COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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PATRICIA TIPPIE, et al., :

PLAINTIFF,

vs. : Case No. 299575

SHOBHA R. TAMASKER, M.D., : Judge Corrigan

DEFENDANT.

- - -

Deposition of Michael S. Baggish, M.D., a witness herein, taken by the defendant as upon cross-examination pursuant to the Ohio Rules of Civil Procedure, and pursuant to agreement and stipulations hereinafter set forth, at the offices of Michael S. Baggish, 375 Dixmyth Avenue, Cincinnati, Ohio, at 5:30 p.m. on Wednesday, August 4,1999, before Daniel T. Neumeister, a notary public within and for the State of Ohio.

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APPEARANCES:

On behalf ot the Plaintiffs:

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On behalf of the Defendant:

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that the deposition of MICHAEL S. BAGGISH, M.D., a witness herein, may be taken at this time by the defendant as upon cross-examination, pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement; that the deposition may be taken in stenotypy by the notary public-court reporter and transcribed by him out of the presence of the witness; that the deposition is to be submitted to the deponent for his examination and signature, and that signature may be affixed out of the presence of the notary public-court reporter.

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EXIBITS

(WHEREUPON, Defendant's Exhibit #1 was marked for identification.)

MICHAEL S. BAGGISH, M.D.,

being first duly sworn, was examined and deposed as follows:

CROSS-EXAMINATION

BY MR. AUCIELLO:

Q. Doctor, my name is Ernie Auciello. I'm the attorney for Dr. Tamasker in the case of Patricia Tippie versus Shobha Tamasker, Case Number 299575, Cuyahoga County Common Pleas Court. We're here by agreement to take your discovery deposition concerning your opinions regarding the care provided by Dr. Tamasker to Patricia Tippie. I guess I'll start out by asking you to state your name and professional address.

A. Michael Baggish of Obstetrics and Gynecology, Good Samaritan Hospital, 375 Dixmyth -- D-I-X-M-Y-T-H -- Avenue, Cincinnati, Ohio 45220.

Q. Okay, Doctor. Just prior to the deposition you handed me a curriculum vitae which I had marked Exhibit #1. Could you identify the document I had marked Exhibit #1 and tell us whether that is a current CV for you?

A. That is a current CV.

Q. Okay. Having that I won't waste time

with going through questions about your background and education. How did you become involved in analyzing or reviewing the care of Patricia Tippie?

A. I received a letter from Mr. Landsdown. I think it was in 1997 or thereabouts. Maybe it was before September of 1997. It was sometime, I think, in that year in which he sent me a letter and asked me to review this case.

Q. Do you have that letter with you now?

A. I don't. I have one from September 17 in which he enclosed reports of your experts.

Q. Okay. And at that time on September 17 he sent you Dr. Silgore's report and Dr. Madhav's report?

A. Yeah. So I know I have seen this data before then.

Q. Okay. And in addition to the material -- the expert reports you received -- Dr. Silgore's and Dr. Madhav's -- what other materials have you reviewed?

A. I have the medical records of Mrs. Tippie from the time of her delivery until the time of her last surgeries.

Q. So you have reviewed records up to her last surgery?

A. I believe so, if the last surgery, according to what I have, was at Metro Health in 1996.

Q. Okay. In addition to the medical records and the expert reports, have you reviewed anything else in this case?

A. I have reviewed the depositions of Ms. Tippie and of, I believe, Dr. Tamasker.

Q. Is that all that you reviewed records of, the expert reports and the two depositions?

A. That's it.

Q. Doctor, to cut to the chase, I believe you issued a report or a written letter to Mr. Landsdown in March of 1997 which has been presented as an expert report in this litigation. And that concerns criticisms you have of the care of -- by Dr. Tamasker. I'll show you a copy of it.

A. That's correct.

Q. Okay. I would like to gain a complete understanding of what your criticisms are before, so I know what to expect at trial.

A. Sure.

Q. Do you have any criticism of Dr. Tamasker's prenatal care of Patricia Tippie?

A. No.

Q. When is your -- I would like to itemize them. That's what I'm going to try to do is get a list of what criticisms you have and then discuss each with you.

So if you could tell me what is your first criticism of Dr. Tamasker's care of Patricia Tippie?

A. The criticism I have is fairly straightforward. That is, the patient ended up with a deficient sphincter ani either as a result of an inadequate repair and that it wasn't repaired properly at the time the injury occurred, or that it was traumatized after the repair was done and broke down and not recognized.

Q. All right. So essentially in layman terms, her sphincter muscle never healed, is that correct?

A. Well, I'm saying there is either of two things.

Q. Okay.

A. If it was not repaired and the ends of the sphincter were not brought back together again as a result of Dr. Tamasker's delivery, the episiotomy that was cut extended beyond its normal confines.

