

1 COURT OF COMMON PLEAS

2 CUYAHOGA COUNTY, OHIO

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4 PATRICIA TIPPIC, et al., :

5 PLAINTIFF,

6 . vs. .

: Case No. 299575

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

8 DEFENDANT.

9 - - -

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

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20
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22 813 Broadway
23 Cincinnati, Ohio 45202
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25

1 APPEARANCES:

2 On behalf of the Plaintiffs:

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6 On behalf of the Defendant:

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S T I P U L A T I O N S

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.

I N D E X

Witness

Cross

Michael S. Baggish, M.D.

By Mr. Auciello 4

E X I B I T S

Marked

Defendant's Exhibit #1

4

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

3 MICHAEL S. BAGGISH, M.D.,
4 being first duly sworn, was examined and deposed as
5 follows:

6 CROSS-EXAMINATION

7 BY MR. AUCIELLO:

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

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

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

24 A. That is a current CV.

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

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

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

9 Q. Do you have that letter with you now?

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

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

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

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

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

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

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

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

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

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

8 A. That's it.

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

15 A. That's correct.

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

19 A. Sure.

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

22 A. No.

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

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

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

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

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

14 Q. Okay.

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

19 Q. Okay.

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

22 Q. Right.

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

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

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

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

15 A. That's correct.

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

18 A. Yes.

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

22 A. Correct.

23 Q. -- or you had another alternative?

24 A. Or it was traumatized and broke.

25 Q. I would assume that under this scenario

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

3 A. In that scenario, that's correct.

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

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

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

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

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

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

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

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

18 Q. Okay.

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

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

24 A. She never repaired it --

25 Q. -- she never repaired it.

1 A. -- which would fall below the standard.

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

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

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

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

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

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

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

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

18 A. No. It's my opinion.

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

21 A. I would say if you want a percentage, I
22 would say that, in my opinion, it's probably better than
23 50 percent.

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

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

3 A. Because the patient was incontinent.

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

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

9 Q. I was going to get to that.

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

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

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

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

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

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

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

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

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

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

19 A. Yes.

20 Q. What are those?

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

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

4 Q. What instructions should have been given?

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

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

21 Q. In what respect is the discharge summary
22 inaccurate?

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

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

5 Q. These circles are circles you made?

6 A. Yes, sir....

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

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

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

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

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

1 it --

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

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

7 A. I would do it between six and eight
8 weeks

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

14 A. Yes.

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

17 A. Yes.

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

21 A. Nothing.

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

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

1 myself about it.

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

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

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

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

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

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

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

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

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

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

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

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

11 A. I believe she was

12 Q. And what --

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

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

25 A. I believe the health care coordinator

1 didn't know.

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

4 A. I saw it.

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

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

9 Q. Looking under section six --

10 A. I see it, "adequate dietary."

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

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

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

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

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

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

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

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

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

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

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

15 A. I think it's inaccurate, really.

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

20 A. Yes, the post-partum visit in July --
21 7/29/94.

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

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

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

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

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

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

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

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

1 hopefully.

2 A. Sure.

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

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

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

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

19 A. I believe that's it.

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

23 A. Yes, sir.

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

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

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

9 A. Yes.

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

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

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

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

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

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

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

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

15 A. In the 1990's and certainly even in the
16 1980's.

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

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

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

24 A. Yes.

25 Q. Do you have any opinion as to why his

1 surgical attempts failed?

2 A. I really don't.

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

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

11 Q. Right.

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

19 Q. It doesn't matter.

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

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

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

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

7 A. Okay.

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

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

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

15 A. They can be.

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

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

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

1 A. That's correct.

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

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

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

9 A. Yes.

10 Q. That's your opinion?

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

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

15 A. Sure.

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

18 A. May 12, 1999.

19 Q. What was the purpose of that visit?

20 A. For me to examine her.

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

24 A. **An** opinion on the degree of injury she
25 had.

1 Q. And what did you observe during that
2 examination?

3 A. By the objective?

4 Q. Uh-huh.

5 A. You have a copy of **my** report.

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

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

18 Q. And is this something that would cause
19 discomfort?

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

23 Q. What does that indicate to you?

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

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

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

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

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

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

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

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

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

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

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

1 advice?

