes that things flow down, they require coordinated neurologic feedback in order for you to swallow and do that, and so that any disruption to the nervous system could certainly cause abnormalities in one's ability to swallow depending on, once again, which nerves were growing and what time in the pregnancy it is.

Q. Do you believe, to a reasonable medical

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probability, that the disruption to the blood flow is what caused the GERD?

A. I think its not unreasonable. Certainly, as you know or may not know, GERD is not an uncommon abnormality in that babies are born with -- particularly premature babies. We're not talking about run-of-the-mill GERD here, at least from what records I've been given, we're talking about a baby that was just incapacitated that had no stomach bubble, there was no evidence of any swallowing, no evidence of any fluid moving down the esophagus. We're talking about more than just a little about a weak epigastric- esophageal junction sphincter, we're talking about a major disruption in the innervation of the esophagus and the stomach. This is not your classic GERD. The variety that was described to me, I think, was extremely extraordinary.

Q. Did you say there was no stomach bubble?

A. I remember when the baby came in there was concern because there was no stomach bubble seen, but obstructive abnormalities. Now, there are true

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obstructions and pseudo obstructions, that is in the same way that one can get a bowel obstruction or disruption because the nerves aren't there to move things along, they present the same way as if you tied a string around the bowel. Nothing gets by there. The same thing can happen in the stomach.

Q. I'm not asking what can happen. Do you have an opinion, to a reasonable degree of medical probability why there was no stomach bubble?

A. Yes.

Q. Why that was?

A. I believe it was caused by the same mechanism that gave the baby the GERD. The baby couldn't effectively swallow amniotic fluid, and, therefore, you couldn't see fluid in the stomach.

Q. Let's go back to the GERD, are you saying that, and I think you said before it would not be unusual, my question now is, are you saying to a medical probability that the GERD was caused by the interruption in blood flow?

A. That's a different question. I can't say

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that with a reasonable medical probability. I would leave that to the embryologist. What I said was it's not unreasonable to think it was.

Q. And, again, as you said, you can't say to a reasonable medical probability that the GERD was caused by the interruption of the blood flow. Is it correct, then, that you also can't say to a reasonable medical probability that the lack of the stomach bubble was caused by the interruption?

A. That would be correct. That would go into the same category.

MS. BARNETT: Could we have a recess?

MR. HEFFLER: I only have five or ten more minutes.

MS. BARNETT: Okay, let's finish it, then.

BY MR. HEFFLER:

Q. You mentioned that the baby was born prematurely, correct?

A. Yes.

Q. Do you have an opinion as to what caused the premature birth?

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A. I do.

Q. What is that?

A. The failed termination, with a reasonable medical certainty, caused a rupture of the membranes and a premature birth.

Q. You're saying the membranes were ruptured on July 18, is that what you're saying?

A. I'm not saying the exact date. I'll check the records.

Q. Assuming that is the date of the failed termination?

A. At Twenty-eight weeks the ruptured membranes occurred. No, no, failed termination was back in July. I'm not saying the ruptured membranes in July, I'm saying the ruptured membranes that occurred in November were a consequence of the termination. My reading of the literature would suggest that premature rupture of the membranes is a common consequence of failed first trimester abortions.

Q. Three months later?

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A. Yes.
Q. Tell me what literature says that.
A. I'm not going to give a quote and verse, but certainly I've seen in the past that failed terminations have been associated with premature rupture of the membranes. I certainly can go to the literature and pull out some articles for you if you want.
Q. So you're saying that you have seen literature saying that a failed abortion procedure can cause premature rupture of the membranes three months later?
A. Yes.
Q. Specifically?
A. Yes.
Q. When did you last see literature that said that?
A. I can't quote you chapter and verse, but certainly in the last five years.
Q. I guess I was confused. I thought you said that usually if there is a failed procedure -- strike

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that.
So you're saying the membranes ruptured in October?
A. I think November. I think October is when they found out. I don't think she delivered until a month after that. She was admitted in November, so actually the rupture of the membranes occurred a month after she discovered she was pregnant in October. Remember, she came in 10/18, they found she was 23 weeks and it was November when she had the premature delivery and the premature rupture of the membranes. I may be wrong.
Q. You're correct. Actually, what we have is November 20 is when she goes to the hospital.
A. That's when she was admitted.
Q. I believe she said the membranes had ruptured a couple days before that?
A. I think so, yes.
Q. You're saying the membranes ruptured in November because of the failed termination?
A. There is a distant association with that.

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I'm not ruling out all the causes. I'm saying with a reasonable medical probability the premature rupture was a consequence of the failed termination. I'm not saying it is the only possibility. I'm saying the way I read the records and the literature, I'm saying it is reasonable to assume that it was related to that.
Q. Again, I'm going to try to ask the question clearly, are you saying that you believe, to a reasonable medical probability, that the membranes ruptured in November prematurely because of the failed termination procedure in July?
A. Correct.
Q. Tell me how that happened.
A. Good question. Not everything in medicine is logical. All I'm representing to you is that my reading of the literature would suggest that premature rupture of the membranes is a complication of failed terminations. Whether it's an abnormality in the chorion developing, whether it's a low-grade infection, whether it's a failure for that part of the membranes to develop properly, whether it's caused by

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congenital abnormalities in the baby for which the baby triggers preterm labor, the point is there is a significant association with premature rupture of the membranes in failed terminations.
Q. And so I understand it, you're saying you believe that there was premature rupture of the membranes and premature birth in November because of the termination procedure in July, but you can't say how that procedure caused it to happen?
A. Yes. I think when people look at those problems that occur, I don't think we're going to go out there and find 150 cases of failed termination and have enough experience for people to dissect through the facts and get enough placental tissue and membranes and come up with a realistic reason why it happens.
The point is, in the cases in the literature it appears to show that there is a higher incidence of ruptured membranes associated with failed termination, and I don't think they've gone to the extent of arriving at saying why this happens, other

DATE	VISIT/ PROB. #	WRITE ON THIS SIDE FIRST

ELIZABETH MUSOKE, M.D.
7399

Copeland, Sharen
6310 637 67
DOB: 3/8/64

AGE: 36 WEIGHT: 284
BP: 130/70 LMP: ?
10/16/00 G2 P1 AB1
Last Pap: 3/00
c/o: Contraceptive Consult
No menses since TAB 7/00.
Also c/o pelvic pain. Using condoms. Requests to resume OCP's.

PE: Deferred.

A/P: Amenorrhea / Obesity.
√ βHCG today.
Provera 10 mg x 10 d.
After normal menses, may resume Modicon. 2 f/u
Consider u/s if pain persists.

10/16/00 Addendum
βHCG positive. Message left for pt to call for results.
Quant pending.

KAISER PERMANENTE

PROGRESS NOTES CONFIDENTIAL

6310 63767
COPELAND, SHAREN
DOB: 3/8/64

DATE	VISIT/ PROB. #	WRITE ON OTHER SIDE FIRST
10/18/00		ELIZABETH MUSOKE, M.D. # 7339

AGE: 36yo. WEIGHT: ~~271~~ 271 Last. Rep 3/30/00

BP: 130/80 LMP: ?

G 3 P 1 AB 1

C/O: follow-up (Beta quant. SJ

Pt uncertain as to how far along she is. Had VIP 7/15/00.

Limited office sono: IUP @ 23 wks
(+) FHR

Asp: IUP @ 23 wks - probable
(failed VIP)
Begin PNC
OB sonogram ASAP.
OB labs today.

EM Musoke MD

Addendum
Pt called to report OB sono scheduled 11/1/00. Also is anemic
So encouraged to begin iron and PNV

SM

48003734 (4/96) Med. Rec.

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called clinic complications, when the patient is physically present at the clinic.

Q Okay. Can you read in the top portion of page 13?

A "Copeland, Sharen, 10-20-2000, referred by self," and then her address will be 37 Barberry Court, Upper Marlboro, telephone 301-499-5010. "Age 36, last normal menstrual period 4-24, gravida 3, para 1, abortion 1. Insurance, she paid in cash. Date of surgery, 7-18-2000. Surgeon, Dr. Linwood Turner. Size of gestation ten to 11 weeks.

"Nature of complaint, patient came in today accompanied by male significant other for counseling with Dr. Earl Horton.

"AB was missed on 7-18-2000," semi-colon, "patient's gestation was diagnosed at Kaiser-Permanente on 10-18-2000." Signed off, Caridad Wright, RN.

Q Can you read Dr. Horton's notes? I mean, if you can't read them --

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A I can.

Q Okay. Go ahead.

MR. HEFFLER: If there's any problem, any part that you're not sure of, don't try to guess at it.

MS. BARNETT: Right.

THE WITNESS: Begins with, "Patient and boyfriend, risks of pregnancy. Patient with missed AB and continuing pregnancy. Options discussed at length. Patient advised that I do not do late terminations, but referral given to patient for OB care," slash, "or termination. Earl Horton, M.D."

BY MS. BARNETT:

Q Okay. Were you present when Dr. Horton had the conversation with Miss Copeland and her significant other?

A Yes, I was.

Q Did you document your observations of that conversation on page 12?

A Yes, I did.

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Q Okay. Can you slowly read in your notes on October 20th, 2000 on page 12?

A "10-20-2000, 10:30 a.m. Patient and significant other were counseled by Dr. Earl Horton regarding their options available to them carrying the pregnancy to full term, as opposed to having an abortion. The patient inquired from Dr. Horton how the procedure could have been missed, and Dr. Horton replied that those are the risks involved in performing this type of procedure.

"Dr. Horton informed patient and male companion that there are procedures performed in the late mid-trimester such as the ENE and saline AD.

"Patient inquired as to partial birth, and Dr. Horton replied that this procedure is performed when pregnancy reaches term. The male companion had several questions about late mid-trimester procedures, and a brochure from Dr. Alan Klein of Philadelphia was given to them.

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"Dr. Horton stated that this could happen," enclosed in parentheses, "missed ~~AD.~~ AB And that the patient signed the consent form informing that the clinic will not be held responsible for costs.

"Patient and male companion left, seemingly satisfied with Dr. Horton's counseling. Caridad Wright, RN., 10-20-2000."

Q The last section that you read that Dr. Horton advised them that when they signed the consent form that said that the clinic will not be held responsible for costs. What costs?

A They were inquiring as to the costs for the late mid-trimester abortion.

Q Did you participate at all in the conversation or were you just present?

A I was present.

Q Okay. What did Dr. Horton advise them as to mid, late mid-trimester abortions?

A I said he informed them they can still go in and have this procedure done at this stage

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of the pregnancy.
Q He said, I don't do it, but you can have it done?
A Yes.
Q Did he give them any information as to the risks of a late mid-trimester abortion?
A No.
Q Just told them it was available?
A Yes.
Q When Dr. Horton discussed with them that one of the options was carrying the pregnancy to full term, did he discuss with them any potential complications or problems that could result from the missed or the incomplete termination?
A I cannot, I cannot answer that question, because I don't --
Q You don't recall whether he advised them as to any potential damage that could have been done to the fetus?
A I'm not sure.

