The State of Ohio,)
) SS:
County of Lorain.)

IN THE COURT OF COMMON PLEAS

Lura M. Keller, Admx., etc., et al,

Plaintiffs,

vs. No. 90CV104980

Anthony E. Bacevice, Jr., M.D., et al,

Defendants.

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Deposition of a Defendant, ANTHONY E. BACEVICE, JR. M.D., called by the Plaintiffs as upon cross-examination, taken before Kathleen A. Hopkins, a Notary Public within and for the State of Ohio, at the offices of Maynard, Jacobson, Tuschman & Kalur, Co., LPA, 1001 Lakeside Avenue, Cleveland, Ohio, on Thursday, the 5th day of September, 1991, at 10:00 a.m., pursuant to agreement of counsel.

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APPEARANCES:

On behalf of the Plaintiffs:

Michael F. Becker Co., LPA, by
Michael F. Becker, Esq.;

On behalf of the Defendants:

Jacobson, Maynard, Tuschman
& Kalur Co., LPA, by
Michael M. Djordjevic, Esq.

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ANTHONY E. BACEVICE, JR., M.D.,
of lawful age, a Defendant herein, called by the Plaintiffs for the purpose of cross-examination as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF ANTHONY BACEVICE, JR., M.D.

BY MR. BECKER:

Q. Doctor, would you state your full name, please, and spell your last name for me?

A. Anthony Edward Bacevice, Jr., B-A-C-E-V-I-C-E.

Q. Have you ever had your deposition taken before?

A. Yes, I have.

Q. Okay. Let me just review some things for you then. This is a question and answer session under oath. It is important you understand the question that I ask you. If you don't understand the question, if I don't make sense, tell me so, and I'll attempt to restate or rephrase the question. I don't want you answering a question that you don't understand. Okay?

A. Yes.

Q. It is important you answer verbally, because it's difficult for her to pick up a head nod.

A. I understand.

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CURRICULUM VITAE MARKED DEFENDANT'S EXHIBIT 1 FOR IDENTIFICATION.

* * *

Q. Doctor, I'm going to hand you what's just been marked as Plaintiff's Exhibit 1 and ask you could identify that for us?

A. Yes, I can. This is my curriculum vitae.

Q. And would you take a look at it and tell me if it is current?

A. It is current.

Q. As I interpret this, Doctor, you have a background in engineering, correct?

A. That is correct.

Q. And you finished your engineering -- in fact, you've got a Master's in engineering?

A. Yes, sir.

Q. In 1975?

A. Yes, sir.

Q. Between '75 and the time you started medical school in '77, what did you do?

A. I practiced as a research engineer and biomedical computer consultant for University Hospitals of Cleveland, both in the Division of Cardiology and

in the Division of Pediatric Pulmonary Medicine.

Q. Were you actually an employee of UH?

A. Yes, I was.

Q. And then you started medical school in '77. And you finished and got your M.D. degree in '81. And you did an internship at the Cleveland Clinic in '81 to '82. And you started your residency in OB/GYN also at Case, and I assume that's University Hospitals?

A. University Hospitals and Cleveland Metropolitan General Hospital.

Q. Okay. You kind of rotated between the two institutions?

A. Yes.

Q. And you finished your residency in '86. And then you did a Fellowship between '86 and '88, also at Case, in maternal/fetal medicine?

A. Yes, sir.

Q. And you gained your Board certification in '89 in OB/GYN?

A. Yes, sir.

Q. Have you gained a certification in maternal/fetal medicine?

A. Not as of yet.

Q. Are you eligible for the maternal/fetal medicine

Board?

A. Yes, I am.

Q. Have you taken the exam?

MR. DJORDJEVIC: Objection. Go ahead, Doctor.

A. I took the written exam.

Q. And did you pass that?

A. No.

MR. DJORDJEVIC: Objection.

A. No, I did not.

Q. When did you fail that?

MR. DJORDJEVIC: Objection.