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

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

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

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

14 A. That's it.

15 Q. Okay.

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

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

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

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

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

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

8 Q. I guess --

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

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

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

21 Q. Okay. Is that all?

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

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

1 A. Yes.

2 Q. About how many occasions, if you can tell
3 me?

4 A. Total?

5 Q. Yeah, if you can.

6 A. This year?

7 Q. This year.

8 A. Maybe about 10 or 15.

9 Q. Is that about average for the year?

10 A. No. That's a high number of depositions.

11 Q. High? Most of those instances you are
12 retained as an expert witness on behalf of someone in
13 litigation, are you serving as an expert?

14 A. Approximately 70 percent for the
15 defendant and about 30 percent for plaintiff.

16 Q. And you are going to send me a bill for
17 your time today. How much will that be on an hourly rate?
18 -- I mean, per hour?

19 A. 450 an hour.

20 Q. Last thing, if you have copies of the
21 expert reports from Dr. Silgore and Dr. -- the reports I
22 guess starting with Dr. Silgore's report, I take it that
23 you are familiar with these reports?

24 A. I read them. I don't know how familiar I
25 am with them, but if you point the page out, I could look

1 it over.

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

4 A. Yes.

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

7 A. Yes.

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

11 A. I don't.

12 Q. Why is that, if you can?

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

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

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

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

1 you obviously disagreed with.

2 A. Yes.

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

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

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

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

17 Q. This is not inconsistent with your
18 experience?

19 A. No.

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

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

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

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

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.

1 IN WITNESS WHEREOF, I hereunto set my
2 hand and official seal of office at Cincinnati, Ohio, this
3 27th day of August, 1999.

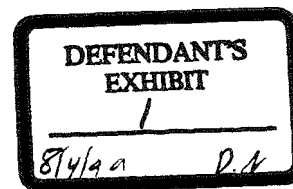
4 *Daniel T. Neumeister*

5 My commission expires:
6 May 18, 2003

 Daniel T. Neumeister
 Notary Public State **of** Ohio

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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 1983-1991
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 - Diplomate 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
 Diplomate 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 Endoscopy
 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)

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- 13) Baggish, Strummer and Frank: Human ovary under isolated perfusion: A model system. Obst. & Gynec. 38:463, 1971
- 14) Baggish and Woodruff: Vascular lesions of the uterus. Obst. & Gynec. 1972.
- 15) Baggish and Woodruff: Uterine stromatosis: Clinicopathologic features and hormone dependency. Obst. & Gynec. 40:487, 1972.
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- 34) Baggish et al.: Complications of Laparoscopic Sterilization. Obst. & Gynec. 54:54, 1979.
- 35) Baggish: The Contact Hysteroscope, A New Technique to Examine the Uterine Cavity. Obst. & Gynec. 54:350, 1979.
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rev.5/99