Q. Okay.

A. An episiotomy is essentially a surgical cut to avoid an uncontrolled laceration.

Q. Right.

A. In this case that cut extended beyond where it had intended to stop. It extended through the sphincter muscle of the anus. That sphincter muscle has

to be repaired; otherwise, the patient will be incontinent of feces. It is the thing that closes the rectum. Everybody can do it. You squeeze your muscles, and that is the sphincter working. And what one needs to do is to recognize it.

I have no criticism because Dr. Tamasker recognized it. There was a third degree laceration charted. The next step is you have to repair it, and that means you must identify both ends of the cut sphincter and adequately bring them back together. If that's done, the sphincter is repaired, and the patient recovers and she is not incontinent.

Q. All right. So your criticism isn't the fact that a third degree laceration occurred?

A. That's correct.

Q. Is it true that that's a recognized complication of childbirth?

A. Yes.

Q. And your criticism relates to you said either the sphincter muscle tear was not repaired correctly --

A. Correct.

Q. -- or you had another alternative?

A. Or it was traumatized and broke.

Q. I would assume that under this scenario

the muscle was repaired; however, something happened after surgery that caused it?

A. In that scenario, that's correct.

Q. Do you have an opinion as to between these two alternatives which is more likely or probable between the two?

A. One of the two happened. We know that. So it really makes little difference. If it was traumatized, then Dr. Tamasker fell below the standard, and she fell below the standard because any gynecologist who injures an anal sphincter knows that like any injury, if you broke a bone, you splint the bone. What you want to do is to rest that sphincter, and you don't want to put anything in it.

There was a big sign when I did my training, and I have subsequently told the residents it's a good thing to put in the chart, no rectals, no enemas, because you don't want to traumatize the sphincter after it's been repaired.

If you test it during that period of time, you stretch it. You can tear out the stitches that were put in. And clearly she ordered an enema, which was completely and diametrically opposite to what should have been done, and she mentions that in her deposition. I'll tell you exactly where it is.

Q. It's okay. You don't have to. I remember it being there.

A. You recall when it was taken and she, herself, admitted that she doesn't -- wouldn't give an enema? And it sounded to me as if she was surprised that it was ordered, and if it's ordered, then it's going to be carried out. And according to Ms. Tippie's deposition, it was carried out. She had an enema in the immediate post-partum period.

Q. While she was still in the hospital right after birth?

A. Yes. And so here the reason for no enema is because people have had experience that if you do those things, you tear open the sphincter muscle. It's newly repaired, and it typically -- muscle can tear easily under those circumstances. It's swollen. So the slightest kind of injury to that will cause that to part --

Q. Okay.

A. -- from it's suture, and an enema is the coarsest way to accomplish that.

Q. All right. So let me try to get that. I think so far I have gotten two criticisms, and one is a possibility. You said it's possible --

A. She never repaired it --

Q. -- she never repaired it.

A. -- which would fall below the standard.

MS. CAVANAUGH: Objection. I don't believe he used the term "possibility."

Q. She either never repaired it or gave an enema that traumatized it is what your testimony is?

A. That she repaired it, and then the enema that was given caused the sphincter to part from the repair that was made.

Q. And you don't have an opinion as to which of those two possibilities are more likely or less likely?

A. I would say it's more likely it is the second.

Q. More likely that if it was repaired, the enema caused it to tear?

A. Yes. That's what I would say.

Q. Are you able to be more specific than -- more likely 60/40, 70/30, something like that?

A. No. It's my opinion.

Q. I wouldn't be a lawyer if I didn't ask you that question.

A. I would say if you want a percentage, I would say that, in my opinion, it's probably better than 50 percent.

Q. Okay. Now, examining the second possibility, the more likely possibility, how do we know

that the enema caused the sphincter muscle to tear open or the repair to fail?

A. Because the patient was incontinent.

Q. Are there any other causes that could have resulted in failure of the --

A. No, sir. I assume you are asking me whether I agree with the opinion of your expert -- one of your experts.

Q. I was going to get to that.

A. Well, I don't, so that takes care of that.

Q. That's not a big surprise, but nonetheless --

A. I don't think there is a pudendal nerve injury there. I'll tell you why, too, if you want to know.

Q. Tell me now. Maybe we will save time.

A. Because the injury she has is in the midline. The pudendal nerve -- there is no evidence of that anywhere in the medical record. In fact, there is evidence to the contrary that she had good sensation, that there was not a pudendal nerve injury, and this interior portion, the fiber of the pudendal nerve coming across from both right and left. So you would have to postulate a bilateral pudendal nerve injury, and your expert would

have to tell me exactly where that occurred and how it would have occurred during this procedure.