Q. What month and what year?

A. In June of 1989.

Q. Did you take it again?

A. Yes, I did.

Q. Okay. And were you unsuccessful the second time?

A. The results are pending. I do not know.

Q. Were you successful with your OB/GYN Boards the first time you took them?

A. Yes, I was.

Q. All right. As I understand it then, you finished your training in 1988, and then you started your private practice?

A. Correct.

Q. And you started your private practice according to this vitae, would that be with Wisler?
A. Yes, sir.
Q. And you were with Dr. Wisler as an associate or partner?
A. I was an associate.
Q. You were with him a little bit less than a year?
A. Exactly one year.
Q. One year. And you finished with him in June of '89. And then you started your own practice or did you join Dr. Bartek?
A. I joined Dr. Bartek.
Q. As an associate or as a partner?
A. As an employee.
Q. Okay. And you were working with Dr. Bartek from July of '89 until December of '90. And what happened in December of '90; is that when Dr. Bartek left town?
A. Yes.
Q. Incidentally, where is Dr. Bartek today to your knowledge?
A. To the best of my knowledge he is in Michigan.
Q. You started your own practice in January of '91?
A. Yes, sir.
Q. And do you have any employees, any other

physicians working with you?
A. No, I do not.
Q. And would you consider yourself a perinatologist?
A. I would.
Q. And would you define what that means for me?
A. A perinatologist is a practitioner of the subspecialty of obstetrics and gynecology dealing with maternal and fetal medicine.
Q. And in rough terms is that an OB/GYN that specializes in high risk obstetrics?
A. Yes, it is.
Q. And how would you did define high risk obstetrics?
A. The definition is difficult to pin down, but it would have to do with the management of pregnancies that are complicated, either as far as the outcome is concerned with respect to the fetus or the outcome with respect to the mother.
Q. What is Delta Electronics?
A. Delta Electronics is a company that I am the sole proprietor of that has been in existence since 1964. We specialize in electronic consulting, maintenance of broadcast radio equipment and design of communication electronics.
Q. Do you do any work for Delta Electronics?
MR. DJORDJEVIC: Objection. Go

ahead, Doctor.

A. Not at the present time.

Q. And are you presently affiliated with Case Western Reserve as an Assistant Clinical Professor?

A. Yes, I am.

Q. And what does that entail?

A. I provide resident teaching and medical school teaching to the medical students on a regular basis, approximately once a month. I also participate in the research activities, clinical faculty meetings and exercises.

Q. Do they come to you or do you go to them?

A. For the most part I go to them.

Q. And can you give me an example of how that works?

A. Next week I will be giving a lecture to the medical students on the management of diabetes in pregnancy.

Q. So you just kind of come over to the medical school or do you go to UH and do rounds?

A. I go to the school of medicine, depending on where the lectures are assigned. Sometimes they are assigned in the medical school proper. Most of the time they are assigned in one of the conference rooms at University Hospitals. I will from time to time make attending rounds.

Q. Have you ever written or coauthored anything regarding the subject of premature labor or incompetent cervix?
A. No, I have not.
Q. Have you ever lectured on, to any of the medical students or anyone else, any other medical group, regarding that same subject matter?
A. Not that I recall.
Q. You have privileges, at least in Lorain County, at EMH, Lorain Community and St. Joe's?
A. Yes, I do.
Q. As well as Amherst I see too?
A. Yes, I do.
Q. What does it mean to -- what is the difference between active affiliation and associate and courtesy priveleges; could you distinguish those for me?
A. Yes. Courtesy privileges state that I have admitting privileges to the hospital, provided that I do not admit more than 12 patients per year. For this I do not attend regular meetings. I function essentially as a consultant and am able to see and treat patients within the hospital.
Q. Okay. And how about associate and active?
A. Associate, active and affiliated represent tiers,

that is T-I-E-R-S, of membership in the medical staff starting with, depending on the hospital, lower levels which may be such as provisional affiliate, active. It usually requires so many years of membership at a given level before you can move on to the next level.

In most of the situations there I am either affiliate or associate because I haven't been connected with the hospitals any longer than two to three years.

Q. What about active?

A. Active is the highest level of membership of a currently active practitioner. In the case of Amherst Hospital the requirement was one year of associate membership prior to election as active membership.

Q. So there was kind of a nominal requirement to become an active at Amherst?

MR. DJORDJEVIC: I think I'm going to object to the term nominal.

Q. Well, you know what I mean, Doctor, or do you know what I mean?

A. I don't think I know what you mean.

Q. Okay. Minimum prerequisite of years before you can become an active as compared to Lorain

Community or St. Joseph?

MR. DJORDJEVIC: I'm going to object again. He's told you it's one year. You can ascribe any adjective to that that you want.