#1 4:21	advantage31:16 advice30:15;31:1 advised31:8 aforesaid37:8	Barber25:20, 21 basically20:13; 26:23; 27:8 beat35:10 become5:2; 30:10	14, 15, 16, 17, 22 changes18:17 chaps25:20 chart9:17; 14:20;8:8; 15:3, 9, 15 chase6:9	4:6 current4:22, 24 curriculum4:20 cut6:9; 7:18, 21, 23;8:9 Cuyahoga4:11 CV4:24
1 12 27:18 1533:8 1980's 24:16 1990's 24:15 199424:14 19965:25 19975:5, 6; 6:11 1999 27:18	again7:16; 14:18; 32:20 age24:3, 13 ago17:13, 14 agree12:7; 22:16;34:6, 10, 16;35:5, 8 agreement4:12; 37:13 al25:18, 21 alerted15:18 almost27:8; 29:24 alternative8:23; 13:17; 20:17; 9:5 always23:3, 5 American32:11 amount13:5 anal9:11; 29:13 analysis26:20 analyzing5:2 anatomy13:7; 32:1, 10 ani7:5; 29:9 anorexia19:12 answered23:13 antritis28:12, 14 antroidal29:25 anus7:25; 20:25; 28:11; 29:20; 32:19 apart24:10 appeared28:11 applied13:5 appropriate21:20 Approximately33:14 area29:10, 12, 24, 25 around30:11 articles32:17 aspect28:9 assume8:25; 12:6; 27:8; 29:15 atlas31:25; 32:1 attempted23:21; 24:22 attempts25:1 attorney4:9; 37:19 AUCIELLO4:7, 8; 22:9; 35:20 available32:5 Avenue4:18 average33:9 avoid7:21 away15:19	behalf33:12 believes22:13 below9:9, 10; 11:1; 14:19 best25:9 better11:22; 24:7 beyond7:18, 23 big9:15; 12:12 bilateral12:25; 13:15 bill33:16 birth10:11 bladder21:17 blood23:5 board29:20 bone9:12, 12 both8:9; 12:24; 13:6 bother31:8 bowel19:6, 14, 24; 20:5, 11; 30:17; 14:12 box17:2, 6; 18:22 boxes19:13 braided24:8 breaks25:12 bring8:10 broke7:8; 8:24; 9:12 brought7:16	childbirth8:17 choice24:21 chromic24:2, 10 Cincinnati4:18 circled16:10, 19, 22, 24; 17:5 circles15:5, 5 circumstance15:24; 10:16 clean31:19 clear16:11 clearly9:22 closes8:2 coarsest10:20 colostomy30:16; 31:4 column16:11 coming12:23 commissioned37:6 Common4:11; 34:6 communicate30:25 complete6:16 completely9:23 complication8:17; 15:1; 14:23; 17:4; 21:16 computer-aided37:15 conception20:2, 4 concerning4:12 concerns6:12 concluded36:1 condyloma32:18 confines7:18 consciously29:12 continent14:11 contract32:6 contrary12:21 control30:7, 7, 8, 17, 18 controlling14:11 coordinator14:14; 18:19, 23, 25 copies33:20 copy6:14; 28:5; 35:25 corrected22:22 correctly8:21; 26:25; 27:3 counsel22:10; 37:21 County4:11; 37:4 Court4:11 criticism6:20; 7:1, 3; 8:6, 13, 19; 20:22; 22:7; 24:17; 6:12, 17, 25; 10:22; 13:17; 20:18; 21:24, 25; 22:3, 11 CROSS-EXAMINATION	D D-I-X-M-Y-T-H4:18 Daniel37:5 data5:14 day24:3, 13 days18:1; 21:14; 24:12 deal23:4 death35:10 defendant33:15; 4:1 defense22:10 deficient7:5 deformity28:11 degree8:7, 14; 18:20; 19:21; 21:3; 26:3; 27:24; 34:6, 9 delivery5:20; 7:17; 16:16, 25; 17:24; 23:15 demonstrating29:22 depose37:9; 4:4 deposition4:12, 20; 9:24; 10:7; 18:13; 36:1; 37:8, 11, 12, 14, 16; 6:4, 7; 32:25; 33:10 describe26:19; 29:8 detail31:18 develop34:17 deviated24:18 deviation24:20 diametrically9:23 diet14:24; 17:14 dietary19:10 difference9:8 different25:3 difficult31:5; 34:15 direct22:7 disabling29:16 disagreed35:1 discharge14:21; 15:7, 16:16; 19; 18:23 discomfort28:19, 21; 30:23 discovery4:12 discuss6:25; 19:21, 24; 18:6 disruption23:18 Dixmyth4:17 Doctor4:8, 19; 6:9; 16:10; 20:25; 22:6; 24:22; 29:4; 31:19; 32:23; 35:22 document4:21 done7:8; 8:10; 9:24; 17:7; 21:1; 30:16 down7:8; 18:17; 25:12; 28:21; 30:22
2 2995754:10				
3 3754:17				
4 45033:19 452204:18				
6 6/14/9419:19 60/4011:17 6:1536:1				
7 7/29/9420:21 70/3011:17				
A abdomen28:8 able11:16 above29:10 absorbable24:6, 9 accomplish10:20 according5:25; 10:7; 20:24; 24:17 across12:23 action37:22 Activity14:24 acuminata32:18 addition5:16; 6:1 address4:15; 34:25 adequate19:10, 11; 20:14 adequately8:10 admitted10:4	B back7:16; 8:10; 29:24; 35:9 background5:1 bag30:18 BAGGISH4:3, 16;36:3; 37:9, 12 band28:13	C call14:17 can8:3; 9:21; 10:15; 13:3; 18:16; 26:16; 27:8; 29:22; 30:18; 33:2, 5; 34:12 candid31:6 care4:13; 5:3; 6:13, 21; 7:2; 12:10; 13:18, 25; 14:2, 13, 13; 15:20; 17:10; 18:23, 25; 20:19; 21:9; 22:4, 14; 23:22; 24:18, 20; 27:2, 4 carried10:7, 8 case4:9, 10; 5:8; 6:3; 7:23; 32:14 catgut24:2, 10 cause10:17; 13:12; 15:9; 28:18; 37:20; 9:2; 11:7, 14; 12:1; 13:10, 22; 15:14; 23:17; 12:4; 26:17; 28:15; 30:13 CAVANAUGH11:2; 20:7; 22:5, 16; 23:12; 26:10; 29:4; 35:22 centimeters28:14 certain35:13 certainly16:3; 24:15; 31:25 CERTIFICATE37:1 certify37:7, 18 chance23:2, 3; 25:5, 8, 9,		