The only way that that typically can occur is if the vacuum extractor may have -- may have been improperly applied and put a tremendous amount of pressure on the pudendal nerve on both sides, which I, myself, knowing the anatomy very well, would have a very hard time explaining how that could occur.

Q. Okay. And I have gone through either she never repaired it, or she repaired it and the enema caused it to part, and there -- in your mind, there is no other cause possible? If it was repaired, it was separated by the enema, simple as that?

A. I told you I didn't think it's paralyzed because of the bilateral pudendal nerve injuries.

Q. And those two are somewhat in the alternative. Do you have any other criticisms of Dr. Tamasker's care?

A. Yes.

Q. What are those?

A. Well, Dr. Tamasker knew that she had caused a pudendal -- sorry. You have got me saying that. I was misspoken -- a sphincter injury. Yet on the post-partum where the instructions are typically for the care givers at home, there is no mention of this

whatsoever even though there is a place for it to be checked, and there are no special instructions on the care for that type of injury.

Q. What instructions should have been given?

A. Pretty much the same things I have already mentioned, that, one, the patient -- somebody ought to check up and make sure the patient is taking her stool softener or give her mineral oil so she won't have hard stool. Two, she should have no rectals and no enemas, and that somebody should keep track of whether this patient is continent or having trouble controlling her bowels, and unfortunately without that kind of previous information, the care giver at home -- the care coordinator who is going to visit this patient at home knows nothing.

She can't instruct the patient on anything -- what to look for, who to call, what to do, and so, again, we are in a period of great no information for this patient. And I would say that it does fall below the standard that this chart summary is inaccurate.

Q. In what respect is the discharge summary inaccurate?

A. It says, "Complications of Operative," and she has checked, "None." It says, "Activity, diet, medications," etcetera, "unrestricted routine." So even

though she knows this patient has had a complication and should be given specific instructions, none of these things are charted. In fact, it's the opposite. It's as if nothing happened to this person. Here is the page..

Q. These circles are circles you made?

A. Yes, sir....

Q. All right. On the obstetric discharge summary -- first of all, right now when we are talking about an issue of charting, what harm did that cause Patricia Tippie?

A. I think I have just gone through it all with you.

Q. I guess what I don't understand is if the enema while in the hospital caused the muscle to tear, what further harm resulted from the charting on the discharge summary?

A. Well, there is no recognition of this. The patient could have been alerted to the fact that if she is incontinent, to come in right away so that this patient could have been either taken care of by the obstetrician or gynecologist, that a plan could be made for getting this thing repaired in a timely manner, or getting referred.

Q. Is it important in a circumstance like that for a surgical repair to be made immediately, or is

it --

A. No, you wouldn't do it immediately, but certainly by six weeks. I would be inclined to do it early rather than late.

Q. What would be the range of time that you would find reasonable to do it?

A. I would do it between six and eight weeks

Q. All right. On that form you showed me, Doctor, you have circled the one section. Just so the record is clear, on the right-hand column toward the middle where she has checked "episiotomy," I think that's "midline episiotomy'! if I'm reading that like you.

A. Yes.

Q. And she also has checked "vacuum delivery"?

A. Yes.

Q. You have that little section of the discharge summary circled. What else should have been checked there?

A. Nothing.

Q. Okay. I saw it circled. I thought maybe you were indicating something else.

A. I circled it because when I went through it, I saw the vacuum delivery, and I wanted to remind

myself about it.

Q. Okay. Is there a box on that form that should have been checked that is not checked?

A. Yes. Right here it says "complications."

Q. Okay. And you are looking -- you circled the box where it says "perineal"?

A. She should have done that one and checked it out.

Q. All right. And as a result of this, the home health care people were unaware to check -- in your mind, to check to see whether she was incontinent?

A. If the patient remembers one enema -- it's a long time ago. I couldn't tell you what happened as part of my diet or something three or four years ago. Who knows? Maybe she took more than one enema.

Q. Would you expect a patient to know if they are incontinent?

A. These patients, they don't know. They will ask.

Q. Okay. The patient might not know they are incontinent?

A. They might not know. They may think it's part of what they are supposed to feel. Typically after a delivery many women will experience a temporary period of incontinence of urine, but usually that typically resolves

in a few days, but unless they are told, they may not even ask about it. And similarly, people don't -- particularly lay people who are -- who don't have a lot of medical knowledge, when it's issues of **soiling** themselves with fecal material or urinating uncontrollably, they are very shy about discussing that withaother people,. **You** have **to** ask about it typically.

Q. All right. Now, is there any evidence in the record to indicate to you that Patricia Tippie was incontinent and didn't know it for a period of time?