Q. Well, I don't want to make a big deal of this, Doctor. Just tell me what kind of years are required at Lorain Community and St. Joseph before you can become active status?

A. Two years at each of the lower levels, which is four years in both cases.

Q. Have you authored or coauthored any chapters in any textbooks in obstetrics or gynecology?

A. No, I have not.

Q. Did you bring with you your chart on Lura Keller?

MR. DJORDJEVIC: The office chart?

MR. BECKER: Yes.

MR. DJORDJEVIC: Did you leave that in my office, Doctor?

THE WITNESS: Yes.

MR. DJORDJEVIC: Why don't we go get it.

Q. I'm going to ask you some questions and it would be a lot easier if you have that in front of you.

* * *

Thereupon, a discussion was had off the record.

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MR. DJORDJEVIC: Okay. We've got the chart.

Q. Doctor, I want to talk a little bit about your practice presently. Can you tell me on an average how many deliveries you have a year?

A. Considering the fact that I have only been in practice for eight months, I can project that I do approximately 10 deliveries, 10 to 15 deliveries per month.

Q. And were you doing 10 to 15 a month when you were working for Dr. Wisler?

A. I don't recall.

Q. Do you recall how many you were doing per month when you were working with Dr. Bartek?

A. More than 10 to 15 per month for the two of us.

Q. Okay.

A. I don't recall.

Q. If you had a high risk case while you were with Dr. Wisler or with Dr. Bartek, a high risk patient came in to see you would you manage it or would you refer it out to another perinatologist?

A. For the most part I would manage the patient.

Q. Can you generalize as to when you would refer your

high risk patients out to another perinatologist?

MR. DJORDJEVIC: Again, if you can generalize, answer. If you can't generalize --

A. I really can't generalize.

Q. Okay. Are you familiar with the risk scoring system that indicates how high a patient would be for risk factors, specifically the Creasy scoring system; are you familiar with that?

A. I have heard of it. I'm not intimately familiar with it.

Q. No?

MR. DJORDJEVIC: How do you spell that, Mike?

MR. BECKER: C-R-E-A-S-Y.

MR. DJORDJEVIC: The author of the book?

MR. BECKER: I don't know if it the same one or not.

Q. Would you consider a woman with cervical incompetence a high risk patient?

A. Yes, I would.

Q. Maybe we should talk about some definitions before we get too far along here.

What is cervical incompetence?

A. Cervical incompetence in general terms refers to the cervical, premature cervical effacement and dilatation usually occurring in the first and second trimesters of the pregnancy.

Q. Okay. Do you have an opinion as to what is responsible for that?

A. No. Nor does anyone else at this time.

Q. Do you have an opinion whether or not DES exposure has any effect on or relation to cervical incompetence?

A. DES has been associated with cervical incompetence in some patients.

Q. How do you diagnose cervical incompetence?

A. It is very difficult to make a diagnosis. It's usually done after the fact. And it usually is made on the basis of history that excludes other causes of second trimester loss, heralded by painless cervical dilatation, followed by precipitous delivery.

Q. Define preterm labor for me, please?

A. Preterm labor is labor that occurs prior to 37 completed weeks of pregnancy.

Q. Going back to diagnosis of incompetent cervix, so you would rely on history as well as any observable cervical changes in the first or second

trimester?

A. Correct. We would rely on history and cervical changes. It's extremely difficult to diagnose owing to the nature of the cervix and the way in which these measurements are made.

Q. What is the appropriate standard of care or standard of treatment for managing a patient during her pregnancy who has an incompetent cervix?

A. That is extremely variable. It may or may not include surgical intervention.

Q. And when you talk about surgical intervention are we talking about stitching?

A. Yes, I am.

Q. When is that indicated and when is it not indicated?

MR. DJORDJEVIC: Objection to the broad nature of the question. He can't possibly list every indication and every contraindication.

Q. Well, just give me your best.

MR. DJORDJEVIC: I want the record to be clear that this can not be nor is it intended to be an exclusive list.

Q. That's fine. Just do the best you can right now,

Doctor.

A. Well, I can't even give you a list, because most of the literature just does not agree with indications.

Historically, in the presence of prior cervical incompetence diagnosed clinically based on first or second trimester loss with painless cervical dilatation and subsequent expulsion of the fetus. With that history of incompetent cervix cervical cerclage, that's the surgical closure of the cervix, may be indicated in a subsequent pregnancy.