Dr 4:9, 13; 5:13, 13, 17, 17:6; 5, 13, 20; 7:2, 17; 8:6; 9:9; 13:17, 21; 20:19; 22:3, 11; 23:22; 24:22; 25:8, 13, 15, 15, 16, 17, 21; 31:25; 33:21, 21, 22; 34:3, 24; 35:3 duly 4:4; 37:6, 9 during 9:20; 13:2; 28:1	express 22:7 extended 7:18, 23, 24 extends 28:16 extracting 29:15 extractor 13:4	given 11:7; 14:4; 15:2; 27:12; 32:24; 37:11 giver 14:13; 13:25 giving 27:23; 37:8 goes 29:1 Good 4:17; 9:17; 12:21; 29:9; 30:2 gracilis 28:25; 29:8, 15; 30:19 graft 28:25; 29:3, 8; 30:19 graph 32:19 great 14:18 gross 28:11 group 34:18 guess 4:14; 15:13; 23:20; 26:5; 32:8; 33:22; 34:2; 35:6 guidance 18:21 gynecologic 32:2 gynecologist 9:10; 15:21; 21:13 Gynecology 4:17	improperly 13:5; 23:15 improve 30:4 inaccurate 14:20, 22; 19:17; 20:15 inadequate 7:6 inclined 16:3 includes 32:2 including 25:6 inconsistent 20:6; 35:17 incontinence 17:25; 20:6; 34:17 incontinent 8:1, 12; 12:3; 15:19; 17:11, 17, 21; 18:10; 26:4 indicate 18:9; 19:5; 28:23 indicating 16:23; 29:21 indirectly 32:17, 20 information 14:13, 18; 18:24; 34:20 injures 9:11 injuries 13:15 injury 7:7; 9:11; 10:17; 12:15, 18, 22, 25; 13:23; 14:3; 24:11, 23; 27:24 inside 24:13 instances 33:11 instruct 14:16 instructions 13:24; 14:2, 4; 15:2; 20:18 intake 19:12 intended 7:24 intercourse 30:22 interest 37:21; 28:20 interior 12:22 into 30:1 involved 5:2 issue 15:9; 31:22; 34:25; 35:9; 6:10; 18:4; 32:14 itemize 6:23	L laceration 7:21; 8:7, 14; 19:22; 20:2, 3; 21:3; 26:3; 34:5 lady 31:5 Lambert 24:22; 25:6, 13, 17 Landsdown 5:4; 6:10 laser 32:17 last 5:20, 23, 24; 33:20 late 16:4 latex 29:20 lawyer 11:19 lay 18:3 layman 7:10 leaks 30:8 least 22:12; 25:22; 30:16, 18, 22 left 12:24; 28:16; 29:1, 19 leg 28:10, 21; 29:14; 30:13, 14, 20 less 11:10; 23:3; 24:4; 25:5, 14, 16 letter 5:4, 7, 9; 6:10 levator 29:9, 10 life 30:10 likely 9:5; 11:10, 10, 11, 13, 17, 25; 23:7 likewise 35:15 linked 29:7 list 6:24; 21:25; 31:21 litigation 6:12; 33:13 little 9:8; 16:18 long 17:13 look 14:17; 19:8; 29:5; 33:25; 17:5; 19:9; 29:5; 32:15, 22 loose 31:20 lot 18:3; 21:17; 28:15; 30:23; 32:2, 23 low 27:12 lower 30:21