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MR. HEFFLER: Well, don't guess. If you don't remember, you don't remember.
THE WITNESS: I don't remember, I don't remember.
BY MS. BARNETT:
Q And I think you told me earlier that while you've been at Hillcrest, this situation has never occurred?
A No.
Q So you wouldn't be able to tell me what Dr. Horton's normal conversations in a situation like this would be since it's never happened, to your knowledge?
A It's just that I could not remember, you know.
MR. HEFFLER: She's not asking about this conversation, she asked --
THE WITNESS: This conversation.
MR. HEFFLER: I don't know why she asked, but she said -- you said it's never happened before, and she said, so, therefore, you

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don't remember him discussing it happened before; is that correct?
THE WITNESS: I don't.
MR. HEFFLER: Okay.
MS. BARNETT: Actually, that was my question, but I think that her answer was the same.
BY MS. BARNETT:
Q The brochure for Dr. Alan Klein, what is that?
A It's a, what you call a handout that came from Dr. Alan Klein's office, from Philadelphia, which informs them that late mid-trimester procedures can be performed at different stages and the costs.
Q Did you make -- did Dr. Horton make any referrals to any other physicians or facilities other than Dr. Alan Klein with reference to a late mid-trimester abortion?
A No.
Q You still have the brochure from Dr.

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Alan Klein?
A Yes, we do.
Q Do you know whether or not that brochure discusses risks involved in a late mid-trimester abortion?
A No.
Q No, you don't know, or no, it does not?
A It does not discuss the risks.
Q Do you have a recollection of this visit with Miss Copeland?
A Yes.
Q Okay. Separate and apart from what's written, what do you recall, if anything?
MR. HEFFLER: Of anything other than what's written.
THE WITNESS: The two of them were, you know, were very congenial, that's what I remember.
BY MS. BARNETT:
Q How long do you think they spent discussing with Dr. Horton the explanation as to

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

SHAREN COPELAND, Individually and as Mother and Legal Guardian of Minor Plaintiff SYDNEE COPELAND,	:	
Plaintiff	:	**Case No. 1:02CV01290 TPJ**
v.	:	
HILLCREST WOMEN'S SURGI-CENTER	:	
Defendants	:	

AFFIDAVIT OF JUDITH G. HALL, M.D.

Under penalty of perjury I do hereby affirm and attest to the following:

1. My name is Dr. Judith Hall. I am a clinical geneticist and pediatrician. I am a Professor of Pediatrics and Medical Genetics at the University of British Columbia and British Columbia's Children's Hospital. I am a fellow of the American Board of Pediatrics, American Board of Medical Genetics and the American College of Medical Genetics. A copy of my curriculum vite is attached to this Affidavit and is incorporated herein as if set forth in full.

2. I have been retained as an expert witness on behalf of Plaintiff in the above captioned case. I expect to provide testimony as to the issues of causation and damages. I expect my testimony to be consistent with the information set forth in Plaintiff's Preliminary Expert Disclosures filed on June 26, 2003, and it is expressly incorporated herein as if set forth in full.

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Halperin & Long, P.L.L.C.
1919 M Street, NW
Suite 350
Washington, D.C. 20036
202-463-3030

3. Specifically, it is my opinion that Defendants' failed termination caused intrauterine vascular compromise to the minor Plaintiff, Sydnee Copeland, and this vascular compromise led to a failure of the anterior horn cells to develop, to decreased fetal movement, and ultimately caused Sydnee Copeland's club feet and hip dysphasia. Additionally, it is my opinion that the failed termination caused loss of amniotic fluid that compounded the effect of the vascular compromise. This resulted in temporary hypotension which led to hypoxia that then produced the limb defects, gastroenterological difficulties, improper lung development and prematurity that led to Sydnee's multiple injuries and damages.

4. It is my opinion that Sydnee's profound injuries and damages, as set forth in her medical records, were directly and proximately caused by the negligent attempted termination of Sharon Copeland's pregnancy on July 18, 2000.

5. It is also my opinion that at the time that Sharon Copeland presented to Hillcrest Women's Surgi-Center in October, 2000, and discussed the fact that Dr. Turner and the Center had failed to perform a successful termination on July 18, 2000, Defendants' had a duty to inform Ms. Copeland that due to vascular compromise during the negligent attempted termination, it was likely that if she continued the pregnancy, the child would be born with multiple congenital defects.

6. To the extent called upon, I am able to testify as to the validity of the opinions discussed by Defendants' Expert, Dr. Charlotte Lawson in her deposition. Specifically, I am prepared to discuss the validity of Dr. Lawson's theory that this was a twin pregnancy. It is my opinion that this was not a twin pregnancy, as evidenced by

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Halperin & Long, P.L.L.C.
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Suite 350
Washington, D.C. 20036
202-463-3030

the sonogram done at Kaiser Permanente on June 26, 2000, the sonogram done on July 18, 2000 by Dr. Turner, and both of the pelvic examinations performed on these dates.

FURTHER SAITH AFFIANT NOT.

I HEREBY DECLARE AND AFFIRM UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND AFTER CONDUCTING DILIGENT AND REASONABLY INVESTIGATION AND RESEARCH INTO THE MATTER SET FORTH ABOVE.

DATED: January 20, 2004.

JUDITH G. HALL, M.D.

Regan,
Halperin & Long, P.L.L.C.
1919 M Street, NW
Suite 350
Washington, D.C. 20036

202-463-3030

0310-63767

(L)

WASHINGTON HOSPITAL CENTER
DISCHARGE SUMMARY

PATIENT: Copeland, Sharen
ADMISSION DATE: 11/20/2000
DISCHARGE DATE: 12/04/2000
ATTENDING PHYSICIAN: MARK TRETIAK, MD

MEDICAL RECORD NO.: 128-18-76
DOB:
SSN:

CHIEF COMPLAINT: Rupture of membranes.

HISTORY OF PRESENT ILLNESS: This is a 36-year-old G3, P1-0-1-1, at 28 weeks and four days of gestation by 26-week ultrasound, who presented to Labor and Delivery with report of blood-tinged fluid for two days prior to admission with a continuous leakage of fluid. The patient denied contractions, fevers and chills, headaches, visual changes and edema and did note decreased fetal movement.

PAST HYPERTENSION: Hypertension for two years.

PAST SURGICAL HISTORY: C-section in 1994 for failure to dilate, elevated blood pressure noted during surgery. Baby was full-term and weight was 5 pounds, zero ounces.

ALLERGIES: No allergies.

MEDICATIONS: Calan 240 mg b.i.d., Vitron-C and prenatal vitamins.

SOCIAL HISTORY: The patient denied tobacco, alcohol and drug use.
FAMILY HISTORY: Positive for diabetes.

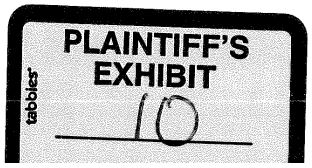
PRENATAL HISTORY OF THIS PREGNANCY: Significant for failed termination at 11 weeks. Patient had only two prenatal visits prior to admission.

PRENATAL LABS: Her hematocrit was 31. GC and Chlamydia were negative as well as syphilis, hepatitis B and HIV, all were negative. She was rubella immune. Blood group was O positive. Her Pap was normal, except limited by lack of endocervical cells and her one hour Glucola was 73. A baseline 24-hour urine protein was 120 mg. Baseline preeclamptic labs were within normal limits with a creatinine of 0.9. Blood pressures during her prenatal care were normal at 110/80.

PHYSICAL EXAMINATION: On presentation to Labor and Delivery, the patient's blood pressure was 225/116, which went down to 178/90. She was afebrile. Exam was essentially normal with a nontender abdomen, a fundal height of 28. Pelvic exam showed that the patient was grossly ruptured with positive Pool, Fern and Nitrazine. AFI was zero on sono and ultrasound showed a transverse lie. Estimated fetal weight consistent with dates. Cervix was thick and closed by speculum.

HOSPITAL COURSE: Patient was admitted to Labor and Delivery for ruptured membranes, for rule out preeclampsia. Betamethasone was given as well as ampicillin and erythromycin. Magnesium was not given because the patient was not contracting. Calan was continued and PIH labs were performed. Neonatology and Physical Therapy Consults were obtained. The patient had intermittent variables which were consistent with her lack of fluid. Blood pressure remained about 150/90 and sometimes came down to 120/70 or so.

Copy for MARK TRETIAK, MD



WASHINGTON HOSPITAL CENTER
DISCHARGE SUMMARY

PATIENT: Copeland, Sharen **MEDICAL RECORD NO.:** 128-18-76
ADMISSION DATE: 11/20/2000
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ATTENDING PHYSICIAN: MARK TRETIAK, MD

Initial labs showed a white count of 19, LFTs normal with a creatinine of 0.8, hematocrit 29 and a 24-hour urine total protein was 381 mg. Cervical cultures showed moderate G. vag. Urine culture was negative. Sonogram showed lack of stomach bubble and consistently short extremities.

Patient was observed on Labor and Delivery for variable decels, which always recovered. The longest one was about four minutes. Cervix remained thick and closed. Flagyl was added for G. vag. BPP was eight out of 10 on 11/24/00. On 11/27/00, the cervical exam progressed to 50 and 2 cm on digital exam. The digital exam was done because of pelvic pressure. As the patient's hospital stay progressed, she remained stable and was observed on the floor. Her urea Mycoplasma culture came back positive and she was already being treated with erythromycin for that. She completed her courses of antibiotics and continued observation. Sonos showed the position to be breech.

On 11/29/00, the patient noted cramping and contractions. She was monitored and found to be contracting. Digital exam was still 2 cm. She was still breech. She was sent to Labor and Delivery for observation and was found to be contracting still every three minutes. C-section was discussed versus vaginal delivery and it was decided to proceed with c-section. Classical c-section was performed under spinal anesthesia with Duramorph by Dr. Tretiak and Dr. Wolfe with a vertical incision. EBL was 1000 cc with a viable female infant, Apgars 8 and 9, who was sent intubated to the ICU. Breech presentation was noted. Placenta was spontaneous and intact. There was no sign of abruption. Tubes and ovaries were normal and there was 2-cm fibroid in the incision line. The placenta was sent to Pathology. The count was incorrect. Two instruments were missing. These were instruments which had not been used during the procedure and x-ray was taken after the procedure and found to be negative.

Postpartum care was remarkable for some elevated blood pressures. Calan was restarted. Magnesium was administered on Labor and Delivery. She developed a temperature to 101.6° and white count was 20. She was treated with antibiotics, ampicillin and gentamicin.

On hospital day #5, she was afebrile. Blood pressure was 118/74. She was noted to have a positive UA and treated with p.o. Keflex and sent home on this. She was also sent home on her previous medication of Calan. She was discharged home with Percocet and Keflex and instructed to follow up at Kaiser for staples. Discharged on postop day #7.

