DOC. 22

COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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SHIREEN ALIKHAM, ET AL,

PLAINTIFFS, :

-VS- : CASE NO. 150921

EUCLID GENERAL HOSPITAL,

DEFENDANTS. :

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Deposition of TOM P. BARDEN, M.D., a witness herein, taken by the defendants as upon cross-examination pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement and stipulations hereinafter set forth at the Radisson Inn-Greater Cincinnati Airport, Boone County, Kentucky at 4:10 p.m. on Thursday, April 25, 1991 before Katherine L. Warren, a notary public within and for the State of Ohio.

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

It is stipulated by and among counsel for the respective parties that the deposition of TOM P. BARDEN, M.D., a witness herein, may be taken as upon cross-examination pursuant to the Ohio Rules of Civil Procedure, and pursuant to agreement; that the jurisdiction of the notary-public court reporter is waived; that the deposition may be taken in stenotypy by the notary public-court reporter and transcribed by her out of the presence of the witness; and that the submission of the

transcribed deposition to the witness for his signature is expressly waived;

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I N D E X

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MR. RHOA: Dr. Barden, my name is Albert Rhoa, and I'm representing Dr. Edward Depp, who, since your deposition which was taken in September of 1990, has been added as a new party defendant to this suit. And therefore, I'm going to ask you a few questions on his behalf, okay?

THE WITNESS: Yes.

TOM P. BARDEN, M.D.

of lawful age, a witness herein, being first duly sworn as hereinafter certified, was examined and deposed as follows:

CROSS-EXAMINATION

BY MR. RHOA:

Q. Now, as I understand from riffling through your prior deposition, Doctor, you are an MD in this state. I don't want to go through all the CV or anything. It's already been recorded. But your specialty apparently is obstetrics-gynecology, and also do you do some work in pediatrics, too?

A. No, I don't, I'm an obstetrician gynecologist, and I hold an academic title in the Department of Pediatrics at the University of Cincinnati, but I am not trained as an obstetrics

pediatrician.

Q. You're not trained as a pediatrician; you're trained only as an OB-GYN?

A. That's correct.

Q. And you're not trained, I take it, as an anesthesiologist either?

A. No.

Q. Now, you were retained by the plaintiff's attorney in this case to review the records and testify on behalf of his client, apparently, as an expert then in OB-GYN?

A. That's correct.

Q. Now, I have here a copy of your prior deposition, and attached to it is a report which you submitted to Mr. Stege, and it's dated February 25th, 1990. Have you furnished him other reports other than this one?

A. NO.

Q. All right. Now, have you conferred with him since the deposition on September 18th of '90?

A. Yes.

Q. Okay. And how many times have you -- how many occasions?

A. We met yesterday, and we net briefly prior to this deposition today, and I believe that we have talked on the telephone on perhaps two or three occasions since the deposition.

Q. All right.

A. I don't recall the dates.

Q. Now, when you conferred with him, was that in regards to any of the actions by my client, Dr. Depp, or not?

A. Yes, there were conversations related to Dr. Depp.

Q. Now, are you intending to testify as an expert as to the responsibilities of an anesthesiologist in this case?

A. To the extent that, as an obstetrician, I have opinions regarding the conduct of resuscitation in the Delivery Room; namely, that the obstetrician primarily is responsible to assure that the newborn is properly resuscitated, os at least to arrange for qualified persons to be present to resuscitate the baby.

In the situation of this case where the obstetrician is performing a cesarean delivery, there's no practical way for him to leave the

mother to care for the baby.

Then, it becomes the duty of who is qualified and present to take over the resuscitation when it's indicated. In this case, it's my understanding that there was a surgical assistant helping Dr. Barrett, who I assume was not qualified to do newborn resuscitation.

Q. Why do you assume that?

A. Because typically surgical assistants are not trained to perform newborn resuscitation.

Q. Well now, just along that line, is there anything that you have reviewed to date which has indicated that that individual was not competent to do that?