A. I believe she was

Q. And what --

A. If you read her deposition and from when I talked to her when I examined, she didn't know what was going on. She thought everything was normal. She said, quote -- I can remember this quote very well -- "I was opened up down there, and there were changes made, and I didn't know what to expect." Nobody talked to her and told her. That's a job of the health coordinator to some degree, but somebody has to give that person some guidance.

Q. And because the box wasn't checked on the discharge summary, you believe the health care coordinator didn't have that information?

A. I believe the health care coordinator

didn't know.

Q. Did you review the maternity services visit report in the record?

A. I saw it.

Q. Does it indicate that the patient reported having normal bowel pattern at that time?

A. Everything is pretty well checked normally here if you look.

Q. Looking under section six --

A. I see it, "adequate dietary."

Q. -- that's checked, "yes," then, "adequate fluid intake, yes," "anorexia" is checked "no." So they didn't just check the boxes?

A. She wrote, "returned to normal bowel function," and I find it hard to believe with the patient's systematology. It's my opinion that this is inaccurate.

Q. And this was filled out by a home health nurse visiting her on 6/14/94?

A. That's correct. And there is really no mention on this thing that they discussed her third degree perineal laceration, is there? I can't find it.

Q. There is evidence on here that they discussed her bowel pattern, isn't there?

A. I would say this: She has "episiotomy"

checked but has that negative sign in front of "laceration," which means she has no conception that this patient had a laceration.

Q. But even if she has no conception of that and the patient reports a normal bowel pattern, isn't that inconsistent with incontinence?

MS. CAVANAUGH: I'm going to object. You are speaking in a hypothetical that I don't think is her -- Patricia's testimony.

A. I don't even know if the patient had a bowel movement by then. The one enema she got she didn't get any returns on.

Q. So you basically don't believe this form is adequate?

A. I think it's inaccurate, really.

Q. Okay. All right. So I went through the first two, and the alternative, then the third was the no mention or instructions. Do you have further criticisms of Dr. Tamasker's care?

A. Yes, the post-partum visit in July -- 7/29/94.

Q. Right. What is your criticism about that visit?

A. Well, according to the medical record, the doctor never even examined this person's anus, and

that's the time she should have done a rectal, because it's six weeks post-partum to see what the status of the third degree laceration was, whether the sphincter was tight, relaxed, etcetera, because this is the time that if it's not right, she should have made her referral.

Q. And I believe -- I want to make sure I understand. If at that time the sphincter was not functioning properly, it would have been a surgical referral to be taken care -- you keep using the word "referral."

A. Here it wouldn't be a surgical referral. We have people who would do this operation, and a gynecologist is trained to do it if they feel they are skilled enough to do that. Many of them these days refer them to others. We have a uro-gynecology. We do fibular repairs, sphincter problems, surgical complications of the perineum and vagina, bladder, rectum. So a lot of referrals are made here for that.

Q. All right. Would the time be -- it would be an appropriate time, in your mind, to proceed with the surgery or just the referral after six weeks?

A. I think I said I would do it between six and eight weeks.

Q. All right. I have got four criticisms. I want to get to the end of the list of criticisms

hopefully.

A. Sure.

Q. Do you have any further criticisms of Dr. Tamasker's care?

MS. CAVANAUGH: I'm going to just object for the record that the doctor is going to be free to express criticism if he is asked other direct questions.

MR. AUCIELLO: Well, I mean, it's a fair question for a defense counsel to ask him all the criticisms he had of Dr. Tamasker, and I will persist on at least trying to get him to tell me everything he believes wrong that is a violation of the standard of care. I'm not asking you about imperfections.

MS. CAVANAUGH: I agree it's a fair question. I'm just noting an objection for the record.

A. I believe that's it.

Q. Okay. You also reviewed the records of the subsequent surgeries she underwent to have this corrected?

A. Yes, sir.

Q. Do you have an opinion as to why those surgeries failed?

A. Well, I don't know. I would tell you that after the first chance of the repair, subsequent repairs always have less chance of success. Each succeeding surgery has more problems to deal with. There is always scarring after subsequent surgeries, and blood supply gets to be a problem.

Q. So the one surgical procedure most likely to succeed would have been the first one?

A. Yes.

Q. Do you have an opinion as to why the first one failed?

MS. CAVANAUGH: Objection. That's asked and answered.

A. I think so. Either it was repaired in the first place improperly at the time of the delivery in the immediate post-partum period, or that when it was repaired, the enemas -- enema or enemas -- caused the disruption.

Q. Okay. But I was asking you about when the repair was -- I guess I poorly phrased that question. I'm talking about the first surgical -- attempted surgical repair after Dr. Tamasker's care. After the problem was recognized, she received surgeries to try to correct it.