WASHINGTON HOSPITAL CENTER
DISCHARGE SUMMARY

PATIENT: Copeland, Sharen **MEDICAL RECORD NO.:** 128-18-76
ADMISSION DATE: 11/20/2000
DISCHARGE DATE: 12/04/2000
ATTENDING PHYSICIAN: MARK TRETIAK, MD

DICTATED BY MICHELLE D WOLFE, MD

SIGNATURE OF ATTENDING PHYSICIAN _____ DATE _____
MARK TRETIAK, MD

cc: MARK TRETIAK, MD
MICHELLE D WOLFE, MD
SR:mdi:ljs
D:01/29/2001
T:01/29/2001 4:02 P
Doc:244772
Job Number: 001638

[redacted]

WASHINGTON HOSPITAL CENTER

Progress Note: Epidural requested by Dr. Tretick

Allergies: NKDA

Medications: aldomet

Spinal HTN x 10 yrs.

Epidural placed by Robawbi

Age 36 Ht 5'3" Wt 286 Physical Status 1 (2) 3 4 5 (E)

Operating Room Time 0845 09 X 30 X 10 X 30 X 11 X

N₂0/0₂ 1/min Fm

ancef 1 gm

Ephedrine mg 5 | 5 | 10 Pitocin 20u ... Pitocin 20u

Fluid LR 1000 1500

Check List FiO₂

☒ Airway ☒ Suction SaO₂ 99 99 99 99 99 99 99 99 99 99

☒ Drugs ☒ Machine ECG SR SR SR SR ST SR SR SR SR SR

☒ Monitors ErCO₂

EBL 800 1000

☐ Ventilator T v ____ UO 150

Rate ___ PIP ___ Temp

Continous Epidural Flowsheet

Bupivicaine % Fentanyl ug/cc

Time	Comments	Signature
854	Spinal 0.75% Marcaine 1.5cc 20 mcg of Fentanyl 0.35 mg of Duramorph	
1145		

Temp ☐ Oral ☐ Skin

P ☒ Cuff (R) L

☐ Arterial R L

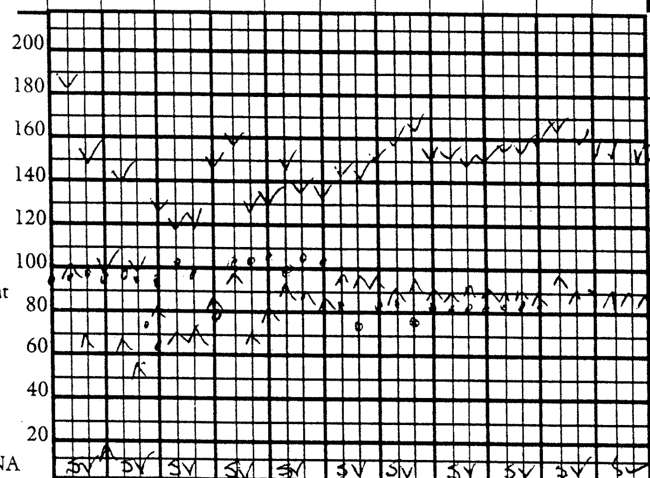
Stethoscope

☐ Precordial

☐ Esophageal

☐ NG ☐ OG

☒ L Uterine Displacement



Signature of Staff at Delivery:

Robawbi, MD

D Browning, CRNA

Time of Remarks

GENERAL

☐ Rapid Sequence

Blade ____

ETT Size ____

☐ Placement Confirmed

☐ BBS equal

☐ No difficulty

☐ Difficult

☐ Traumatic

REGIONAL

☐ Epidural ☒ Spinal

☐ Sterile Prep ☐ LOR

Needle Gauge 25 Space L4-L4

☒ Sitting ☐ Lateral

CSF ☒ yes ☐ no

Blood ☐ yes ☒ no

Paresthesia ☐ yes ☒ no

☐ Catheter inserted

RECOVERY

Time ____

☐ LDR

☒ PACU

☐ ICU

EBL 1000 mls

Urine output 150 mls

Fluids In 1

Report by:

BP 135/95

Pulse 1

Resp 14

Airway 1

SaO₂ 99 %

Procedure

☐ Vaginal Delivery

☒ Cesarean Section

☐ PP Tubal Ligation

☐ PP D&C

☐

Remarks In Rm 0847, monitors on, pt. in sitting pos for SAB. Then assisted supine.

0914: Classical incision made, feds present

0915: Live female birth

[illegible]

[illegible]

Finish time: 1035

Wait for X-RAY – ? instrument count

☐ Epidural catheter removed intact by:

OBSTETRICAL

ANESTHESIA RECORD

DATE 11/29/00

Page 1 **of** 1

11/20/00
COPELAND, SHAREN
128-18-76 F 03/08/1964
COOPER, WILLIAM A.
13086376
DR12-P

FORM 237 R/8/94

The following Legend is to be used

for documentation of intra-operative

events:

	START	STOP
ANES.	A	X
OPER.	⊙	O

INTUBATION - I
EXTUBATION - E

MAP = X

	CUFF		ART.
B.P	V	SYS.	Y
	Λ	DIAST	Λ
PULSE			●
RESP.			o
SPONT.			s
ASSIST.			a
CONTROL			c
VENTIL.			v

WASHINGTON HOSPITAL CENTER
OB OPERATIVE COUNT SHEET

	First		Final
KNIFE HANDLES	2		2
KNIFE BLADES	2		2
FORCEPS, SMOOTH	2		
FORCEPS, W/TEETH	2		
FORCEPS, RUSSIAN	3		
FORCEPS, ADSON	2		
HEMOSTATS, CURVED	6		6
STRAIGHT	2		2
KELLYS, SHORT	8		8
LONG	2		2
ALLIS CLAMPS, SHORT	4		4
LONG	4		4
BABCOCKS, SHORT	2		2
LONG	/		
KOCHERS, STRAIGHT	2		2
NEEDLE HOLDERS	6		6
SPONGE STICKS	8		8
SCISSORS	5		5
TOWEL CLIPS	4		4
RETRACTORS	7		7
OB SIMPSONS	1		1

	First		Final
SUCTION TIPS	1		
BOVIE TIPS	1		
REELS			
NEEDLES	5	4+2+1+2=	
		10+1 (11)	
TAPES	15	+5	(20)
4 X 4S	10		(10)
OTHER			
ADAIR CLAMP	6		6

Circulating Personnel	Scrub Personnel	Comments:
First: [illegible]	First: Patricia Evans - CST	
Relief:	Relief:	
Final:	Final:	
Signature	Signature	

Patient ID

11/20/00
COPELAND , SHAREN
128-18-76 F 03/08/1964
COOPER, WILLIAM A.
13086376
DR08-P

Form 982 11/00 (Trial)

WASHINGTON HOSPITAL CENTER
MedStar Health

Operating Room – Nursing Record

Date 11/29/00 | OR Room No. 1 | Allergies NKDA | Blood Prod. Avail.

Patient in Room 0847 | Procedure Began 0908 | Procedure Ended 1035 | Patient Out of Room 1153

POSITIONING

Position: ☒ Supine ❑ Prone ❑ Lateral ↑R ↑L ❑ Lithotomy ❑ Jackknife ❑ Other:

☒ Armboards (R) (L)	❑ Hand Table	❑ Bean Bag	❑ Lateral Roll
❑ Arms Tucked R L	❑ Headrest	❑ Chest Rolls	❑ Shoulder Roll
☒ Safety Strap (R) (L)	❑ Frame	❑ Egg Crate	❑ Leg Rolls
❑ Kidney Rest R L	❑ Stirrups	❑ Axillary Rolls	❑ Other:

Shave By: E. Fagan MAPC RN | Skin Prep: Betadine / alcohol | By: C Brathwaite RN

Preprocedure Diagnosis preterm labor @ 29 wks, PROM, repeat c-section

Postprocedure Diagnosis same

Procedure Title or Description Repeat c/sec

Anesthesiologist Rebi B / Browning | SRNA Anesthetist ~~Rubin~~ | Type of Anesthesia SPINAL

Scrub Personnel	In	Out	In	Out	Circulating Nurse	In	Out	In	Out
P. Evans	0847	1153			C Brathwaite RN	0908	1153		
					A. Essien RN	0908	1000		

Entry of the physician's name on this document indicates the physician's presence during the procedure

Surgeons	Assistant 1	Assistant 2	Assistant 3
TRETIAK	Wolfe	Ennen MS III	—

INTAKE

Total Crystalloid Intake 1200 cc
Packed Cells
Albumin
Hespan
FFP
Platelets
Other
Total Colloid Intake cc

OUTPUT

Total Urinary 150 cc
EBL 1000 cc
Other cc
Other cc

DRAINS ❑ N/A

Type	Size	Location
Foley	16F	Bladder by: E. Plum RN
Chest Tube	⊘	Mediastinum
		Pleura R L
Salem Sump	⊘	Stomach
Hemovac	⊘	

BIO-MED EQUIPMENT USED

ESU/PAD No(s): Lot #48343 Valleylab bovie pad
Applied By:
R/A: (R/L) thigh L/A: L/L: Other:

Description	Bio Med#	Description	Bio Med #
ESU		Tourniquet ⊘	
ESU Pad Sensor			
Bipolar			
Hypo/Hyper			
SCD			

Tourniquet: Applied by: ⊘ Location:
Up Down Pressure @

DRESSINGS & IMPLANTS Type/Location

Packing ❑ Yes ☒ No
Cast/Splint ❑ Yes ☒ No
Implant ❑ Yes ☒ No ❑ See Attached Implant Record

COUNTS

Instrument Count Correct	❑ Yes	☒ No	❑ N/A
Sharps & Small Supplies Count Correct	☒ Yes	❑ No	❑ N/A
Sponge/Tape Count Correct	☒ Yes	❑ No	❑ N/A

SPECIMENS

Permanent/Fresh ❑ Yes ❑ No | Culture ❑ Yes ❑ No
Frozen ❑ Yes ❑ No | Cytology ☒ Yes ❑ No — blood

WOUND CLASSIFICATION

☒ Clean ❑ Clean Contaminated ❑ Contaminated ❑ Dirty

ASA CLASSIFICATION

❑ I ☒ II ❑ III ❑ IV ❑ V

Notes (Donor Site, Lot Nos., etc.)
0905: FHT 140's ā abdominal prep. C Brathwaite
Final count incorrect. Pt awaiting
Stat abdominal X ray. Dr Tretiak @ B.
Incision closed ē staples & covered
c̄ sterile blue cloth.
Abd X ray done. No foreign objects noted

DATE PATIENT INFORMATION
Copeland Sharon

COPELAND ,SHAREN
STS IA SEX: F 5F 5F15-P
13086376 MR# 128-18-76
OR# 1 11/20/00 22:20
COOPER, WILLIAM A.