E early 16:4 easily 10:15 eating 30:9 education 5:2 effects 28:7 eight 16:7; 21:23 either 7:5, 12; 8:20; 11:4; 13:9; 15:20; 23:14; 24:7; 26:24 else 6:2; 16:19, 23 employee 37:20 enclosed 5:11 end 21:25 ended 7:4 ends 7:15; 8:9; 31:20 enema 9:22; 10:5, 8, 12, 19; 11:5, 6, 14; 12:1; 13:10, 13; 15:14; 17:12, 15; 20:11; 23:17; 27:4; 9:17; 14:10; 23:17, 17 enough 21:14 episiotomy 7:17, 20; 16:12, 13; 19:25 Ernie 4:8 essentially 7:10, 20 etcetera 14:25; 21:4 even 14:1, 25; 18:1; 20:4, 10, 25; 24:11, 15; 26:1; 28:25 Everybody 8:3 evidence 12:19, 21; 18:8; 19:23 exactly 9:25; 13:1 exaggeratedly 27:12 exam 29:21; 30:1 examination 28:2, 12; 37:17 examine 27:20; 4:4; 18:14; 20:25 examining 11:24; 27:21, 22 excess 27:13 excuse 29:18 Exhibit 4:1, 21, 22 expect 6:18; 17:16; 18:18 experience 10:13; 17:24; 35:18 expert 5:17; 6:2, 7, 11; 12:7, 25; 33:12, 13, 21; 5:11; 12:8 explain 35:15; 13:8	F fact 8:14; 12:20; 15:3, 18; 30:5 fail 12:2; 26:15, 20; 35:4, 7, 13; 22:25; 23:11; 25:1; 26:24; 27:7; 35:15, 11 failure 12:5 fair 22:9, 16; 26:11 fairly 7:3 fall 11:1; 14:19 familiar 33:23, 24 far 10:22 fecal 18:5 feces 8:2; 30:8 feel 17:23; 21:13; 28:21 fell 9:9, 10 felt 29:23 few 18:1; 26:2; 31:20, 20 fiber 12:23 fibular 21:15 figure 26:14; 27:12 filled 19:18 final 26:20 find 16:6; 19:15, 22 finger 29:18, 11 finished 32:7 first 4:4; 7:1; 15:8; 20:17; 23:2, 8, 11, 15, 21; 24:1; 25:8, 24; 27:16; 37:9 fix 31:7 floor 29:20; 30:21; 32:10 fluid 19:12 follow 29:10; 4:5 foregoing 37:11 form 16:9; 17:2; 20:13 forth 25:17 four 17:14; 21:24; 24:9 fraction 35:7 free 22:6 front 20:1 function 19:15; 30:11, 17; 21:8 further 15:15; 20:18; 22:3; 25:7; 31:9; 35:21; 37:18 future 30:4	H half 30:8 HAMILTON 37:4 handed 4:20 happened 9:1, 7; 15:4; 17:13 hard 13:7; 14:9; 19:15; 26:19 harm 15:9, 15 heal 34:8; 35:4, 8, 16; 7:11 Heath 5:25; 17:10; 18:19, 23, 25; 19:18 helps 29:4 hereby 37:7 herself 10:4 high 26:2; 33:10, 11 higher 26:2, 13, 14; 29:1 historically 29:8 histoty 31:17 home 13:25; 14:13, 14; 17:10; 19:18 hopefully 22:1 Hospital 4:17; 10:10; 15:14; 25:21 hour 33:18, 19 hourly 33:17 hypothetical 20:8	J jerk 30:13 job 18:19 July 20:20 June 32:7	M M.D. 4:3; 36:3; 37:9, 12 Madhav 35:3; 5:13, 18; 34:24 major 26:21 makes 9:8 malpractice 26:9, 15; 27:8 manner 15:22 many 17:24; 21:14; 31:21; 33:2; 34:8 March 6:11 marked 4:2, 21, 22 material 5:16; 18:5; 24:21; 5:18; 24:5 maternity 19:2
	G gain 6:16 gas 30:8 gave 11:4; 26:21 Generally 25:23, 25 gets 23:6	I ideal 24:3 identification 4:2 identify 4:21; 8:9; 32:12 immediate 10:8; 23:16 immediately 15:25; 16:2 imperfections 22:15 important 15:24	K Karram 32:1 keep 14:10; 21:9 kind 10:16; 14:12; 24:3, 11; 34:15; 35:10 knee 28:9 knew 13:21 knowing 13:7; 31:16 knowledge 18:4; 34:17 knows 9:11; 14:15; 15:1; 17:15; 34:13, 19	