Q. Well, if you choose not to surgically intervene what other treatment is available?

A. Bed rest.

Q. Is that the extent of the alternative treatment?

A. Yes.

Q. What is the appropriate time during the pregnancy, assuming that a cerclage is indicated, as to when one should be placed?

A. That also is variable and depends on the clinical situation.

Q. You would -- would you agree that cerclage if indicated should be placed between the 14th and 17th week?

A. If at that time that it has been diagnosed and has been clinically judged as indicated, yes, that would be an appropriate time to place a cerclage.
Q. Would you agree with me that once a cerclage is placed in a woman with a previously diagnosed incompetent cervix there is a strong probability, that is more likely than not, that the woman will go to term?
A. I didn't hear the end of the question.
Q. Will go to term?
A. Will go to term. I would not agree with you on that statement.
Q. What is your opinion as to the effectiveness then of a cerclage placement in an incompetent cervix?
A. It will prolong pregnancy.
Q. More likely than not it will prolong pregnancy, but you can't state in terms of how many weeks it will prolong the pregnancy?
A. That's correct.
Q. Is that fair?
A. That's fair.
Q. Are there any contraindications for placing a cerclage?
A. Yes, there are.
Q. What are they?

MR. DJORDJEVIC: Again, I don't intend this to be an exclusive list. Doctor.

A. Some of them include vaginal bleeding, cervical infection or cervical irritation.

Q. What do you mean, cervical irritation?

A. Inflammation of the cervix, chronic cervicitis which, saying it again, is an inflammation of the cervix irrespective of the etiology.

Q. Are there any side effects of placing a cerclage?

A. Increased risk of infection, increased risk of ruptured membranes, increased risk of preterm labor.

Q. And is there anything that an obstetrician can do at or about the time of placement of cerclage to reduce those risks that you have just told me about?

A. I don't understand the specific nature of the question.

Q. You told me that there are some side effects --

A. Correct.

Q. -- of placing a cerclage. And I want to know, is there anything that an obstetrician can do by way of additional therapy in addition to the cerclage to reduce those risks?

MR. DJORDJEVIC: Do you

understand the question, Doctor?

THE WITNESS: I do at this time.

A. The one thing one can do is place the patient on tokolytic therapy, that is to say, drugs that will help to arrest contractions, in an effort to decrease the irritability of the uterus after a foreign body has been placed within it.

Q. What are the tokolytic drugs that you utilize?

A. There are several, and it depends on the clinical situation.

Q. Could you just name a few drugs that you utilize?

A. Ritodrine, Terbutaline, magnesium sulfate, Indomethacin.

Q. Do you have any opinion as to what the risk factors are in terms of percentage of a person with an incompetent cervix who is untreated of subsequently developing preterm labor?

A. No, I do not.

Q. Doctor, is it your practice when you're treating a woman in her pregnancy to obtain her obstetrical records from her previous obstetrician?

A. We make an effort to obtain records whenever possible.

Q. And did you do that in Mrs. Keller's case?

A. At the time I practiced with Dr. Bartek, we made requisition for the records to be transferred from Dr. Wisler's practice.

Q. What if a woman came to you who had just moved into the area and had been treated by an obstetrician out of city or out of the state, is it still your practice to get copies of those records?

A. We made attempts to get copies of records in general.

Q. And you don't know specifically whether that attempt was done with Mrs. Keller?

A. I don't know specifically with regard to the current -- the pregnancy that we're discussing.

Q. Do you keep yourself current in the field of maternal/fetal medicine by reviewing journals and suscribing to journals, I trust?

A. Yes, I do.

Q. Which journals do you subscribe to?

A. I have an extensive list that includes the American Journal of Obstetrics and Gynecology, Obstetrics and Gynecology, Clinical Obstetrics and Gynecology, Clinics in Perinatology, the Journal of the American Institute of Ultrasound in Medicine.

Q. What about textbooks that you have at your office that you regularly refer to, would you cite some of those for me if either in maternal/fetal medicine or OB/GYN?

A. Maternal and Fetal Medicine, edited by Creasy and Resnik; Obstetrics, edited by Steven Gabbe G-A-B-B-E; Williams Obstetrics by Gant and Cunningham, to name a few.