White: Patient's Chart · Green: O.R. Copy · Yellow: Physician's Copy

TRIAL FORM 413 Exp. 7/99

5630

WASHINGTON HOSPITAL CENTER
OPERATIVE REPORT

PATIENT: Copeland, Sharen
MEDICAL RECORD NO. 128-18-76
OPERATION DATE: 11/29/2000
DATE OF BIRTH: 03/08/1964
SURGEON: MARK TRETIAK, MD
SSN: 579-98-4450
FIRST ASSISTANT: MICHELLE D WOLFE, MD
SECOND ASSISTANT:

PREOPERATIVE DIAGNOSIS:	30 WEEKS FROM ZERO DATE OF INTRAUTERINE PREGNANCY; PRETERM LABOR; PROLONGED PRE-TERM RUPTURE OF MEMBRANES; BREECH PRESENTATION, IN ACTIVE LABOR.
POSTOPERATIVE DIAGNOSIS:	30 WEEKS FROM ZERO DATE OF INTRAUTERINE PREGNANCY; PRETERM LABOR; PROLONGED PRE-TERM RUPTURE OF MEMBRANES; BREECH PRESENTATION, IN ACTIVE LABOR.
OPERATION TITLE OR DESCRIPTION:	CLASSICAL CESAREAN SECTION.

ANESTHESIA: Spinal anesthesia with Duramorph.

ESTIMATED BLOOD LOSS: 1,000 cc.

URINE OUTPUT: 150 cc.

INTRAVENOUS FLUIDS: 1,500 cc of lactated Ringer's solution.

OPERATIVE FINDINGS: Viable female infant with Apgars of 7 and 8. To the Neonatal Intensive Care Unit intubated. No nuchal cord, breech presentation. LFP. Placenta spontaneous and intact, no signs of abruption. Normal tubes and ovaries; 2.0 cm fibroids anteriorly in the incision line.

Chart Copy

WASHINGTON HOSPITAL CENTER
OPERATIVE REPORT

PATIENT: Copeland, Sharen **MEDICAL RECORD NO.** 128-18-76
OPERATION DATE: 11/29/2000

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room where spinal anesthesia was administered. She was prepped and draped in the normal sterile fashion in the dorsal supine position with a leftward tilt. A vertical skin incision was made with a scalpel and carried through to the underlying layer of fascia with a scalpel. The fascia was incised and the incision was extended with the scalpel and the Bovie electrocautery. The rectus muscles were dissected off the fascia and the peritoneum was entered bluntly. The incision was extended by stretching. The bladder blade was then inserted and the vesicouterine peritoneum was identified, grasped with the pickups and entered sharply with the Metzenbaum scissors. This incision was extended laterally and the bladder flap was created digitally. The bladder blade was then reinserted and the uterus was incised in a vertical fashion up to the fundus. The incision was started at the lower uterine segment and extended superiorly with the bandage scissors. The bladder blade was removed. The infant's sacrum was delivered and the head was also delivered, atraumatically. The mouth and nose were suctioned with the bulb suction. The cord was clamped and cut. The infant was handed to the waiting pediatricians. Cord gasses and placenta were sent. The placenta was removed manually. The uterus was exteriorized and cleared of all clots and debris. The uterine incision was repaired with #1 Monocryl in a running, locked fashion in three layers. Good hemostasis was achieved after a few figure-of-eight sutures with #1-0 chromic. The gutters were cleared of all clots. The fascia and peritoneum were all closed in a mass closure with PDS. The skin was closed with staples. The patient tolerated the procedure well. All counts were correct. The patient received Ancef after cord clamping. The patient was taken to the recovery room in stable condition.

Key portion(s) of the procedure were performed in my presence.

DICTATED BY MICHELLE D WOLFE, MD

SIGNATURE OF SURGEON _____ DATE 1/24/01
MARK TRETIAK, MD

cc: WILLIAM A COOPER, MD
MARK TRETIAK, MD
MICHELLE D WOLFE, MD

SR:mdi:nap
D: 11/29/2000
T: 11/30/2000 4:34 A
Doc: 235763
Job Number: 003638

Chart Copy

5430

WASHINGTON HOSPITAL CENTER
OPERATIVE REPORT

PATIENT: Copeland, Sharen
MEDICAL RECORD NO. 128-18-76
OPERATION DATE: 11/29/2000
DATE OF BIRTH: 03/08/1964
SURGEON: MARK TRETIAK, MD
SSN: 579-98-4450
FIRST ASSISTANT: MICHELLE D WOLFE, MD
SECOND ASSISTANT:

PREOPERATIVE DIAGNOSIS:

POSTOPERATIVE DIAGNOSIS:

OPERATION TITLE OR DESCRIPTION:

ADDENDUM: At the end of the procedure the instrument count was incorrect. Two instruments were missing. These instruments had not been used during the procedure. The abdomen was searched and the tray and drapes were searched. The patient's abdomen was closed at this point and an x-ray was ordered. The x-ray was completed postoperatively and no instruments were found in the abdomen.

Key portion(s) of the procedure were performed in my presence.

DICTATED BY MICHELLE D WOLFE, MD

SIGNATURE OF SURGEON _____ DATE 1/24/01
MARK TRETIAK, MD

cc: WILLIAM A COOPER, MD
MICHELLE D WOLFE, MD

SR:mdi:sjh
D: 11/29/2000
T: 11/30/2000 7:16 A
Doc: 235846
Job Number: 003646

Chart Copy

WASHINGTON HOSPITAL CENTER
MedStar Health

LABOR SUMMARY

Type & Rh: O+

G	T	P	A	L
3	1	0	0/1	1

Allergies: NKDA
Age: 36 Race: AA
Insurance: Kaiser
Marital Status: ☐ M ☒ S ☐ D ☐ W

EDC 2/7/01 LMP 4/ /00
Gestation 28 6/7 weeks

Presentation
☐ Vertex ☐ Breech
☒ Transverse Lie ☐ Unknown

Sonogram in L&D
Date: 11/20/00 Time: 2200
Results: AFI - 0; ant. placenta; oblique breech to transverse lie; 28[6]

Pregnancy Complications: Chronic HTN; PPROM

Induction: Date:
Oxytocin ☐ Time:
Cervidil ☐ Time:

Augment Date:
Oxytocin Time:

Monitor FHT UC Time:
External ☒ ☒
Internal ☐ ☐

Amniofusion

DELIVERY DATA

Final Position R S A

Cephalic
☐ Spontaneous ☐ Mid Forceps
☐ Low Forceps ☐ Vacuum Ext
Rotation ____ to ____

Breech
☐ Spontaneous ☒ Total Ext
☐ Partial Ext ☐ Forceps to AC Head

Cesarean
☐ Primary ☒ Repeat
☐ Low Transverse ☐ Low Vertical
☐ Classical

Placenta
☐ Spontaneous
☐ Expressed
☒ Manual
☐ Adherent
☐ UT. Exploration
☐ Complete
EBL ☐ < 500 cc ☒ > 500 cc 1000 cc

Appearance of Placenta
☐ Normal
☐ Abnormal: ____
☒ To Pathology

Cord
☐ Nuchal Cord x ____
☐ True Knot
Umbilical Vessels ☐ 2 ☒ 3
Cord Blood to Lab ☐ Yes ☒ No

Episiotomy ☒ None
☐ Median ☐ Mediolateral

Laceration ☒ None
Degree Perineal ☐ 1 ☐ 2 ☐ 3 ☐ 4
☐ Vaginal ☐ Cervical ☐ Peri-Urethral

Attending Physician/Midwife at Delivery
Name: Kaiser/TRETIAK
Signature: Date: 11/29/00

Delivery Room Meds ☐ None

Drug:	Dose:	Route:
Pitocin	20u	IV
Sig: By D Rubabi		Time: 0916
Drug:	Dose:	Route:
Sig:		Time:

Anesthesia
☐ None ☐ Local
☐ Pudendal ☐ Epidural
☒ Spinal ☐ General
Time Start: 0847 End: ____
Anesthesiologist: ☒ CRNA: Rubabi Browning SRNA

	M	D	Y	Time:
Admit to Hospital	11	20	00	2200
Membranes Ruptured	11	18	00	1300
Onset of Labor	11	29	00	0700
Complete Dilatation				
Delivery of Infant	11	29	00	0915
Delivery Placenta	11	29	00	0916

Duration of Ruptured Membranes
____ H ____ M
☒ Spontaneous ☐ Artificial
☒ Clear ☐ Meconium

Duration of Labor
1st Stage ____ H ____ M
2nd Stage ____ H ____ M
3rd Stage ____ H 01 M

Resident
Name: Wolfe
Signature: Date:
Name: Med Student Ennen
Signature: Date:

INFANT DATA

APGAR

	Heart Rate	Respiratory	Muscle Tone	Reflex	Skin Color	Total
1 min	2	2	2	1	0	7
5 min	2	2	2	1	1	8

Resuscitation ☐ None
☒ Bulb ☐ O_2
☒ Bag & Mask
☒ Intubation
☐ Ext. Card Massage
Resuscitation Index: 4

BASIC DATA
ID Bracelet # 90748
Aquamephyton .5mg Dose
☐ Male ☒ Female

Birth Order
1 of ☒ 1 ☐ 2 ☐ 3 ☐ 4

Weight
grams 1090 lbs./oz. 2#6.2

Output ☐ Urine ☐ Meconium

Feeding ☐ Breast ☒ Bottle

To ICU 5A Nursery

Neonatologist at Delivery
PARK

Attending Pediatrician
Kaiser

Comments
Betamethasone
11/20 12mg @ 0001
Cord gases sent Tab

Nurse Name: Strathwaite RN
Signature: Date:
Nurse Name: ☒ Essien RN
Signature: Date:

Medications in Labor

Date	Time	Medication	Dose	Route	Initials
ated	11/21	Amp x ___ doses			
ted	11/21	Reglan x ___ doses			
ted	11/21	Erythromycin x ___ doses			

LABOR AND DELIVERY SUMMARY RECORD

DATE

White: Mother Chart
Yellow: Infant Chart
Pink: Delivery Room Copy
Gold: Physician's Copy

ADDRESSOGRAPH
11/20/00
COPELAND, SHARON
128-18-76 F 03/08/1964
COOPER, WILLIAM A.
13086376
DR11-P

FORM 1002 REV. 1/98

Washington Hospital Center

Date:

1000cc LR IVF	IV meds IVF	IVF	IVF	P.O.	Hour Total	Cum Total	Time	Cum Total	Urine	Blood	Emesis	Other
							08					
							09					
							10					
							11					
							12					
							13					
							14					
							15					
							16					
							17					
							18					
							19					
							20					
							21					
							22					
							23					
							24					
100	200				300	300	01	100	100			
125					125	425	02	160	60			
125					125	550	03	200	40			
125					125	675	04	230	30			
125	100				225	900	05	580	350			
125					125	1025	06	780	200			
125	100				225	1250	07	880	100			
24 HOUR INTAKE					1250			880	OUTPUT			

Urine Specific Gravity q shift	07-15	15-23	23-07

	Test	Time 2300			
	Mg++ Level				
PRO B	Blood Sugar				
PRO B	BUN				
PRO B	Creatinine				
PRO B	Na+ / K+				
PRO B	Cl / CO2				
PRO C	Ca / Phos				
PRO C	Uric Acid				
PRO C	Total Bili				
PRO C	Alk. Phos				
PRO C	SGOT / ALT				
PRO C	SGPT / AST				
PRO C	LDH				
PRO C	Total Protein / Albumin				
CBC	WBC				
CBC	Hg				
CBC	Hct				
CBC	Platelets				
Coags	PT / PTT				
Coags	Thrombin Time				
Coags	Fibrinogen				
Coags	D Dimer				
Coags					
Other					
Other					
Other					
Other					
Other					

Date	Time	IV Device started	Location	Initials	IV Site Assessment	Date	Time	Initials
11/21	2330	#18g angio	(L) hand	TG				

Start Date	Time	Solution & Additives	Initials	End Date	Time	Volume Infused	Initials
#1 11/20	2330	1000cc LR	TG				

Signature and Title	Initials
R. Stanley, RN	RS
T. Freeman	TG
[illegible], RN	[illegible]

11/20/00
COPELAND, SHAREN
128-18-76 F 03/08/1964
COOPER, WILLIAM A.
13086376
DR11-P

PRELIMINARY

LIFE CARE PLAN

CLIENT: Sydnee Copeland

DATE OF BIRTH: November 29, 2000

Prepared by: Sharon L. Reavis, R.N., M.S., C.R.C., C.C.M.