A. Well, no. I thought you were talking about Tamasker's. One of the problems that -- if you

asked me about that first, which is Tamasker's repair, as I recall she repaired that with chromic catgut. In this day and age that is not the ideal suture for that kind of repair. It's a week suture and has much less tensile strength than other materials.

And an absorbable **suture** that would have been a better one to use would have been Vicril either braided or monophi·lament, and those are sutures that are absorbable but remain reasonably strong for four to six weeks whereas chromic catgut is starting to come apart even without any kind of traumatic injury at about ten days.

Q. And you said, "inside this day and age." Were you referring to 1994?

A. In the 1990's and certainly even in the 1980's.

Q. Is that according to criticism where you would believe she deviated from the standard of care?

A. I'm not saying it's a -- I don't know if I could say it's a deviation of the standard of care, but it was a very poor choice for suture material.

Q. **All** right. Doctor, Dr. Lambert attempted to repair this sphincter injury also, did he not?

A. Yes.

Q. Do you have any opinion as to why his

surgical attempts failed?

A. I really don't.

Q. Did I -- maybe we were on different pages before. When you were saying that each subsequent repair has a less chance of being successful, were you also including -- I think Lambert operated, and then there were further surgeries.

A. The first repair chance was Dr. Tamasker's. That's number one. That has the best chance of success.

Q. Right.

A. If that breaks down we are now at the second one. That would be Dr. Lambert's. That's the second check. His chance for this success is less than it was for Dr. Tamasker. Then the third chance is Dr. Strong's, and his chance for success is less than Dr. Lambert's, and then the forth chance was Dr. Rappert's, et al. I believe that's the name.

Q. It doesn't matter.

A. The chaps at Barber. Sorry. Sorry. It's Dr. Barber, et al., at the Metro Hospital, and they have the least chance.

Q. Generally speaking, is it possible to give me a percentage of what the -- how often the first surgical repair of such a tear is successful, generally?

A. I would say 80 to 90 percent, maybe even higher. It's a very high success rate. There are few women who sustain third degree lacerations and are incontinent after.

Q. I guess I'll use the 90 percent as opposed to the 80 percent.

A. Okay.

Q. Is it your opinion that the other 10 percent are the result of malpractice?

MS. CAVANAUGH: I'm going to object. I think that's not a fair statement of the percentages.

Q. He said 80 or 90 or higher. If you want to say higher, I'll pick another figure. The ones that fail, are they necessarily the result of malpractice?

A. They can be.

Q. Okay. Are there other potential causes that are not?

A. Hard for me to describe that -- why they would fail. I think in the final analysis of it, the two I gave you would have to be the major ways.

Q. And that's why I'm asking you the question, because you basically said -- it seemed to me your reasoning is it failed; therefore, either it wasn't repaired correctly --

A. That's correct.

Q. -- and violated the standard of care by not repairing it correctly, or you violated the standard of care by ordering an enema?

A. And the answer to your question would be yes.

Q. So, therefore, if it failed it's almost -- you can basically assume malpractice?

A. Yes.

Q. That's your opinion?

A. That's my opinion. And I would say I have probably given you an exaggeratedly low figure for repair. I think it would be well in excess of 90 percent.

Q. If it was 95 or 98 or whatever --

A. Sure.

Q. Okay. Now, when did you first see Mrs. Tippie?

A. May 12, 1999.

Q. What was the purpose of that visit?

A. For me to examine her.

Q. Were you examining her for the purpose of rendering treatment or examining her for the purpose of giving testimony?

A. An opinion on the degree of injury she had.

Q. And what did you observe during that examination?

A. By the objective?

Q. Uh-huh.

A. You have a copy of my report.

Q. I do. You don't have to read it, just what you think the effects are.

A. She had a midline scar on the abdomen. She had scars running on the medial aspect of the knee on the right leg and the thigh and scarring in the perineum. She has a gross deformity of the anus. The vulva appeared to be normal as does the antritis. On pelvic examination there is a band of tissue about three -- two to three centimeters up from the antritis on the posterior wall of the vagina which causes a lot of just touching it, and it's obstructive, and this extends upwards on the left side.

Q. And is this something that would cause discomfort?

A. It's very interesting, because when you press it, she feels discomfort there but down in her leg as well.

Q. What does that indicate to you?

A. It's probably related somehow to the gracilis muscle graft. If the pain is referred, even

though it goes up higher on the left, the pain is referred to the right, and I believe -- let me just check that. I believe that's where the graft was taken from.

MS. CAVANAUGH: Doctor, if this helps you to look at this, if this is what you are looking for.