Q. Which of those journals that you have cited and textbooks that you would consider prestigious or authoritative?

MR. DJORDJEVIC: Well, I'm going to object to the compound nature of the question. Ask him which he considers prestigious and which he considers to be authoritative.

Q. One at a time then. Which of those do you consider to be pretigious?

MR. DJORDJEVIC: If any.

A. Are we speaking about journals or textbooks?

Q. Either one.

A. They are all well known textbooks. I can't say as I consider any one of them to be pretigious or authoritative in a specific sense.

Q. Okay. Doctor, I'm going to ask you a few questions about -- probably more than a few

questions -- more specific questions about Mrs. Keller. And I want you to understand this is not a memory contest. You're more than free to look at her chart before responding to the question.

A. Thank you.

Q. When did you first meet Mrs. Keller?

A. I don't recall. It was when she was pregnant with her second child.

Q. Okay. Was there anything by way of history that was unusual when she came in to see you the first time?

A. Yes. She had a prior miscarriage at six weeks and a prior preterm delivery at 34 weeks gestation.

Q. Okay. Did you ask her when she came in to see you whether or not she had any history of being exposed to DES?

A. Yes, I did.

Q. And what was her response to that?

A. I don't recall the exact words, but to the best of my knowledge there was no exposure that was, that was documented or recounted on her part.

Q. Do you have a standard questionnaire sheet that new patients fill out and is that part of the questionnaire sheet, that is, previous history to DES?

MR. DJORDJEVIC: Well, does he have it now or did he have it then?

Q. First of all, was there ever one in existence, that standard questionnaire sheet for new patients?

A. We have a standard history form that we follow for new patients.

Q. Okay. And do you have one for Mrs. Keller?

A. I have the one that was filled out for her in the pregnancy at hand.

Q. Okay. And is there any reference on there relative to previous exposure to DES?

A. No, there is not. Specifically I ask all patients about exposure to DES, because although it is not a matter that is printed on the form, it is something that we have some concern or an interest in.

Q. Okay. We've talked about her history that she came in with. And how did that pregnancy go?

A. Which pregnancy? I'm sorry.

Q. The first pregnancy that you managed for Mrs. Keller.

A. That pregnancy was complicated by premature labor, premature contractions at approximately 32 weeks gestation. I admitted her to Elyria Memorial

Hospital as I recall and airlifted her to Fairview General, because delivery appeared inevitable.

She subsequently delivered a four pound one ounce infant at 32 weeks gestation by clinical means.

Q. What do you feel was responsible for the preterm labor?

A. I don't think anyone knows. We have no way of knowing. Her history was such that she began having contractions.

Q. And then when did she come to you after that -- what was the child's name, do you know?

A. I don't recall.

Q. Okay. What was the date of that delivery?

A. The specific date I don't have. I have the month and year.

Q. All right. What month and year are we talking about?

A. December 1988.

Q. When did she come to you after December of 1988?

A. She saw me for postpartum care and was also followed and evaluated for chronic pelvic pain. The diagnosis of pelvic inflammatory disease was made.

Q. Okay. And did she subsequently come to you for

another pregnancy?
A. Yes, she did.
Q. When did she come to you; what month, what year?
A. Her first visit to the office for the subsequent -- for the pregnancy that is under discussion was September 22nd, 1989.
Q. Okay. And at that time did you indicate to Mrs. Keller that she had an incompetent cervix?
A. No, I did not.
Q. Did you ever indicate that to Mrs. Keller?
A. No, I did not.
Q. Did you ever conclude during the course of that pregnancy that she had an incompetent cervix?
A. No, I did not.
Q. What, if anything, unusual occurred with that pregnancy?
A. That pregnancy being the one currently under discussion?
Q. Yes.
A. That pregnancy was complicated by spontaneous rupture of membranes on or approximately December 28th, 1989.
Q. What is the relationship between incompetent cervix and spontaneous rupture of membranes?
A. There is no direct relationship that is known.

Q. And when were you notified about the spontaneous rupture of the membranes?
A. She presented to the hospital on the morning of December 28th with symptoms of bleeding. At that time she was seen by Dr. Bartek, who on seeing me in the office later that day indicated that Mrs. Keller was admitted to the hospital with vaginal bleeding and spontaneous rupture of membranes.
Q. How do you treat spontaneous rupture of membranes?
A. Expectant management.
Q. And by expectant management what do you mean?
A. We wait to see what will happen.