June, 2003

INTRODUCTION

Sydnee Copeland is a two-year-old female, who was born prematurely on 11/29/00 pursuant to an incomplete abortion. Sydnee now demonstrates a number of sequelae with developmental delay and severe pulmonary disease, as well as orthopedic anomalies. She has, nonetheless, progressed extraordinarily; and although she does continue to manifest a number of serious medical sequelae, she has the ability to retain quality of life and would benefit from a comprehensive plan of care to detail those services necessary to insure her highest functional level.

Sydnee Copeland lives with her mother, Sharen Copeland, in Largo, Maryland. Ms. Copeland is a single mother employed by the U.S. Department of Commerce, who works full-time. Sydnee does have one older sibling, Shelby, who is age nine and a third grade honor roll student in the Maryland school system. As previously mentioned, Sydnee's medical complications are significant and she does require continuous care of a skilled nature. Her mother is extremely involved in her caretaking and in educating herself regarding Sydnee's ongoing needs as well. Sydnee has benefited from the ongoing medical care she has received and continues to require additional medical care, supportive services, and therapeutic, as well as medical interventions to reach her highest level of independence within the confines of her disability. The following plan describes her medical history, her current status, and outlines those services she will require.

MEDICAL HISTORY

Ms. Sharon Copeland presented to Hillcrest Surgi-Center on 07/18/00 for a therapeutic abortion. Dr. Linwood Turner performed the procedure, and noted embryonic tissue and no complications.

On 08/01/00, Ms. Copeland returned to the Surgi-Center and completed the follow-up form. She noted that post procedure, she bled for 2 days; however, the bleeding was less than her normal period. Dr. Turner completed his portion of the form and noted there were no retained products, and that Ms. Copeland was no longer pregnant.

On 10/19/00, Ms. Copeland called the Surgi-Center and notified them that she was seen at Kaiser the day before, and was informed that she was approximately 7 months pregnant.

On 10/20/00, Dr. Earl Horton provided counseling to Ms. Copeland and her significant other, regarding risks of the pregnancy and their options. He informed Ms. Copeland that he did not do late term abortions, but referred her for obstetrical care.

Ms. Copeland's membranes ruptured on 11/18/00 at 1300, and she was admitted to Washington Hospital Center on 11/20/00 at 2200.

An ultrasound was performed on 11/21/00, which indicated an estimated date of confinement of 04/25/00, and estimated date of delivery of 02/07/01.

An 11/28/00 Fetal Assessment Report indicated a total score of eight.

On 11/29/00 at 0915, Sydnee Copeland was born via C-section with Apgar scores of 7 and 8 at one and five minutes, respectively. Sydnee's birth weight was 2 lbs. 6.2 ounces, length was 38 cm, and head circumference was 28 cm. Gestational age was 28-29 weeks.

Due to cyanosis and mild subcostal retractions, Sydnee was intubated and resuscitated with IPPB, however, was extubated on admission to NICU and placed on nasal CPAP. By 11/30/00, she was advanced to nasal cannula O2.

Head sonograms performed on 11/30/00 and 12/07/00 were normal. Sydnee was evaluated by Orthopaedics on 12/14/00 and diagnosed with bilateral talipes equinovarus, treated with splints; and left hip dysplasia, treated with double diapers.

Due to continued episodes of bradycardia and apnea, bag and mask ventilation were required, as well as brief intubation from 01/13/01 to 01/15/01. These symptoms were thought to be from severe gastroesophageal reflux disease and inability to control

secretions. Because of increasing bradycardia and apnea, Sydnee had to be intubated again on 02/04/01. A 2.0 ETT was used due to marked distortion of airway.

Initially, Sydnee received TPN and lipids intravenously, but was slowly advanced to NG feeds, which she tolerated sporadically. A barium swallow on 01/02/01 demonstrated severe GERD, necessitating a GI consult with Dr. Mohan, and GER regime of Zantac, Robinul, Maalox, and Reglan. At the time of transfer, Sydnee was being evaluated by Dr. Powell and Dr. Newman for G-tube/fundoplication.

Genetically, chromosomes were normal and no deformities were diagnosed by Children's Hospital National Medical Center Genetics Department.

Infectious Disease was consulted, and Sydnee was prescribed intravenous Ampicillin and Cefotaxime for suspected sepsis at birth.

An eye exam on 01/17/01 revealed immature retina Zone II.

On 02/05/01, Sydnee was transferred to Children's Hospital National Medical Center for tracheostomy, and evaluation for G-tube and Nissan procedure.

On 02/05/01, Sydnee was admitted to the Children's Hospital National Medical Center under the services of Dr. K. Rais Bahrami. Diagnoses included GE Reflux, Bilateral Club Feet, Hip Dysplasia, Upper Airway Obstruction, Respiratory Distress Syndrome, and Upper Airway Obstruction. Sydnee remained on the ventilator 02/05/01 through 02/07/01, received CPAP from 02/08/01 to 02/10/01, and was placed back on the ventilator 02/10/01 and 02/11/01.

Sydnee was an inpatient at The Hospital For Sick Children from 03/15/01 through 09/05/01, at which time she was discharged home with her mother. Upon discharge, Sydnee's weight was 3.76 kg, length 52 cm, and head circumference 40 cm. Sydnee was afebrile, vital signs were stable, and she had a #3.0 Neonatal Shiley tracheostomy tube in place. Cardiovascularly, Sydnee's heart rate and rhythm was regular with no murmurs. Lung sounds revealed good bilateral air movement and transmitted course breath sounds throughout. Sydnee's abdomen was soft, non-tender, and non-distended with no masses. Granulation tissue around the GT stoma was resolved and the surrounding area of her site was clean. Minimal crusting of her GT insertion site was noted, but no active drainage. Sydnee exhibited arthrogrypotic positioning of her legs. Sydnee was to follow-up with the following physicians:

1. Dr. Nicole Rochester, General Pediatrics.
2. Dr. Michael Thomas, Orthopaedics, CNMC.
3. Dr. James Gilbert, Neuromuscular, for evaluation and EMG/NCS.

4. Dr. Maybodi, Ophthalmology.

Dr. Elaine Ziavras examined Sydnee on 10/02/01 and noted no ROP, strabismus or myopia.

On 11/12/01, Sydnee presented to Dr. Samuel Rosenberg of the Pediatric Pulmonary and Asthma Center regarding repeated episodes of tracheitis with wheezing, one of which required hospitalization to Children's Hospital. Dr. Rosenberg noted Sydnee was fed exclusively through a gastrostomy tube. He discussed respiratory issues at length with Sydnee's mother and her home nurse, and noted Sydnee would benefit from more aggressive RAD (reactive airway disease) therapy, and recommended discontinuing Intal in favor of daily Pulmicort 0.25mg nebulized. An influenza vaccine was recommended, as well, and follow-up in 3 months.

Between September 2001 and December 2001, Sydnee presented to Dr. Rochester several times for tracheitis and bronchitis, as well as an 8-day inpatient hospitalization for tracheitis.

On 01/08/02, an EEG interpretation was normal during sedated sleep and brief waking. This Eeg was performed because of a several week history of left leg shaking.

In January 2002, Sydnee reportedly underwent left hip open reduction and internal fixation with femoral traction pin and

application of spica cast, performed by Dr. Zeleska at Children's National Medical Center.

Sydnee returned to see Dr. Rosenberg on 03/11/02. Sydnee's weight was 17 lb 9 oz, and her respiratory rate was 28 and unlabored. Sydnee's mother reported no significant respiratory problems except occasional tracheitis treated with antibiotics. Dr. Rosenberg expressed concern that Sydnee had a very small tracheostomy in place, which he noted was essentially for secretion clearance. Sydnee's mother was asked to call Dr. Pena to inquire if a bigger tracheostomy would be more appropriate. A follow-up visit in 3 months was recommended.

Between January 2002 and July 2002, Sydnee presented to Dr. Rochester on an average of 1x/month for pneumonia, otitis media, and viral illness. Additionally, she was hospitalized twice for 3-day stays for increased tracheal secretions and hypoxia.

Dr. Rochester and Dr. Rosenberg discussed placing Sydnee on Robinul in July 2002. On 07/31/02, Sydnee's mother reported Sydnee's secretions were decreased on Robinul.

During 08/02, Sydnee's G-tube came out and she had to go to CNMC ER where they replaced the 14 FR Mickey with a 12 FR catheter with much difficulty. She later followed up with Ginny Gebus on 09/09/02; and Ms. Gebus was unable to reinsert PEG

despite multiple attempts. Sydnee was to continue with the catheter in place.

Sydnee presented to Dr. E. Ziavras, Ophthalmologist, on 10/02/02 for what appeared to be a routine exam. Sydnee was noted to be very uncooperative during the exam. Bilateral ptosis was noted; however, extraocular movements were intact, pupils were equal and reacted to light, and there was no strabismus or myopia. Sydnee was to follow-up in one year.

Dr. Rochester noted in a phone encounter on 10/22/02 that Dr. Zeleske recommended braces for Sydnee's feet; however, Sydnee did not have benefits for braces.

On 11/19/02, Sydnee presented for a well child check with Dr. Rochester. Course upper airway sounds were noted, as well as decreased flexion and abduction of the left hip. Sydnee continued with no gag reflex.

On 03/10/03, Sydnee presented to Dr. Rosenberg after a year of not requiring any antibiotics and no significant wheezing episodes. Sydnee's physical examination was significant for a 3.5 tracheostomy in place, and oxygen saturation on room air was 98%. Dr. Rosenberg made no changes in Sydnee's regime. Follow-up in 6 months was recommended.