A. That's it. So it is linked to that gracilis muscle graft, and she describes historically that the sphincter -- she had pretty good levator ani tone above that area. You could follow the levators by asking the patient to squeeze on your fingers. So they were okay in that area, but if you ask her to try consciously to squeeze the anal sphincter, she didn't get much of that. She squeezed, but she got the pain in her leg, which I assume she was extracting that gracilis muscle, and this is rather disabling.

And then I did a rectal vaginal, one finger in the rectum. You have to excuse the shape of this model. This summer somebody left it in the sun. The latex stuck on the floor board, but -- here is the anus here (indicating). It's stenotic. So this is the exam I did, and you can see where I am in that (demonstrating).

And this is where the scar was felt right up in here right back in this area like a "U" almost, but up in the vagina. This is the antroidal area here, right

up into there. And with this rectal vaginal exam, there really is not any good sphincter tone.

Q. Is there any prospect for the sphincter to improve in the future?

A. I don't think there is. In fact, my recommendation was to this patient because now she can't control her -- she has no sphincter control, so she can't control gas or feces. She leaks. She spends half of her time worrying what she is eating and whether she is near a toilet, so it becomes an obsession to make your whole life function around that. And then on top of it, she can't perform sexually because of the pain. And the pain is a peculiar pain, because it causes her leg to jerk and pain to occur in her leg.

And I told her it would be my advice to have a colostomy done, because at least she has got control of her bowel function. That way it's going to be in a bag, but at least you can see it and control it. You could then pull that gracilis graft out of there so she doesn't have the pain in her right leg and just take it out and reconstruct the floor of the vagina from the lower third down so that at least she could have intercourse without a lot of discomfort.

Q. Do you know -- I mean, did she communicate to you whether she was going to take that

advice?

A. I don't think she could right now psychologically. She did not want to think about another surgical procedure, and, two, about a colostomy. I think psychologically it would be very difficult for this lady, because I was quite candid with her and told her I didn't think anybody could fix that sphincter.

Q. You advised her not to bother with further surgical repairs?

A. That sphincter isn't going to be repaired ever, I don't think.

Q. Did you only see her on that one occasion?

A. That's it.

Q. Okay.

A. But I -- I had -he advantage of knowing the history of everything before I saw her and of all the surgery in detail.

Q. All right. Doctor, I need to clean up a few loose ends. On your CV I notice there are quite a few publications listed. Are any of these many publications particularly relevant to the issue of perineal tears or sphincter tears?

A. Well, some of the work I'm doing now certainly is, and right now I'm writing an atlas. Dr.

Karram and myself are writing an atlas of pelvic anatomy and gynecologic surgery which includes a lot of this stuff.

Q. It's a work in progress? It's not available yet?

A. No. We have -- we are under contract, and it should be finished by next June for sure.

Q. I guess --

A. And there are two publications we just submitted on the anatomy of the pelvic floor at the American Panel of OBGYN.

Q. If you could identify for me by the number which publications on your CV you regard as relevant to the issues in this case, if any, I should say.

A. From just looking through here to see whether any of this mentioned this in particular -- well, indirectly any of the articles I wrote on laser treatment of condyloma acuminata, because we were treating in the anus, and number 70 doing graph replacement for vaginectomy might again indirectly.

Q. Okay. Is that all?

A. I'm just looking through. That's it.

Q. Okay. Doctor, you have -- I ask a lot of questions I know the answers to. Have you given depositions before?

A. Yes.
Q. About how many occasions, if you can tell me?
A. Total?
Q. Yeah, if you can.
A. This year?
Q. This year.
A. Maybe about 10 or 15.
Q. Is that about average for the year?
A. No. That's a high number of depositions.
Q. High? Most of those instances you are retained as an expert witness on behalf of someone in litigation, are you serving as an expert?
A. Approximately 70 percent for the defendant and about 30 percent for plaintiff.
Q. And you are going to send me a bill for your time today. How much will that be on an hourly rate? -- I mean, per hour?
A. 450 an hour.
Q. Last thing, if you have copies of the expert reports from Dr. Silgore and Dr. -- the reports I guess starting with Dr. Silgore's report, I take it that you are familiar with these reports?
A. I read them. I don't know how familiar I am with them, but if you point the page out, I could look

it over.

Q. Well, I guess I'm going to -- see on the middle paragraph of Dr. Silgore's report --

A. Yes.

Q. -- he says, "Perineal lacerations of this degree are very common." **Do you** agree with that?

A. Yes.

Q. He also says that many heal with some degree of muscle separation of the sphincter. Do you agree with that?

A. I don't.

Q. Why is that, if you can?

A. I would like him to tell me how he knows that.

Q. Okay. It's kind of difficult for you to answer, and -- you agree with usually these patients do not develop incontinence, because there is no knowledge there are a group of patients like that?