Let me back up and say, it depends on the gestational age as to how the expectant management will be handled.

Q. In this circumstance?
A. In this circumstance options included induction of labor and expulsion of the fetus, of a previable fetus, or if the patient requests, understanding that the outcome will be poor, continuing to wait and see if fluid would reaccumulate and if the rent in the membranes would close.
Q. So Mrs. Keller had two options. She could have terminated the pregnancy or she could have gone forward with the pregnancy with a risk that the

baby may be in jeopardy later on?
A. And the answer to that is, yes, but also with the risk that she might be in jeopardy later on.
Q. What would jeopardy to her be; infection?
A. Infection.
Q. Anything else?
A. No.
Q. And what did you advise or recommend to Mrs. Keller?
A. I presented both options to her. I left the choice with her as to what would be the best option. In her case I was concerned about infection because of her prior history and told her that if she chose to terminate the pregnancy I could in good conscious proceed with inducing labor and allow her to expel the fetus.

I allowed some time to pass for her and her husband to consider that option as well as the option of expectant management or waiting and let her make her own decision.
Q. And she chose the latter?
A. Yes.
Q. She and her husband chose the latter?
A. That's correct.
Q. Did you go over and see Mrs. Keller that day, do

you know?
A. Yes, I did.
Q. Of the day that she was admitted by your partner?
A. Yes.
MR. DJORDJEVIC: I don't think they were partners at that time.
Q. Your associate or whatever.
A. Yes.
Q. Going back to the second pregnancy that was delivered in December of '88, was there any evidence of uterine contractions at or about 28 weeks of gestation?
A. I do not have the prenatal records from the prior pregnancy. When the records were requested from Dr. Wisler's office I only received a -- I received no information about the prior pregnancy. And I cannot recall.
Q. Was there a problem between you and Dr. Wisler as to why you wouldn't get all the records you requested?
MR. DJORDJEVIC: I'm going to object. It would be better for you to ask Dr. Wisler. If you know why you didn't get all the records tell Mr. Becker.
A. No, I don't know. We made a request for records.

As a matter of fact we made a request for all records in your possession, meaning Dr. Wisler's, on September 22nd, 1989. And I only received records that began with February 24th, 1989 and went forward. Nothing here was ever recovered or received relating to the prior pregnancy.

Of my own knowledge I don't have any recollection of contractions at 28 weeks of pregnancy in the prior pregnancy.

Q. When you began to manage this new pregnancy of September of 1989, would it be fair to classify Mrs. Keller as a high risk obstetrical patient at that time?

A. Yes, it would.

Q. For what reason?

A. Two prior preterm deliveries in the third trimester.

Q. As well as a spontaneous abortion at six weeks, correct?

A. One spontaneous abortion in the first trimester does not increase the patient's risk as such.

Q. Well, what was she at risk for?

A. She was at risk for another preterm labor.

Q. It is your opinion that that history isn't sufficient to fairly call her an incompetent

cervix?

A. Not at all.

Q. What's missing, if anything?

A. Painless cervical dilatation in the second trimester of pregnancy. No history of bulging cervical membranes without any evidence of -- I'm sorry -- no history of bulging cervical membranes in the absence of any contraction activity.

Q. What about excessive vaginal discharge, would that be a factor pointing toward incompetent cervix as well?

A. No, it would not.

Q. Is it your opinion that Mrs. Keller never complained about any uterine tightness or irritability or contractions during the pregnancy that was ultimately delivered in December of '88?

MR. DJORDJEVIC: Again I'll object to the compound nature of the question. I'd like him to answer as to each of those.

A. I have no recollection.

Q. Do you utilize in your practice an outside perinatal nursing service for home uterine activity monitoring?

A. I have in the past, yes.

Q. What organization do you utilize?

A. I don't recall. I have utilized such an organization once in the past, but I can't recall the name.
Q. Tokos, does that ring a bell?
A. I have heard of Tokos, but I can't honestly say that I have consulted them in the past. I don't recall.
Q. Did you ever indicate to Mrs. Keller that the reason you couldn't stitch her was because of her allergic reaction to a tokolytic drug?
A. The answer to that is that I don't recall ever having told her that I would stitch her. I was aware that she had a reaction to a tokolytic drug.