A. No, but beyond knowing that, he was occupied with Dr. Barrett with the surgery and would not been available.

Q. You're assuming that?

A. Yes.

Q. All right. Go ahead.

A. There also was Nurse Melson, who was the circulating nurse. And from her testimony, and from what's recorded in the patient's record, the mother's record, I cannot discern what her exact

role was in the resuscitation. She doesn't recall specifics, and the record doesn't reflect her actions --

Q. All sight. Mow, is there --

A. -- but particularly, a nurse is not qualified or trained to do intubation, tracheal suction, or deep suction, as was required, or as was indicated in this particular case.

Q. You're assuming then that Nurse Melson was incompetent to suction the baby?

A. She was not incompetent to suction the baby, but not to do the type of suction that was indicated here, and that was to go beyond the mouth and nares into the posterior pharynx and look down into the trachea.

And the other people that were present were a nurse, who was scrubbed as the scrub nurse. I believe her name was Kelli, but; I don't recall precisely.

MR. STEGE: Clark, I think.

A. Clark, excuse me, and she would not be available to break away from the surgical procedure. The team doing the surgery was obliged to continue.

So the reason that I made the statements regarding Dr. Depp in my first deposition were simply that, as far as I know, he was the only qualified person present in the Delivery Room; and therefore, I believe it was his obligation to become involved in the resuscitation of the baby, particularly since he is the one that assigned the Apgar score of three.

And it is my -- I know that, in 1975, the general feeling was that, given a baby that has a one-minute Apgar score of zero, one, two, or three, that intubation was indicated, and in fact that same approach persists yet today.

Q. Well, is it your opinion that -- are you saying that you felt Dr. Depp should have left the -- his patient?

A. I think that, given the circumstances that I understand of the case, he had administered a spinal anesthetic, and the patient's vital signs, according to the anesthetic record, and according to his testimony in deposition, was stable; that is, she had normal blood pressure and pulse, and her respirations were normal.

And from my experience over the years

in obstetrics, given that circumstance, I don't know of anything that would hold him at the head of the table with the mother when the baby was a short distance away, and by his assessment, had an Apgar score of three.

And I simply mentioned that I felt that the anesthesiologist, given the fact there wasn't a pediatrician present, was the only logical person in that room at that time to help this baby.

Q. And was it your opinion that a pediatrician should have been present?

A. Yes, I so testified.

Q. Now, was there anything in the record that indicated that anyone requested Dr. Depp to undertake any suctioning or anything with the child?

A. No.

Q. Was there anything to indicate in the record that the nurse was having any problems with the child?

A. No.

Q. Now, you brought some material there with you, Doctor; what do you have there?

A. I have two copies of my CV, and I

have a copy of the letter that you referred to, and I have a list of the various depositions that I've reviewed, plus the attorneys' names, including yours.

Q. Okay. Is this pretty much what you had reviewed prior to the deposition in 1990, or have you reviewed something in addition?

A. No, there were the last two depositions listed -- if I could see -- depositions --

Q. There's a couple reports there, I know.

A. -- of Charles Kennedy and Cheryl Hall came to me after the deposition. Plus, I read more recently reports from Gerald Ostheimer, Barry Cork.

Q. And what was your reasoning in reading Ostheimer and Cork?

A. They were supplied to me by Mr. Stege.

Q. Those are two doctors which are in the field of anesthesiology?

A. Yes.

Q. Now, in your report of February 25th, 1990, you indicate there you reviewed the Euclid

chart bcth for the mother and the child, and you also reviewed the University Hospital's chart covering the care given there after the baby was transferred when she was six hours old, right?

A. Yes.

Q. All right. Now, I've read your criticisms of the hospital and all these personnel and in your earlier deposition. Prom your review of the University Hospital's chart, did you have any criticism of any the care given to the baby at University Hospital?