A. **I** would like to know where he knows that information from, because I don't see how he would have that. How does one peek in there and see whether the sphincter is open or not open, and I would not rely on an ultrasound study.

Q. Okay. All right. Going to Dr. Madhav's report, I think you already addressed the nerve issue that

you obviously disagreed with.

A. Yes.

Q. Dr. Madhav notes that he -- he says, "A percentage of primary repairs fail to heal properly." Do you agree with that?

A. Well, I would guess a percentage or a fraction of a percentage of the primary repairs fail to heal properly. I would agree with that proviso, yes.

Q. Does that get back to the issue we already kind of beat to death with whether it would be negligence if it fails?

A. Well, he has got to tell me what number of -- what certain percentage of these primary ones fail, because I really don't know, as I have already said, and he would have to likewise explain to me why they failed to heal properly.

Q. This is not inconsistent with your experience?

A. No.

MR. AUCIELLO: Okay. I don't have any further questions. Thank you.

MS. CAVANAUGH: Doctor, you have the -- obviously the right to review the transcript.

THE WITNESS: I would like to read it and sign it, but I would just like the copy.

(Deposition concluded at 6:15 p.m.)

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Michael S. Baggish, M.D.

C E R T I F I C A T E

STATE OF OHIO :

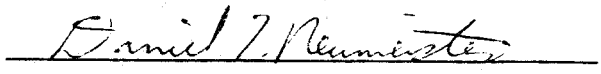
: SS

HAMILTON COUNTY:

I, Daniel T. Neumeister, the undersigned, a duly qualified and commissioned notary public within and for the State of Ohio, do hereby certify that before the giving of his aforesaid deposition, the said MICHAEL S. BAGGISH, M.D. was by me first duly sworn to depose the truth, the whole truth, and nothing but the truth; that the foregoing is a deposition given at said time and place by the said MICHAEL S. BAGGISH, M.D.; that said deposition was taken in all respects pursuant to Agreement; that said deposition was taken by me in stenotypy and transcribed by computer-aided transcription under my supervision; and that the transcribed deposition is to be submitted to the witness for his examination and signature.

I further certify that I am neither a relative of nor attorney for any of the parties to this cause, nor relative of nor employee of any of their counsel, and have no interest whatsoever in the result of the action.

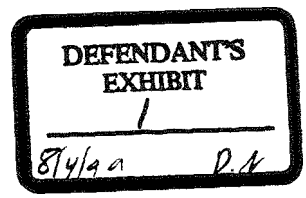
IN WITNESS WHEREOF, I hereunto set my hand and official seal of office at Cincinnati, Ohio, this 27th day of August, 1999.



My commission expires:
May 18, 2003

Daniel T. Neumeister
Notary Public State of Ohio

CURRICULUM VITAE
MICHAEL SIMEON BAGGISH



EDUCATION:

B.S., University of Louisville, Arts and Sciences
M.D., University of Louisville, Medicine with high honors
(Valedictorian)

RESIDENCY

General Surgery, The Johns Hopkins Hospital, Baltimore, Maryland
(under Dr. Alfred Blalock)

Assistant Resident Obstetrics and Gynecology, The Johns Hopkins Hospital

Chief Resident in Gynecology and Obstetrics, The Johns Hopkins Hospital,
Baltimore, Maryland (under Dr. Allan C. Barnes). 1968

FELLOWSHIPS:

Clinical Fellow of the American Cancer Society.. 1967

Post-doctoral Fellow of the United States Public Health Service 1967-1968
Fellowship served at the Kandang Kerbau Hospital, The University of Singapore, Singapore,
(under Professor S.H. Tow).
Gynecologic Pathology Fellowship, The Johns Hopkins Hospital
(under J. Donald Woodruff, M.D.) 1970-1972

MILITARY SERVICE:

United States Navy, Naval Hospital, Portsmouth, Va. Commander USNR 1968-1970

ACADEMIC:

Fellow, Department of Gynecology and Obstetrics, The Johns Hopkins
University School of Medicine 1968
Gynecologist-Obstetrician, Assistant Professor, The Johns Hopkins Hospital,
Baltimore, Maryland 1970-1972
Assistant Chief, Gynecology and Obstetrics, Sinai Hospital of Baltimore, Inc.,
Baltimore, Maryland 1970-1972
Chairman, Department of Obstetrics and Gynecology, Mount Sinai Hospital,
Hartford, Connecticut 1972-1983
Associate Professor, Gynecology and Obstetrics, University of Connecticut
School of Medicine, Farmington, Connecticut 1972-1977
Associate Professor, Pathology, University *of* Connecticut School of
Medicine 1976-1983
Professor, Obstetrics & Gynecology, University of Connecticut School of Medicine,
Farmington, Connecticut 1973-1983
Professor and Chairman, Obstetrics & Gynecology, SUNY Health Science
Center at Syracuse 1933-1991
Professor, Pathology, SUNY Health Science Center at Syracuse 1983-1991