<p>matter 25:19 may 13:4, 4; 17:22; 18:1; 27:18 Maybe 5:5; 12:17; 16:22; 17:15; 25:3; 26:1; 33:8 mean 22:9; 30:24; 33:18; 8:9; 20:2 medial 28:9 medical 5:19; 6:1; 12:20; 18:3; 20:24 medications 14:25 mention 13:25; 19:21; 20:18; 14:6; 32:16; 9:24 Metro 5:25; 25:21 MICHAEL 4:3, 16; 36:3; 37:8, 12 middle 16:12; 34:3 midline 12:19; 16:13; 28:8 might 17:20, 22; 32:20 mind 13:11; 17:11; 21:20 mineral 14:8 misspoken 13:23 model 29:19 monophiliament 24:8 more 9:5; 11:10, 11, 13, 16, 17:25; 17:15; 23:4 most 23:7; 33:11 movement 20:11 Mrs 5:19; 27:16 much 14:5; 24:4; 29:13; 33:17 muscle 7:11, 25, 25; 8:20; 9:1; 10:14, 15; 12:1; 15:14; 28:25; 29:8, 15; 34:9; 8:3 must 8:9 myself 13:6; 17:1; 32:1</p>	<p>notice 31:20 noting 22:17 Number 4:10; 25:9; 32:13, 19; 33:10; 35:12 nurse 19:19</p>	<p>part 10:17; 11:7; 13:11; 17:14, 23 particular 32:16 particularly 18:2; 31:22 parties 37:19 patient 7:4; 8:1, 11; 12:3; 14:6, 7, 11, 14, 16, 19; 15:1, 18, 20; 17:12, 16, 20; 19:5; 20:3, 5, 10; 29:11; 30:6; 19:16; 17:18; 34:16, 18 Patricia 4:9, 14; 5:3; 6:21; 7:2; 15:10; 18:9; 20:9 pattern 19:6, 24; 20:5 peculiar 30:13 peek 34:21 pelvic 28:12; 32:1, 10 people 10:13; 17:10; - 18:2, 3, 6; 21:12 per 33:18 percent 11:23; 26:1, 5, 6, 9; 27:13; 33:14, 15 percentage 11:21; 25:24; 35:4, 6, 7, 13; 26:12 perform 30:12 perineal 17:6; 19:22; 31:22; 34:5 perineum 21:17; 28:10 period 9:20; 10:9; 14:18; 17:24; 18:10; 23:16 persist 22:12 person 15:4; 18:20; 20:25 phrased 23:20 pick 26:14 place 14:1; 23:15; 37:11 plaintiff 33:15 plan 15:21 Pleas 4:11 point 33:25 poor 24:21 poorly 23:20 portion 12:23 possibilities 11:10 possibility 10:23; 11:3, 25, 25 possible 10:23; 13:12; 25:23 post-partum 10:9; 13:24; 20:20; 21:2; 23:16 posterior 28:14 postulate 12:24 potential 26:17 prenatal 6:21 presented 6:11 press 28:21 pressure 13:5 Pretty 14:5; 19:7; 29:9 previous 14:13 primary 35:4, 7, 13 prior 4:19 probable 9:5 probably 11:22; 27:12;</p>	<p>28:24 problem 23:6, 22; 21:16; 23:4, 25 procedure 13:2; 23:7; 31:4 proceed 21:20 professional 4:15 progress 32:4 properly 7:6; 21:8; 35:4, 8, 16 prospect 30:3 provided 4:13 proviso 35:8 psychologically 31:3, 5 public 37:6 publications 31:21, 21; 32:9, 13 pudendal 12:14, 19, 22, 23, 25; 13:6, 15, 22 pull 30:19 purpose 27:19, 21, 22 pursuant 37:13 put 9:13, 17, 22; 13:5</p>	<p>regard 32:13; 4:13 related 28:24 relates 8:19 relative 37:19, 20 relaxed 21:4 relevant 31:22; 32:14 rely 34:22 remain 24:9 remember 102; 18:16; 17:12 remind 16:25 rendering 27:22 repair 7:6, 8; 8:8; 11:8; 12:2; 15:25; 23:2, 20, 22; 24:1, 4, 23; 25:4, 8, 25; 27:13; 7:6, 15; 8:1, 11, 20; 9:1, 19; 10:15, 24, 25; 11:4, 6, 13; 13:10, 10, 12; 15:22; 23:14, 17; 24:2; 26:25; 31:10; 27:3; 21:16; 23:3; 31:9; 35:4, 