A. Care of the baby in the Nursery?

Q. Yes, after she was transferred.

A. No, I don't intend to be a witness to the pediatric care of the baby beyond the Delivery Room.

Q. Well, why did you review the University Hospital chart?

A. Because they were sent to me by the attorney. I didn't review them in great detail, but I looked at the major diagnoses and discharge summaries.

Q. You didn't then review that; chart with the intent to see whether oF not there was

anything in there that might have affected the child; is that what you're saying?

MR. STEGE: Objection.

A. No, I did look at the chart and review it. I didn't do it in as great detail as I reviewed the mother's chart, admittedly. I certainly, in reviewing this case, was interested in the outcome of the baby to that extent that I looked at that record, but I'm not a pediatrician, and I'm not going to criticize pediatric care.

Q. Would you characterize this as a high risk pregnancy?

A. Yes.

Q. What do you mean by high risk pregnancy; what does that indicate?

A. It's a term that's used to indicate that obstetric or other medical circumstances are identified that place the mother and/or baby at greater risk than is usual.

Q. All right. And why do you think that was the occasion here?

A. At what time?

Q. Well, whenever you feel -- When do you first feel that was apparent?

A. Well, on admission to the hospital.

Q. Well, let me just stop you for a minute. What about prior to admission?

A. Yes, I think that she became, by a number of obstetrics factors, became a high risk due to advanced gestational age at approximately July 17th, 1975, when she was two weeks beyond her expected date of confinement as calculated from her first day of last menses and supported by obstetrics evidence such as the size of the uterus at ten weeks gestation, which was the initial prenatal visit, the appearance of fetal heart tones by a consultation at 18 weeks gestation, the size of the uterine fundus as recorded in the prenatal record throughout the second trimester. And I also think she was high risk because of her obesity. Her weight, by the end of this pregnancy was over 200 pounds, which makes it more difficult to manage patients.

I think she was further high risk when, in labor on the morning of her delivery or earlier in the day of the delivery, she had the appearance of vaginal passage of meconium, which is a sign of a possible fetal distress, and in 1975

was considered a sign of fetal distress.

And I think she was further high risk by the recognition of a fetal heart rate deceleration at 6:50 a.m. on the day of delivery that was recorded on this chart by a nurse, and it was a nurse who testified that she always listened to heart rate between contractions, and that the baby's heart rate was at approximately 80 beats per minute between contractions at that point, recovering to approximately 132 shortly thereafter.

I think she further was high risk when Dr. Barrett ruptured her membranes at 8:15 a.m. and noted. thick meconium, which prompted him to arrange for immediate delivery by caesarean section. I think she -- I think that's all.

Q. What about her blood pressure?

A. I wasn't impressed by blood pressure on the prenatal record. As I recall, the blood pressure entries were all normal. I saw no other signs of preeclampsia, and I was not impressed that the blood pressures that were recorded during labor were unusual for a patient in labor.

Q. Was there, in your opinion, any

evidence of preeclampsia or not? You don't think there was?

A. No.

Q. All right. Should anything have been done differently then on the 17th?

A. Yes, I previously testified that, on the 17th, it had already been recorded, on July 8th, the patient had cervix dilated two centimeters, 80 percent effaced and zero station, and, therefore, when she reached 42 weeks gestation or counting from her last menstrual period 294 days, I testified that I believe that labor should have been induced.

Q. So you felt she should have been hospitalized at that point?

A. Yes.

Q. And should she have been hospitalized and arrangements made for a pediatrician to be present?

A. Yes, for -- at delivery, it would not be necessary before.

Q. Yeah, that's right.

MS. GARDNER: Objection. On what day are you talking about now, Al?

MR. RHOA: Whenever he felt that the patient was going to be hospitalized.

BY MR. RHOA:

Q. On or about the 17th?

A. Yes, I said 17th or 18th in the first deposition.

Q. And it's your opinion that the pediatrician should have been notified as to the impending inducement then apparently, right?