In March of 2003, Dr. Rochester provided referrals for continued outpatient physical therapy and occupational therapy at Children's National Medical Center. Physician orders were for physical therapy 2x/week, occupational therapy 2x/week, and speech therapy 3x/week.

On 03/13/03, Karen Longo MA, CCC-A evaluated Sydnee's hearing and noted she was involved in the Infant/Toddler Program in PG County. Responses to narrow band noise and speech appeared to be elevated when testing was done in sound field. Response to speech was 30-35db and narrow band noise was 35-50db. Immittance appeared to show flat tympanograms Au. Retesting was recommended in 3 weeks; and if Sydnee continued with flat tymps and elevated thresholds, she would see an ENT the same day.

Sydnee received skilled nursing care from AATHOME PEDIATRIC NURSING TEAM. A full body assessment is done each shift, significant for a 14 french G-tube, bilateral AFOs, room air oxygen and humidified mist via trach collar, and no suck reflex. It was noted that Sydnee receives Pediasure 200cc at midnight, 0600, 1230, and once during the evening shift, which her mom would provide. Pediasure is followed by 40cc of water. Vital signs are taken once a shift and appear to be stable.

Sydnee presented to Dr. Nicole Rochester on 04/29/03. She was status post left clubfoot surgery on 04/28/03, as well as status post surgery for bilateral hip dysplasia. Medical history

was significant for GERD, status post Nissen/G tube. Medications included Albuterol nebulizer solution 2.5 mg/2ml 1 vial daily, Robinul 1 mg via G-tube 3x/day, Tylenol with Codeine, Bacitracin to trach site, and Nystatin cream to G-tube. Sydnee's mom reported a mild odor to secretions; however, the home nurse did not note this. A culture of tracheal secretions isolated Proteus Mirabilis and antibiotics were prescribed. Sydnee's weight was 26.5 lbs. She received Pediasure 200cc via pump and G-tube 4x/day. Dr. Rochester noted no illnesses, but performed a tracheal culture.

On 05/13/03 and 05/14/03, Sydnee was evaluated through the Maryland Individualized Family Service Plan. Sydnee's chronological age was 29 months and her level of development was at the following age levels:

- Cognitive: 15 months, doesn't attend to one activity for more than a few seconds.
- Communication:
  - Receptive: 13 months, follows some 1-step commands.
  - Expressive: 12 months, uses some gestures and some vocalizations.
- Social-Emotional: 13 months, friendly, plays near other children, says "hi" and "bye".
- Adaptive: 7 months, receives nutrition through G-tube.

- Gross Motor: 10 months; recently had heel cord lengthening on the left & casted; began practicing walking in posterior walker.
- Fine Motor: 17-18 months, builds a two-cube tower, spontaneously scribbles.

Sydnee attends Toddler Group at the H. Winship Wheatley Early Childhood Center and is to begin Pre-school in the September 2003. Sydnee receives the following services:

1. Special Instruction by Preschool Educator, 4-5 times/week for 150 minutes each at ECC.
2. Special Instruction by JoAnn Coronel, YRS Educator, 1x/every other month at home, and 6x/mo for 150 minutes each by PGCPS at ECC.
3. Physical Therapy by PGCPS at ECC 3x/mo for 60 minutes each, and 1x/every other month at home for 60 minutes, each visit by Sue Wise/YRS Physical Therapy. Beginning 08/25/03, Sydnee is to receive physical therapy 1x/week for 30 minutes each through PGCPS.
4. Transportation by PGSPS Bus Driver 4-5x/weekly.
5. Speech Therapy (Group) 1x/week for 30 minutes by PGCPS.

The following goals were set for Sydnee with an initiation date of 11/29/03:

1. Improve cognitive skills from the 20 months developmental level to the 24 months developmental level.
2. Improve gross motor skills from the 12 months developmental level to the 18 months developmental level.
3. Improve adaptive skills from the 13 months developmental level to the 22 months developmental level.
4. Improve fine motor skills from the 15 months developmental level to the 24 months developmental level.
5. Improve personal/social skills from the 17 months developmental level to the 22 months developmental level.
6. Improve receptive language skills from the 12 months developmental level to the 20 months developmental level.
7. Improve expressive language skills from the 12 months developmental level to the 15 months developmental level.

CURRENT STATUS

Sydnee Copeland presents as a well-nourished female who weighs approximately 26 lbs. and is 34 inches tall. Sydnee does attend pre-school on Tuesday and Fridays and receives therapeutic intervention within the classroom, as well as private therapies at Children's Hospital on Wednesday of each week to include physical therapy, occupational therapy, and speech therapy. Sydnee has a nurse that attends her during the day and night time hours, and the nurse does provide services within her school setting as well, traveling with her on the school van. Sydnee will attend this school until age five when she will transition into the Public School System.

Sydnee's developmental milestones included crawling at age two, and standing with support at age two as well. She is currently cruising and is taking independent steps post orthopedic revision of equinovarus. She was able to turn over completely from supine to prone and prone to supine before age two.

At present, Sydnee is dependent in all activities including dressing and hygiene. However, she is able to assist with dressing by raising her arms, etc. She is fed presently by a Mic-Key button, receiving Pediasure, which is pumped four times daily requiring approximately one hour for the nutritional supplement to be pumped. She did receive a barium swallow

approximately a year ago and has had a Nissan Fundoplication, which occurred in 2001. She does not receive recreational feedings, and barium swallows do not suggest the immediate removal of the gastrostomy tube. Moreover, she demonstrates a limited gag reflex. Sydnee is currently continuing to utilize diapers and has no difficulty with bowel movements.

A tracheostomy is present and trach care is required daily. Sydnee does require suctioning to clear the tracheostomy, and she is unable to swallow secretions. On a typical day, she requires suctioning four to six times unless she has an upper respiratory infection, which necessitates additional suctioning. Deep suctioning is necessary, and the tracheostomy is cleaned and irrigated with saline twice daily as well. Sydnee has undergone regular bronchoscopies; however, secretions are so significant as to interfere with visualization. Nebulizations are necessary as well and do require ongoing medication.

Oxygen supplementation is usually not necessary unless congestion or upper respiratory infections are present. Sydnee does retain the necessary O2 equipment, which is transportable to school as well.

As previously mentioned, Sydnee demonstrates equinovarus and the left foot has recently been revised orthopedically. She is upright in a cast at present and is doing extremely well. She previously displayed hip dysplasia, which was surgically

corrected. Scoliosis will be followed, as well, and she will require bracing for a period of time to maintain positioning and ambulation. Bracing may be required permanently and truncal weakness may interfere with ambulation.

Sydnee's auditory and visual skills appear to be adequate; however, auditory screening has been recommended. She does recognize her mother and caretakers, and is extremely social and receptive to interventions by others. Moreover, she uses a passey muir valve and can attempt words such as "bye bye" and "mommy". She uses her passey muir daily and is attempting to communicate. Sydnee is able to hold a cup and release a toy, and does appear to understand cause and effect. Her receptive skills appear to be much more defined than her expressive skills, and she is certainly aware and alert of her environment.

Sydnee's daily care is tedious in nature, as she does require, as previously mentioned, care and suctioning of the tracheostomy, as well as changing out of tubes, care and supply of the Mic-Key button, and nutritional supplementation. She does have secretions that require suctioning and must be surveyed carefully for upper respiratory infection or other complications. Sidney is dependent in all care, however, is becoming more active in her environment. She is monitored on a daily basis including O2 sats; however, O2 sats are only reduced on an infrequent basis and usually corresponds to ongoing infections. DAFOs are

necessary to provide stabilization for ambulation and it is expected that she will need these for some time in the future.

Sydnee does utilize a wheelchair and myriad equipment to provide for her ongoing requirements. Primary difficulties are resultant to the tracheostomy and the inability to suck and swallow with limited gag reflex. However, she does demonstrate reasonable tone with limited spasticity, and seizure activity is not present.

CONCLUSION

Sydnee Copeland is a child who demonstrates a permanent disability with myriad handicaps to daily living. However, she has responded wonderfully to treatment and is able to react to her environment with the capacity to enjoy quality of life. Sydnee will, of course, require significant medical care, surveillance, and supportive services over her lifetime. However, given the appropriate interventions, she should be able to reach her highest level of independence. Her mother is devoted to her care and provides the necessary support to make certain that Sydnee will reach her highest functional level if resources are provided. The following Life Care Plan describes those resources and outlines the cost of care.

PLAN DESCRIPTION

Sydnee Copeland

I. COMPLICATIONS

Sydnee is at risk for complications that would require inpatient hospitalization; and historically, she has required such hospitalizations in the past.

II. DRUGS AND SUPPLIES

Myriad drugs and supplies are necessary to provide tracheostomy care, gastrostomy tube care, and to monitor Sydnee's condition and provide miscellaneous caretaking activities as well. Her care is tedious and complex, and requires significant attention on a daily basis.

III. EDUCATION SERVICES

Sydnee is eligible for Special Education and will attend school if medically feasible.

IV. WHEELCHAIRS

Sidney does require a wheelchair for ambulation; and although she may have the ability to ambulate short distances with braces, it is expected that she will require a wheelchair for distance mobility.

Wheelchairs require seating requirements and replacement pursuant to growth and usage.

V. HOME ACCESSORIES AND EQUIPMENT

Significant equipment is necessary both at home and at school to provide nutritional supplementation, respiratory care, and general caretaking.

VI. EVALUATIONS

Therapeutic evaluations are appropriate to review Sydnee's current treatment requirements and to make recommendations for additional interventions as necessary. In addition, she is a candidate for assistive technology and should be evaluated accordingly with recommendations for assistive equipment. At present, she does require an audiology evaluation; and this may precipitate additional needs as well. Nutritional evaluations are requisite to maintain appropriate nutritional supplementation.

VII. HOME SERVICES

Sydnee does require the services of a homecare nurse to provide nursing care and supervision. She can remain in the home setting as long as an appropriate guardian is present. However, a suitable residential setting would be required if no guardian is present.

VIII. MEDICAL ROUTINE

On a routine basis, Sydnee will be followed by her extensive treatment team; and as an adult, a similar treatment team will be necessary to monitor her condition and provide an ongoing treatment program.

IX. MEDICAL SERVICES

As a baseline, Sydnee will require numerous medical services including blood, pulmonology, and radiological studies. She will, as well, require additional studies on an as needed basis.

X. HOME MODIFICATIONS

Sydnee's home is not wheelchair accessible; and this will, of course, become more problematic with growth and the addition of equipment.

XI. ORTHOTICS AND PROSTHETICS

Sydnee utilizes bilateral bracing for foot/ankle alignment and to encourage ambulation. She will require bracing for at least several additional years and may require bracing over her lifetime.

XII. THERAPIES

Therapies will be provided through the public school system. However, supplemental therapies will be

necessary to maximize Sydnee's potential for development and functional outcome.

XIII. TRANSPORTATION

A van will be necessary to provide community access for wheelchair transport. Vans to require maintenance for the handicapped equipment.