MR. DJORDJEVIC: That's fine. You've answered it.

Q. Let's talk about that reaction that she had to the tokolytic drug. When was that?
A. I recall from the pregnancy that ended in December of 1988, that we had attempted to treated her with Ritodrine. And I believe that tachycardia developed. Tachycardia was symptomatic, and the medication was discontinued.
Q. How much medication was she on? How long did the tachycardia --

A. My next sentence was that I don't have those records and I cannot recall any more specific information about the pregnancy that ended in 1988.
Q. So those records that you are referring to would still be at Wisler's office?
A. Correct.
Q. Well, if a patient -- if a tokolytic drug is indicated for a patient and you know she is allergic to one tokolytic drug, you would agree with me that the appropriate standard of care then is to attempt another tokolytic drug?
A. Only if the tokolytic drug is still indicated.
Q. You don't recall any conversation with Mrs. Keller regarding the '89 pregnancy relative to placement of a cerclage, is that correct?
A. That is correct.
Q. Going back to Mrs. Keller's rupture of her membranes, I believe in December of '89, do you know whether or not Dr. Bartek did any litmus test on the amniotic fluid?
A. I don't have any knowledge of that.
Q. That would be appropriate to do if someone suspected a premature rupture of membranes, correct?

A. That is one modality that is appropriate.
Q. Well, is there another way to test for premature rupture of membranes other than a litmus test?
A. Yes, there is.
Q. What is it?
A. One method is amniocentesis, whereby a dye is injected into the uterine cavity. Observation of the patient's vagina and any vaginal afflux is then made. If the afflux changes color corresponding to that of the dye injected, that would be consistent with membrane rupture.
Q. Did you give Mrs. Keller antibiotics once you were made aware of the rupture of the membranes?
A. No, I did not.
Q. Why not?
A. Because it is not appropriate.
Q. It is not appropriate to prophylactically give antibiotics because she's at now increased risk of infection?
A. No, because the increased risk of infection has to do with infection of the body cavity. Body cavity infections are treated by evacuation of the body cavity, not by giving antibiotics.
Q. Doctor, what have you reviewed in preparation for this deposition today?

A. I reviewed the chart that I have in front of me. I also had the opportunity to look at the videotapes of the ultrasound that were prepared in our office prior to the patient's admission to the hospital.

Q. Were you told or did you review Mrs. Keller's answers to interrogatories?

A. No, I did not.

Q. And you weren't told what the substance of that was?

A. No, I was not.

Q. Doctor, were you advised one week prior to Mrs. Keller's hospitalization for the premature rupture of her membranes that she suspected that there was a rupture?

A. I don't recall if I was advised of that before the fact. I note from my obtaining historical information from her at the time of her hospitalization that she had a small gush of fluid approximately one week earlier. An ultrasound obtained in our office at that same time indicated adequate levels of amniotic fluid. And for that reason the conclusion was that rupture of membranes had not occurred.

Q. Are you saying that when she complained about a

rupture of -- a gush of fluid that you saw her immediately?

A. I'm saying that she complained of the gush of fluid at or about, on or about December 21st. On December 21st she underwent fetal ultrasound and in addition an assessment of the amniotic fluid volume was made. And it was found to be of a normal level. Had she ruptured membranes the fluid level would have been decreased.

Q. So you don't have any records in your chart about a phone call about a week prior to December 22nd with reference --

MR. DJORDJEVIC: Wait a minute. A week prior to December 22nd? The 28th was the original question.

Q. A week prior to -- thank you -- prior to December 28th.

MR. DJORDJEVIC: Which would be December 21st, and I think he just talked about the --

A. I have no records to that effect.

Q. So you really don't know when this gush of fluid by the records you have in front of you actually occurred?

MR. DJORDJEVIC: Or if it

occurred.

A. Well, first off, I don't have firsthand knowledge that it indeed occurred.

Secondly, the information that I have is that if it occurred it occurred approximately one week prior to her admission to the hospital, which was at the same time that she had had a fetal ultrasound performed.

Q. Why do you feel that it occurred prior to her ultrasound?

A. I never said that I did. That is not what I said.

Q. I misunderstood you then. Repeat it, please.

THE WITNESS: Could you read back my answer to the last question?