A. Well, that would be a courtesy to the pediatrician, but I would also at that point, because of the circumstances, think it prudent to have a pediatrician physically present for the delivery.

Q. All sight. Now, that was not done. Patient then appeared apparently voluntarily at the hospital; is that correct?

A. Well, you're talking about on the 25th or the 23rd?

Q. Well, go back to the 2-3rd.

A. On the 23rd, she was, from my understanding of the situation, sent to the hospital for induction of labor, and according to her testimony, there was no room for her in the

labor rooms, and therefore, apparently some communication with her doctor occurred, and she was sent for this x-ray that was taken.

And after the x-ray, Dr. Barrett decided that it was proper for her to wait for induction for another week, although he had, in my understanding, arranged for her to have an ultrasound examination on the 25th, which was the day that she came back to the hospital in labor. So the ultrasound examination was not done.

Q. Then she presented herself in labor at the hospital; is that correct?

A. Well, I understand she spoke to Dr. Sternem at 6 p.m. on the 24th and then appeared at the hospital at about ten minutes after 3 a.m. on the 25th. And then the Nurse Ljubi, who is --

MR. STEGE: L J U B I.

A. Nurse Ljubi, in her first note, indicated she talked with Dr. Sternem by telephone to inform him of the situation at 3:10 a.m.

Q. All right. And then what occurred?

A. The patient was in clinical labor having contractions, and there were recordations of fetal heart rate taken by stethoscope every 30

minutes or so in the record.

And at 6:30 a.m., there was a note that brownish green fluid show had passed, and there was no indication that a physician was notified, which I was previously critical of because I think the nurse should have assumed that that greenish brown fluid represented meconium.

Then at 6:50, the incident of slowing of fetal heart rate to 80 beats per minute for a minute followed by recovery to 132, again, I was critical that the nurse did not contact the obstetrician by telephone with that information as she should have.

And then it's my understanding that, at 7 a.m., Dr. Barrett took over responsibility from Dr. Sternem for further care of the patient, and he came to the hospital at 8:15, and examined the patient.

Q. Is that the first indication of his appearance at the hospital?

A. Yes, as far as I recall.

Q. Was there any indication of any communication between him and the hospital up to the time he arrived there?

A. I don't believe so. He ruptured membranes and recorded thick meconium and arranged for caesarean section delivery, which occurred very quickly thereafter. She had a spinal anesthetic, as I recall, at 8:27, and the delivery occurred at 8:33 a.m.

Q. Okay. Was the baby large or small for the age?

A, It was, I believe, six pounds, thirteen ounces, which is appropriate. It was not an excessively heavy baby, which is one of the problems that we encounter in post-term pregnancies. So I would consider it appropriate for gestational age.

Q. So in your opinion, that 16 (sic), 13, was not particularly significant?

MR. STEGE: Six.

Q. Six pounds, thirteen ounces, one way or the other?

A. No.

Q. In view of the gestational age?

A. I don't believe that's abnormal one way or the other.

Q. You mention in your report that the

baby had questionable lowset ears?

A. That's recorded in the chart.

Q. What's the significance of that?

A. I don't know.

Q. Why did you refer to it?

A. Because it's reported in the chart. I was simply describing the initial condition of the baby as the chart reflected it.

Q. All right. You have no feeling one way or another about that notation regarding the lowset ears then?

A. No.

Q. All right. Now, then you note that it's at 8:45 the Dextrostix was zero, indicating profound hypoglycemia, correct?

A. Yes, that's what I wrote.

Q. And what does that mean, Doctor?

A. Well, it simply means that a test was done of the baby's blood to indicate that there was essentially no measurable glucose by that test strip. And that's a further evidence of the baby's birth asphyxia.

Q. What's the significance of that, the zero Dextrostix; what does that really indicate;

what do you mean by hypoglycemia?

A. It means a low blood glucose level, and a low blood glucose level can be caused by a number of things, The focus in this case is that the baby had birth asphyxia.