Chief, Obstetrics and Gynecology, Crouse-Irving Memorial Hospital, Syracuse, New York.. 1983-1991
Sabbatical Urogynecology at St. Georges Medical School and Hospital under Stuart Stanton, ... 1991-1992
Chairman, Department of Obstetrics-Gynecology, Good Samaritan Hospital Cincinnati, Ohio..... 1993-present
Professor, Department of Obstetrics-Gynecology, University of Cincinnati.. ..... 1993-present

CURRENT ACTIVE LICENSURE:
California and Ohio - Diplomat National Board of Medical Examiners
INACTIVE LICENSURE:
Connecticut, Illinois, Kentucky, Maryland, New York, Virginia .

PROFESSIONAL ASSOCIATIONS:

American Fertility Society
American Association of Gynecologic Laparoscopists
American Society for Laser Medicine and Surgery, President
American Medical Association
American Society for Colposcopy and Cervical Pathology, Board Member (past)
Association of Professors of Obstetrics and Gynecology
Baltimore City Medical Society
Connecticut Association of Board Certified Obstetricians and Gynecologists
Connecticut State Medical Association
Diplomat of the American Board of Obstetrics and Gynecology
Fellow, American College of Surgeons
Fellow, American College of Obstetricians and Gynecologists
Gynecologic Laser Society, President
Hartford County Medical Association
New England Obstetrical and Gynecological Society
Onondaga County Medical Society
Pan American Medical Association
The Allan Barnes Society
The Medical and Chirurgical Faculty of Maryland
American College of Obstetrics and Gynecology, Sectional President
Medical Society of the State of New York
Society of Reproductive Surgery
International Society of Gynecologic Endoscoov
Ohio State Medical Association
Cincinnati, Ob-Gyn Society
British Society of Gynecologic Endoscopy (Honorary since 1991)

OTHER:

- Medical Supervisor and Principal Investigator Cervical Cancer Screening Project for the State of Connecticut (National Cancer Institute Project)
- Board of Directors, American Cancer Society & Member Public Education Committee, Hartford, Connecticut 1976-1977
- Chairman, Permanent Committee DES, State American Cancer Society 1978
- Member, N.I.H. special study group: discussant and reviewer for grant ... 1979 .....applications, Bethesda, Maryland 1980-1981
- Member of Board of Directors American Society for Colposcopy and Cervical Pathology 1984
- Member of Board, American Society for Lasers in Medicine and Surgery 1984
  Council on Scientific Affairs of the American Medical Association, Panel on Lasers in Medicine and Surgery 1984
- Vice President, American Society for Lasers in Medicine and Surgery..... 1986-1990
- President, American Society for Lasers in Medicine and Surgery. 1990
- President, Gynecologic Laser Society 1984-1986
- Vice President, American College of Obstetricians and Gynecologists Section 5, District II New York.. 1987-1989
- President, American College *of* Obstetricians and Gynecologists Section 5, District II New York.. 1990-1991
- Member of New York State Board of Medicine 1989-1991
- NIH Panel - Endometrial Ablation 10/98
- NIH Panel - Obstetrical Hemorrhage 2/99
- Member of Quality Assurance Committee
- Ohio State Board of Medicine 1998-Present
- Vice President, Gynecologic Surgical Society 1998-Present

... SCIENTIFIC **EXHIBITS**

Contac: Hysteroscopy - A New Technique for Exploring the Uterus
American College of Obstetrics & Gynecology Annual Meeting, New York, 1979
First Prize, "College Aware" for Best Scientific Exhibit.

Contact Hysteroscopy: IXth World Congress of Gynecology and Obstetrics, Tokyo, Japan, October 25 - 31, 1979.

Contact Hysteroscopy: American College of Obstetrics and Gynecology Annual Meeting, New Orleans, May, 1980.

President's Award ASCCP and GLS combined meeting, Orlando, Florida, 1984
Poster Exhibit Inter. Society Study Vulvar Disease 1992 (Quebec)
Poster Exhibit Inter. Society Study Vulvar Disease 1997 (Italy)

PUBLICATIONS

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89) Baggish, MS and Baltoyannis, P: New techniques for laser ablation of the endometrium in high risk patients. Amer. J. Obstet. Gynecol, 159:2 287-292, (1988)

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