7 replacement 32:19 report 5:13, 13; 6:10, 12; 19:3; 28:5; 33:22; 34:3, 25; 19:6; 5:11, 17; 6:2, 7; 20:5; 33:21, 21, 23 residents 9:16 resolves 17:25 respect 14:21; 37:13 rest 9:13 result 7:5, 17; 17:9; 26:9, 15; 37:21; 12:5; 15:15 retained 33:12 returned 19:14 returns 20:12 review 5:8; 19:2; 35:23; 5:18, 22; 6:2, 4, 6; 22:20; 5:3 right 7:10, 22; 8:13; 10:10, 21; 12:24; 15:7, 8, 19:16; 9; 17:4, 9; 18:8; 20:16, 22; 21:5, 19, 24; 24:22; 25:11; 28:10; 29:2, 23, 24, 25; 30:20; 31:2, 19, 25; 34:24; 35:23 right-hand 16:11 routine 14:25 running 28:9</p>	
<p>N</p> <p>name 4:8, 15; 25:18 near 30:9 necessarily 26:15 need 31:19; 8:4 negative 20:1 negligence 35:11 neither 37:18 nerve 12:14, 19, 22, 23, 25; 13:6, 15; 34:25 Neumeister 37:5 newly 10:14 next 8:8; 32:7 Nobody 18:18 None 14:24; 15:2 nonetheless 12:13 nor 37:19, 20, 20 normal 7:18; 18:15; 19:6, 14; 20:5; 28:12 normally 19:8 notary 37:6 notes 35:3</p>	<p>O</p> <p>OBGYN 32:11 object 20:7; 22:5; 26:10 Objection 11:2; 22:17; 23:12 objective 28:3 observe 28:1 obsession 30:10 obstetric 15:7; 4:16 obstetrician 15:21 obstructive 28:16 obviously 35:1, 23 occasion 31:13; 33:2 occur 13:4, 8; 30:14; 7:7; 8:14; 13:1, 2 often 25:24 Ohio 4:18; 37:2, 7 oil 14:8 one 5:10; 8:4; 9:7; 10:22; 12:7; 14:6; 16:10; 17:7, 12, 15; 20:11; 23:7, 8, 11, 25; 24:7; 25:9, 13; 29:17; 31:12; 34:21 ones 26:14; 35:13 only 13:3; 31:12 open 10:14; 12:1; 34:22, 22; 18:17 operated 25:6 operation 21:12 Operative 14:23 opinion 9:4; 11:9, 18, 22; 12:7; 19:16; 22:24; 23:10; 24:25; 26:8; 27:10, 11, 24; 4:13 Opposed 26:6 opposite 9:23; 15:3 ordered 9:22; 10:6, 6 ordering 27:4 others 21:15 otherwise 8:1 ought 14:7 out 4:14; 9:21; 10:7, 8; 17:8; 19:18; 30:19, 21; 33:25 over 34:1</p>	<p>P</p> <p>p.m. 36:1 page 15:4; 33:25; 25:3 pain 28:25; 29:1, 14; 30:12, 12, 13, 13, 20 Panel 32:11 paragraph 34:3 paralyzed 13:14</p>	<p>Q</p> <p>qualified 37:6 quite 31:6, 20 quote 18:16, 16</p>	<p>R</p> <p>range 16:5 Rappert's 25:17 rate 26:2; 33:17 rather 16:4; 29:16 read 18:13; 28:6; 33:24; 35:24; 16:13 really 9:8; 19:20; 20:15; 25:2; 30:2; 35:14 reason 10:12; 26:24 reasonable 16:6 reasonably 24:9 recall 10:3; 24:2 received 5:4, 17; 23:23 recognition 15:17 recognize 8:5; 7:9; 8:7, 16; 23:23 recommendation 30:6 reconstruct 30:21 record 12:20; 16:11; 18:9; 19:3; 20:24; 22:6, 18; 5:19, 22; 6:1, 6; 22:20 recovers 8:11 rectal 21:1; 29:17; 30:1; 9:17; 14:9 rectum 8:2; 21:17; 29:18 refer 21:14; 15:23; 28:25; 29:1 referral 21:5, 9, 10, 11, 21, 18 referring 24:14</p>	<p>S</p> <p>Samaritan 4:17 same 14:5 save 12:17 saw 16:22, 25; 19:4; 31:17 saying 7:12; 13:22; 24:19; 25:4 scar 28:8; 29:23; 23:5; 28:10, 9 scenario 8:25; 9:3 second 11:12, 24; 25:13, 14 section 16:10, 18; 19:9</p>