(Notary read back prior answer.)

A. I'll give you the same answer.

Q. Doctor, I'm looking at the ultrasound results, it looks like on the 21st. And it says here, a membranous separation in the uterine cavity was noted near the fundus. What does that mean?

A. It means there was a density or a lucency on the ultrasound pictures that indicated the presence of fluid on both sides of the membrane.

Q. Could that be a, could that be a premonitoring sign of a rupture about to occur?

A. No. It would be an indication. It would not be an indication of a rupture about to occur. Because, number one, it is in the wrong place. And, number two, its location suggests that it may represent an elevation of the membranes and collection of blood behind it.

I also made the comment in the interpretation that that also could represent a degenerating second pregnancy, because that also presents in the same way.

Q. You also referred Mrs. Keller out to another perinatologist, correct?

A. No, I did not.

Q. Well, tell me about the balance of her pregnancy course then, of her last pregnancy?

A. Beginning from when?

Q. From the premature rupture of the membranes.

MR. DJORDJEVIC: I'm going to object to the general nature of this question. If you're happy with the general answer, I'll permit him to give a general answer, but I want it understood that there's no way in the world he can tell you everything that happened in the rest of her pregnancy in the answer to just one question.

If you can synopsize it, Doctor, do it. If

you can't, then we'll wait for more specific questions.

THE WITNESS: Shall I answer?

MR. DJORDJEVIC: Well, if you can synopsize it, synopsize it. If you can't, we'll wait for more specific questions.

A. The patient was discharged from the hospital on December 29th. She was seen back in my office on January 2nd, 1990, having been duly instructed as to the kinds of monitoring that I had wanted her to perform at home as part of her expectant management.

Q. What would that have included?

A. The patient was advised to avoid aspirin and Tylenol for temperature control since these medications continue to mask temperature elevations. The patient was advised to take her temperature three times a day, on awakening, mid afternoon and approximately 8:00 p.m. in the evening. The patient was advised to contact the office immediately for temperature elevations greater than 100 degrees Fahrenheit, reoccurrence or worsening of uterine tenderness and pain. Also should the patient develop lower segment pressure and/or foul smelling discharge, to also contact

the office.

Patient returned on January 2nd indicating at that time, first of all, that there was no temperature. She remained afebrile. There was occasional leakage of fluid. The patient was once again advised that she was at increased risk for fetal loss as well as intrauterine infection.

Follow-up ultrasound was performed on January 8th, 1990. This showed consistent fetal growth as well as marked decrease in amniotic fluid. Cardiac activity was noted as well as fetal limb motion.

The recommendation was for a follow-up in three to four weeks for a continued fetal assessment. The patient was also advised to return to the office on July 9th or, excuse me, January 9th.

She did. And at that time she stated that she was not leaking fluid. She was advised to continue surveillance. I discussed with her that if she was comfortable, in response to her request, that if she was comfortable I also see her on a two week interval basis rather than every week.

And on January 23rd her husband presented to

the office and requested her medical records. I have not seen her since then. And that is the end of my synopsis.

Q. On January 23rd she would have been approximately how many weeks gestation?

A. Approximately 23 weeks.

Q. Doctor, Mrs. Keller is of the opinion that you two discussed the placement of cerclage in her when she came to you with her pregnancy of 1989. Do you deny that now?

MR. DJORDJEVIC: Asked and answered. Go ahead and answer.

A. Yes. At no time did I consider a cerclage in her. She was not an appropriate candidate.

Q. And, finally, Mrs. Keller advises that you informed her that she had an incompetent cervix sometime in the pregnancy of 1989. Do you deny that?

MR. DJORDJEVIC: Go ahead and answer.

A. In the pregnancy under question? Yes, I deny that I ever informed her that she had an incompetent cervix.

MR. BECKER: Okay. That's all I have.

MR. DJORDJEVIC: Good enough. We'll read it.

MR. BECKER: And I'll order it, so type it up.

C E R T I F I C A T E

The State of Ohio,)
) SS:
County of Lorain.)

I, Kathleen A. Hopkins, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, ANTHONY E. BACEVICE, JR., M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced by me to stenotype in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Elyria, Ohio, this 19th day of September, 1991.

Kathleen A. Hopkins, Notary Public
My commission expires 1-10-95
Recorded in Lorain County, Ohio