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
DATE OF BIRTH: 11/29/00
PREPARED: June 13, 2003

P = PERIODIC REPLACEMENT COST
Y = YEARLY COST

CATEGORY: COMPLICATIONS

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
INPATIENT HOSPITALIZATION	RESPIRATORY COMPLICATIONS	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-5000	2003 TO 2018	AS NEEDED	($4,000.00) P
INPATIENT HOSPITALIZATION	RESPIRATORY COMPLICATIONS	WASHINGTON HOSPITAL CTR WASHINGTON, DC 202-877-7964	2018 TO 2081	AS NEEDED	($3,800.00) P

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
DATE OF BIRTH: 11/29/00
PREPARED: June 13, 2003

P = PERIODIC REPLACEMENT COST
Y = YEARLY COST

CATEGORY: DRUGS AND SUPPLIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
PULMICORT RESPULES .25 MG (RX)	CORTICOSTEROID/ 1 X DAY	WAL-MART PHARMACY BOWIE, MD 301-805-8853	2003 TO 2081	YEARLY	$872.35 Y
ROBINUL 1 MG (RX)	DECREASE SECRETIONS/ 1 X DAY	WAL-MART PHARMACY BOWIE, MD 301-805-8853	2003 TO 2081	YEARLY	$335.80 Y
ALBUTEROL SULFATE.083% (RX)	BRONCHODILATOR/ 2-4 X WEEK	WAL-MART PHARMACY BOWIE, MD 301-805-8853	2003 TO 2081	YEARLY	$37.44 Y
4 X 4 GAUZE SPONGES/STERILE	TRACH CARE/ FEEDING TUBE CARE	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$180.00 Y
THERMOVENT T	TRACH SUPPLIES	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$452.70 Y
ADDIPAK 3ML STERILE SALINE	TRACH SUPPLIES/ 10 PER DAY	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$693.50 Y

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
DATE OF BIRTH: 11/29/00
PREPARED: June 13, 2003

P = PERIODIC REPLACEMENT COST
Y = YEARLY COST

CATEGORY: DRUGS AND SUPPLIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
LATEX GLOVES	TRACH CARE/ FEEDING TUBE/ BOWEL & BLADDER	SUBURBAN MEDICAL CAPITOL HEIGHTS, MD 301-333-0563	2003 TO 2081	YEARLY	$288.00 Y
PULSE OX FINGER PROBES	MONITOR OXYGEN SATURATION LEVELS/ 2 BOXES/MONTH	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$720.00 Y
MIC KEY KIT	ENTERAL FEEDING SUPPLIES/ 4 X YEAR	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$760.00 Y
MIC KEY EXTENSION SET	ENTERAL FEEDING SUPPLIES/ 4 X YEAR	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$67.20 Y
TRACHEOSTOMY TUBE	TRACH SUPPLIES/ 1 X WEEK	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$3,229.20 Y
6CC LEUR LOCK SYRINGE	FEEDING PUMP	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$10.40 Y

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
DATE OF BIRTH: 11/29/00
PREPARED: June 13, 2003

P = PERIODIC REPLACEMENT COST
Y = YEARLY COST

CATEGORY: DRUGS AND SUPPLIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM	FREQUENCY	UNIT COST
12CC LEUR LOCK SYRINGE	CARETAKING	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$13.00 Y
1CC SYRINGE	CARETAKING	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$52.00 Y
5CC SYRINGE	CARETAKING	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$52.00 Y
PATROL FEEDING BAG SET	ENTERAL FEEDING SUPPLIES/ 1 X DAY	SUBURBAN MEDICAL CAPITOL HEIGHTS, MD 301-333-0563	2003 TO 2081	YEARLY	$1,460.00 Y
NEBULIZER KIT	NEBULIZER MEDICATON DELIVERY/ 1 X WEEK	SUBURBAN MEDICAL CAPITOL HEIGHTS, MD 301-333-0563	2003 TO 2081	YEARLY	$103.48 Y
TRACHEOSTOMY MASK	TRACH SUPPLIES/ 1 X WEEK	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$113.36 Y

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: DRUGS AND SUPPLIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
COTTON TIP APPLICATORS	TRACH SUPPLIES	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$120.00 Y
TRACHEOSTOMY TIES	TRACH SUPPLIES/ 1 X DAY	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$1,697.25 Y
SODIUM CHLORIDE IRRIGANT	CARETAKING	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$170.28 Y
STERILE WATER	RESPIRATORY SUPPLIES	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$125.64 Y
HYDROGEN PEROXIDE	TRACH SUPPLIES	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$13.80 Y
PEDIASURE	ENTERAL FEEDING SUPPLIES	SUBURBAN MEDICAL CAPITOL HEIGHTS, MD 301-333-0563	2003 TO 2081	YEARLY	$2,379.80 Y

LIFE CARE / REHABILITATION PLAN

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CATEGORY: DRUGS AND SUPPLIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
CORREGATED TUBING	TRACH SUPPLIES	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$338.52 Y
WATER DRAINAGE BAGS	EXCESS WATER FROM HUMIDIFIER TUBING	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$123.24 Y
BACITRACIN OINTMENT	TRACH CARE SUPPLIES	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$48.00 Y
OXYGEN TANK/ PORTABLE	RESPIRATORY NEEDS/ AWAY FROM HOME	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY/ AS NEEDED	($576.00) P
OXYGEN TANK/ STATIONARY	RESPIRATORY NEEDS/ EMERGENCIES	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	(No charge as long as you obtain equipment from supplier) P

LIFE CARE / REHABILITATION PLAN

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CATEGORY: DRUGS AND SUPPLIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
SUCTION CANNISTER W/TUBING	SUCTIONING NEEDS	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$121.80 Y
SUCTION CATHETER	TRACH SUCTIONING NEEDS	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$.00 P
YANKAUER SUCTION TIP	ORAL SUCTIONING NEEDS	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$23.28 Y
DIAPERS/PEDIATRIC	INCONTINENCE	MOMS NATIONAL VENDOR 800-232-7443	2003 TO 2010	YEARLY	$1,076.75 P
DIAPERS/ADOLESCENT/ ADULT	INCONTINENCE	MOMS NATIONAL VENDOR 800-232-7443	2010 TO 2081	YEARLY	$1,131.50 P
CHUX DISPOSABLE PADS	CARETAKING	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-272-4463	2003 TO 2081	YEARLY	$489.10 Y

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: DRUGS AND SUPPLIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
PASSY-MUIR VALVE	MAINTAIN AIRWAY/ ALLOW SPEECH	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-272-4463	2003 TO 2081	YEARLY	$840.00 Y

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: EDUCATIONAL SERVICES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
SPECIAL EDUCATION	PL: 101-476 AS DIRECTED BY IEP	PRINCE GEORGES COUNTY PUBLIC SCHOOL SYSTEM	2005 TO 2018 AGE 18	YEARLY	$.00 P

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
DATE OF BIRTH: 11/29/00
PREPARED: June 13, 2003

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CATEGORY: WHEEL CHAIR

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
MCCLAREN BUGGY	MOBILITY AID	SAMMONS PRESTON NATIONAL VENDOR 800-323-5547	2003	1 X ONLY	$499.00 P
ZIPPIE II MANUAL WHEELCHAIR	DISTANCE AMBULATION/ PEDIATRIC	NAT'L SEATING & MOBILITY ANNAPOLIS JUNCTION, MD 301-776-1140	2003 TO 2010 AGE 10	2 X ONLY	$5,808.00 P
WHEELCHAIR MAINTENANCE	MAINTAIN EQUIPMENT	NAT'L SEATING & MOBILITY ANNAPOLIS JUNCTION, MD 301-776-1140	2006 TO 2010 AGE 10	YEARLY (minus 1 replacment w/c)	$150.00 P
QUICKIE S646 POWER WHEELCHAIR	DISTANCE AMBULATION/ ADOLESCENT	NAT'L SEATING & MOBILITY ANNAPOLIS JUNCTION, MD 301-776-1140	2010 AGE 10 TO 2018 AGE 18	2 X ONLY	$12,138.00 P
QUICKIE S646 POWER WHEELCHAIR	DISTANCE AMBULATION/ ADULT	NAT'L SEATING & MOBILITY ANNAPOLIS JUNCTION, MD 301-776-1140	2018 AGE 18 TO 2081	1 X 5 YEARS	$12,138.00 P

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: WHEEL CHAIR

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
WHEELCHAIR BATTERIES	POWER SOURCE	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-272-4463	2011 TO 2081	YEARLY (minus 13 replacement w/c's)	$267.48 P
WHEELCHAIR MAINTENANCE	MAINTAIN EQUIPMENT	NAT'L SEATING & MOBILITY ANNAPOLIS JUNCTION, MD 301-776-1140	2011 TO 2081	YEARLY (minus 13 replacement w/c's)	$250.00 P

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: HOME ACCESSORIES AND EQUIPMENT

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
FEEDING PUMP/ ROSS PATROL	DELIVER ENTERAL NUTRITION	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	1 X 5 YEARS	$329.00 P
IV POLE	DELIVER ENTERAL NUTRITION	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	1 X 10 YEARS	$33.60 P
PULSE OXIMETER/ NELLCOR	MONITOR STATUS	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	1 X 10 YEARS	$910.00 P
SUCTION MACHINE/ PORTABLE	MAINTAIN PATENT AIRWAY	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	1 X 5 YEARS	$308.00 P
SUCTION MACHINE/ STATIONARY	MAINTAIN PATENT AIRWAY	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	1 X 10 YEARS	$203.00 P
OXYGEN CONCENTRATOR	RESPIRATORY AID	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	1 X 10 YEARS	$764.40 P

LIFE CARE / REHABILITATION PLAN

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CATEGORY: HOME ACCESSORIES AND EQUIPMENT

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
OXYGEN CONCENTRATOR FILTER	REPLACEMENT FILTERS	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$31.08 Y
AIR COMPRESSOR/ STATIONARY	HUMIDIFICATION/ MEDICATION ADMINISTRATION	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	1 X 10 YEARS	$511.00 P
AIR COMPRESSOR FILTERS	REPLACEMENT FILTERS	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	YEARLY	$64.68 Y
NEBULIZER/ PORTABLE COMPRESSOR	HUMIDIFICATION/ MEDICATION ADMINISTRATION	NEIGHBORCARE ANNAPOLIS JUNCTION, MD 800-794-1744	2003 TO 2081	1 X 5 YEARS	$355.90 P
BATH CHAIR/ MEDIUM	BATHING AID	RIFTON NATIONAL VENDOR 800-777-4244	2003	1 X ONLY	$335.00 P
FULLY ELECTRIC HOSPITAL BED	CARETAKING AID	REP ALEXANDRIA, VA 703-370-2100	2018 AGE 18 TO 2081	1 X 10 YEARS	$2,260.00 P