seemed 26:23 send 33:16 sensation 12:21 sent 5:7, 13 separated 13:12 separation 34:9 September 5:6, 10, 12 services 19:2 serving 33:13 sexually 30:12 shape 29:18 Shobha 4:10 show 6:13;16:9 shy 18:6 side 28:17; 13:6 sign 9:15; 20:1; 35:25 signature 37:17 Silgore 33:21; 5:13, 17; 33:22; 34:3 similarly 18:2 simple 13:13 six 16:3, 7; 19:9; 21:2, 21, 22; 24:9 skilled 21:14 slightest 10:16 softener 14:8 soiling 18:4 somebody 14:6, 10; 18:20; 29:19 somehow 28:24 someone 33:12 sometime 5:6 somewhat 13:16 sorry 13:22; 25:20, 20 sounded 10:5 speaking 20:8; 25:23 special 14:2 specific 11:16; 15:2 spends 30:8 sphincter 7:5, 11, 16, 25, 25; 8:4, 9, 11, 20; 9:11, 13, 18; 10:14; 11:7; 12:1; 13:23; 21:3, 7, 16; 24:23; 29:9, 13; 30:2, 3, 7; 31:7, 10, 23; 34:9, 22 splint 9:12 squeeze 8:3; 29:11, 13, 14 standard 9:9, 10; 11:1; 14:20; 22:14; 24:18, 20; 27:2, 3 start 4:14; 24:10; 33:22 state 4:15; 37:2, 7 statement 26:11 status 21:2 stenotic 29:21 stenotypy 37:14 step 8:8 still 10:10 stitches 9:21 stool 14:8, 9 stop 7:24	straightforward 7:4 strength 24:5 stretch 9:21 strong 24:9; 25:16 stuck 29:20 study 34:23 stuff 32:3 submitted 32:10; 37:16 subsequent 22:21; 23:2, 5; 25:4 subsequently 9:16 succeed 23:8, 4 success 23:3; 25:10, 14, 16; 26:2 successful 25:5, 25 summary 14:20, 21; 158, 16; 16:19; 18:23 summer 29:19 sun 29:19 supervision 37:15 supply 23:6 Supposed 17:23 Sure 6:19; 14:7; 21:6; 22:2; 27:15; 32:7 surgeries 5:21; 22:21, 25; 23:5, 23; 25:7 surgery 5:23, 24; 9:2; 21:21; 23:4; 31:18; 32:2 surgical 7:20; 15:25; 21:8, 11, 16; 23:7, 21, 21; 25:1, 25; 31:4, 9 surprise 12:12; 10:5 sustain 26:3 suture 10:19; 24:3, 4, 6, 21:8 swollen 10:16 sworn 4:4; 37:9 systematology 19:16	30:22 though 14:1; 15:1; 29:1 thought 16:22; 18:15; 23:24 three 17:14; 28:13, 13 tight 21:4 timely 15:22 Tippie 4:10, 14; 5:3, 19; 6:5, 21; 7:2; 15:10; 18:9; 27:17; 10:7 tissue 28:13 today 33:17 together 7:16; 8:10 toilet 30:10 told 9:16; 13:14; 18:1, 19; 30:15; 31:6 tone 29:9; 30:2 took 17:15 top 30:11 Total 33:4 touching 28:15 toward 16:11 track 14:10 trained 21:13 training 9:16 transcribed 37:14, 16 transcript 35:23 transcription 37:15 traumatic 24:11 traumatize 9:18; 7:7; 8:24; 9:9; 11:5 treating 32:18 treatment 27:22; 32:17 tremendous 13:5 trial 6:18 trouble 14:11 true 8:16 truth 37:10, 10, 10 try 6:24; 10:21; 23:23; 29:12 trying 22:12 two 6:7; 7:12; 9:5, 6, 7; 10:22; 11:10; 13:16; 14:9; 20:17; 26:20; 28:13; 31:4; 32:9 type 14:3 typically 10:15; 13:3, 24; 17:23, 25; 18:7	unrestricted 14:25 upwards 28:16 urinating 18:5 urine 17:25 uro-gynecology 21:15 use 24:7; 26:5 used 11:3 using 21:9 usually 17:25; 34:16
		V	
			vacuum 13:4; 16:15, 25 vagina 21:17; 28:15; 29:25; 30:21 vaginal 29:17; 30:1 vaginectomy 32:20 versus 4:10 Vicril 24:7 violated 27:2, 3 violation 22:13 visit 14:14; 19:3; 20:20, 23; 27:19; 19:19 vitae 4:20 vulva 28:11
		W	
			wall 28:14 waste 4:25 way 10:20; 13:3; 30:17 ways 26:21 week 24:4; 16:3, 8; 21:2, 21, 23; 24:10 whatsoever 14:1; 37:21 whereas 24:10 WHEREUPON 4:1 whole 30:10; 37:10 within 37:6 without 14:12; 24:11; 30:23 witness 33:12; 35:24; 37:17 women 17:24; 26:3 word 21:9 work 31:24; 32:4; 8:4 worrying 30:9 writing 31:25; 32:1 written 6:10 wrong 22:13 wrote 19:14; 32:17
		Y	
			year 5:7; 33:6, 7, 9; 17:14