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: EVALUATIONS

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
PHYSICAL THERAPY EVALUATION	EVALUATE STATUS/TREATMENT 1 X YEAR	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-5000	2003 TO 2018/ AGE 18	YEARLY	$203.00 P
OCCUPATIONAL THERAPY EVALUATION	EVALUATE STATUS/TREATMENT 1 X YEAR	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-5000	2003 TO 2012/ AGE 12	YEARLY	$203.00 P
SPEECH THERAPY EVALUATION	EVALUATE STATUS/TREATMENT/ 1 X YEAR	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-5000	2003 TO 2012/ AGE 12	YEARLY	$471.00 P
ASSISTIVE TECHNOLOGY EVALUATION	EVALUATE FUNCTIONAL AIDS/ PEDIATRIC	KENNEDY KRIEGER BALTIMORE, MD 410-502-9519	2003	1 X ONLY	$430.00 P
NUTRITIONAL EVALUATION	EVALUATE STATUS/NEEDS	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-3440	2003 TO 2018 AGE18	YEARLY	$225.00 P
NEUROLOGICAL EVALUATION	EVALUATE STATUS/	LOCAL PROVIDER	2003 TO 2003	1 X ONLY	$260.00 P

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: HOME SERVICES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
SKILLED NURSING (LPN)	HOME CARE NEEDS PRE K/ 20 HOURS/DAY WEEKDAYS/ 16 HOURS/DAY WEEKENDS	HOLY CROSS SILVER SPRING, MD 301-754-7740	2003 TO 2005	YEARLY	$227,500.00 P
SKILLED NURSING (LPN) *	HOME CARE NEEDS/ SCHOOL DAYS 12 HOURS/DAY	HOLY CROSS SILVER SPRING, MD 301-754-7740	2005 TO 2018	YEARLY	$75,600.00 P
SKILLED NURSING (LPN)	HOME CARE NEEDS NON SCHOOL DAYS/ 20 HOURS/DAY WEEKDAYS/ 16 HOURS/DAY WEEKENDS	HOLY CROSS SILVER SPRING, MD 301-754-7740	2005 TO 2018	YEARLY	$101,500.00 P
SKILLED NURSING (LPN)	HOME CARE NEEDS/ 24 HOURS 2 DAYS/MONTH	HOLY CROSS SILVER SPRING, MD 301-754-7740	2003 TO 2018	YEARLY	$20,160.00 P
SKILLED NURSING (LPN)	HOME CARE NEEDS/ ADULT	HOLY CROSS SILVER SPRING, MD 301-754-7740	2018 TO 2081	YEARLY	$306,600.00 P

LIFE CARE / REHABILITATION PLAN

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CATEGORY: HOME SERVICES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
CASE MANAGEMENT SERVICES	COORDINATION OF SERVICES/ 3 HOURS/MONTH	LOCAL PROVIDER	2003 TO 2081	YEARLY	$2,700.00 Y

* If School System does not provide nurse at school or Sydnee unable to attend school / additional nursing care will be required

LIFE CARE / REHABILITATION PLAN

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CATEGORY: MEDICAL ROUTINE

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
PEDIATRIC GASTRO-ENTEROLOGIST	FOLLOW-UP STATUS/ 1 X YEAR	DR. ALI BADER WASHINGTON, DC 202-884-5000	2003 TO 2018	YEARLY	$175.00 P
PEDIATRIC PULMONOLOGIST	FOLLOW-UP STATUS/ 2 X YEAR	DR. SAMUEL ROSENBERG ROCKVILLE, MD 301-738-7011	2003 TO 2018	YEARLY	$180.00 P
PEDIATRIC PM&R	FOLLOW-UP STATUS/ 2 X YEAR	DR. KATHERINE SWOBODA WASHINGTON, DC 202-884-5000	2003 TO 2018	YEARLY	$260.00 P
PEDIATRIC ORTHOPEDIST	FOLLOW-UP STATUS/ 1 X YEAR	DR. DAVID ZALESKE WASHINGTON, DC 301-572-3542	2003 TO 2018	YEARLY	$75.00 P
PEDIATRIC OPHTHALMOLOGIST	FOLLOW-UP STATUS/ 1 X YEAR	DR. KELLY HUTCHENSON WASHINGTON, DC 202-884-6115	2003 TO 2018	YEARLY	$80.00 P
PEDIATRICIAN	FOLLOW-UP/ 4 X YEAR	DR. VICTORIA VENIDA LARGO, MD 301-350-0044	2003 TO 2018	YEARLY	$300.00 P

LIFE CARE / REHABILITATION PLAN

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CATEGORY: MEDICAL ROUTINE

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
PEDIATRIC OTOLARYNGOLOGIS	FOLLOW-UP/ 1 X YEAR	DR. MARIA PENA WASHINGTON, DC 301-572-3542	2003 TO 2018	YEARLY	$100.00 P
ADULT GASTROENTEROLOGIST	FOLLOW-UP/ 1 X YEAR	DR. JAMES CHESLEY CHEVERLY, MARYLAND 202-884-5000	2018 TO 2081	YEARLY	$75.00 P
ADULT PULMONOLOGIST	FOLLOW-UP/ 1 X YEAR	DR. BERNARD GRAND ALEXANDRIA, VA 703-931-4746	2018 TO 2081	YEARLY	$100.00 P
ADULT PM&R	FOLLOW-UP/ 1 X YEAR	DR. CHRISTOPHER BERMAN CLINTON, MD 301-877-5800	2018 TO 2081	YEARLY	$100.00 P
ADULT OTOLARYNGOLOGIST	FOLLOW-UP	DR. MARY CZAN WASHINGTON, DC 202-223-3560	2018 TO 2081	AS NEEDED	($125.00) P

LIFE CARE / REHABILITATION PLAN

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CATEGORY: MEDICAL SERVICES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
SCOLOSIS SERIES	MONITOR STATUS/ AS NEEDED	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-4700	2003 TO 2018	AS NEEDED	($202.00) P
BILATERAL HIP X-RAY	MONITOR STATUS/ 3 X ONLY	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-4700	2003 TO 2018	3 X ONLY	$264.00 P
BARIUM SWALLOW	ASSESS SWALLOWING FUNCTION/ 3 X ONLY	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-5048	2003 TO 2018	3 X ONLY	$552.00 P
TRACHEOSTOMY CULTURE	MONITOR TRACHEOSTOMY/ 1 X YEAR	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-3744	2003 TO 2081	YEARLY	$166.00 Y
CBC W/DIFFERENTIAL	MONITOR STATUS/ 2 X YEAR	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-3744	2003 TO 2081	YEARLY	$118.00 Y
CMP	MONITOR STATUS/ 2 X YEAR	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-3744	2003 TO 2081	YEARLY	$100.00 Y

LIFE CARE / REHABILITATION PLAN

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CATEGORY: MEDICAL SERVICES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
BRONCHOSCOPY	RESPIRATORY EVALUATION	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-3194	2003 TO 2081	AS NEEDED	($1,550.00) P
FLU VACCINE	PROPHYLACTIC IMMUNIZATION/ 1 X YEAR	LARGO PEDIATRICS LARGO, MD 301-350-0044	2003 TO 2081	YEARLY	$10.00 Y

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: HOME MODIFICATIONS

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
HOME MODIFICATIONS	ACCESSIBILITY/ CARETAKING	CREATIVE DESIGN BRYANS ROAD, MD 301-283-2416 OR COMMENSURATE	2003	1 X ONLY	TO BE DETER-MINED P

LIFE CARE / REHABILITATION PLAN

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CATEGORY: ORTHOTICS/PROSTHETICS

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM	FREQUENCY	UNIT COST
AFO'S - BILATERAL *	FOOT/ANKLE ALIGNMENT	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-3086	2003 TO 2006	YEARLY	$782.00 P
WRIST SPLINTS (2)	ALIGNMENT	SAMMONS PRESTON NATIONAL VENDOR 800-323-5547	2003 TO 2012 AGE 12	YEARLY	$21.90 P

* AFO's may be required for life

LIFE CARE / REHABILITATION PLAN

CLIENT: SYDNEE COPELAND
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CATEGORY: THERAPIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
PHYSICAL THERAPY	PL: 101-476 AS DIRECTED BY IEP	PRINCE GEORGES COUNTY PUBLIC SCHOOL SYSTEM	2003 TO 2018 AGE 18	YEARLY	$.00 P
OCCUPATIONAL THERAPY	PL: 101-476 AS DIRECTED BY IEP	PRINCE GEORGES COUNTY PUBLIC SCHOOL SYSTEM	2003 TO 2018 AGE 18	YEARLY	$.00 P
SPEECH THERAPY	PL: 101-476 AS DIRECTED BY IEP	PRINCE GEORGES COUNTY PUBLIC SCHOOL SYSTEM	2003 TO 2018 AGE 18	YEARLY	$.00 P
PHYSICAL THERAPY	SUPPLEMENTAL THERAPY 36 SESSIONS	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-5000	2003 TO 2018 AGE 18	YEARLY	$5,472.00 P
OCCUPATIONAL THERAPY	SUPPLEMENTAL THERAPY 36 SESSIONS	CHILDREN'S HOSPITAL WASHINGTON, DC 202-884-5000	2003 TO 2012 AGE 12	YEARLY	$5,472.00 P

LIFE CARE / REHABILITATION PLAN

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CATEGORY: THERAPIES

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
SPEECH THERAPY	SUPPLEMENTAL THERAPY 36 SESSIONS	CHILDREN'S HOSPITAL WASHINGTON, SC 202-884-5000	2003 TO 2012 AGE 12	YEARLY	$3,348.00 P

LIFE CARE / REHABILITATION PLAN

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CATEGORY: TRANSPORTATION REQUIREMENTS

SERVICE OR PRODUCT	PURPOSE	SUPPLIER	INIT./ TERM.	FREQUENCY	UNIT COST
VAN MODIFICATIONS	COMMUNITY ACCESS	BEDCO MOBILITY COLLEGE PARK, MD 301-585-0700	2003 TO 2081	1 X 6 YEARS	$17,830.00 P
VAN MAINTENANCE	MAINTAIN EQUIPMENT	LOCAL PROVIDER LARGO, MARYLAND	2004 TO 2081	YEARLY (minus 12 van modifications)	$250.00 P

LIFE CARE / REHABILITATION PLAN

COST SUMMARY

SYDNEE COPELAND

June 13, 2003

CATEGORY	COST
COMPLICATIONS	$.00
DRUGS AND SUPPLIES	$1,336,875.13
EDUCATIONAL SERVICES	$.00
WHEEL CHAIR	$211,993.36
HOME ACCESSORIES AND EQUIPMENT	$53,250.08
EVALUATIONS	$13,176.00
HOME SERVICES	$22,587,180.00
MEDICAL ROUTINE	$34,875.00
MEDICAL SERVICES	$33,337.60
HOME MODIFICATIONS	$.00

LIFE CARE / REHABILITATION PLAN

COST SUMMARY

SYDNEE COPELAND

June 13, 2003

CATEGORY	COST
ORTHOTICS/PROSTHETICS	$2,543.10
THERAPIES	$161,460.00
TRANSPORTATION REQUIREMENTS	$248,040.00
LIFETIME TOTAL	$24,682,730.27