And the mechanism for low glucose is that, when the baby's organs are not supplied adequate oxygen, its body shifts into an anaerobic metabolism that uses a larger amount of glucose stores to produce energy. And as time passes, the glucose levels go down, and down, and down.

In this case, the combination of Apgar score of three at one minute, the thick meconium, the likelihood that the baby had -- we know that it had what's described as one late deceleration at 6:50 a.m., and its condition shortly after birth as I described it in the letter, including the hypoglycemia, all are supportive of a diagnosis of birth asphyxia, which was quite apparent from reading what pasts of the baby's chart I read. So I think it's a consistent pattern of a baby that was hypoxic and reflected that at birth,

Q. This baby, did it suffer damage prior

to the caesarean section then, in your opinion?

A. I don't know when damage occurred. I suspect from the evidence that's available to me, that there was hypoxia during labor, but I don't wish to speculate when damage began to occur or when it did occur.

Q. What would be the result of this zero dextrose reading; apparently from what happened here, there was no dextrose administered for three hours?

A. That's my understanding, Dr. Scharg did not arrive. The pediatrician did not arrive until 11:20 when he established an intravenous infusion and gave the baby glucose solution.

Q. And what would be the significance of this lack of glucose for that thsee-hour period?

A. I would defer that to pediatric testimony.

Q. You have no opinion on that at all?

A. Yes, I do.

Q. What's you opinion?

A. This is a nonexpert opinion.

Q. You've been giving nonexpert opinions earlier on.

MR. STEGE: I'm going to object on two grounds; both to the comment and also to the question. But I'm not going to prevent you from answering.

BY MR. RHOA:

A. Baby without glucose is very much at risk of having brain damage.

Q. From the lack of glucose alone, right?

A. Yes, because the brain is extremely dependent on glucose and oxygen for survival of its cells.

Q. Now, I note in your record that there were convulsions during this period?

A. Yes.

Q. More than one apparently, right?

A. That's simply a reiteration of the newborn chart.

Q. What is the significance of the convulsions?

A. It's a sign of central nervous system disorder. But in terms of how it relater; to this particular baby, I wouldn't wish to testify.

Q. Would a convulsion be a contributing

fact to lack of dextrose; would it use up dextrose?

A. I don't know of any relationship of convulsions versus lack of or producing lack -- hypoglycemia. But conversely, hypoglycemia can lead to convulsions, and that's well established.

Q. So this was another indication of a lack of dextrose?

A. Possibly.

Q. What else would it be an indication of, in your opinion?

A. The hypoglycemia?

Q. Yes -- No, the convulsion.

A. Central nervous system damage from asphyxia.

Q. And what about from the lack of dextrose?

A. Well, I just answered that. That is well known that babies that have profound hypoglycemia can have seizures.

Q. All right. That's well established; is that correct?

A. From my perspective, yes.

Q. All right. Now, in addition to that, the baby was diagnosed as having hypokalemia.

Would you tell us what that means?

A. I have to see what you're reading.

Q. From your record on page 3.

A. That's low potassium.

Q. Okay. What's the significance of that?

A. That means the baby has abnormal electrolytes in its blood.

Q. And what effect does that have on the well-being of the child?

A. It could produce seizures.

Q. Was it treated prior to or even tested for, if you know?

MR. STEGE: Mote an objection, Al, because there's nothing to indicate that she had hypokalemia at Euclid. That finding appears at Rainbow.

Q. My question was: Was she tested for any of that prior to the tests at Rainbow?

MR. STEGE: That meaning hypokalemia?

Q. Yeah.

A. I don't know.

MR. RHOA: Bid you want some

coffee?

THE WITNESS: No, I'm fine. Thank you.

Q. Okay. Now, also the baby was diagnosed as having hypocalcemia, correct?

A. Yes.

Q. And what is that?

A. That's low calcium levels in the blood.

Q. What's that significance?

A. That is another electrolyte disorder which could potentially contribute to seizure activity.

Q. All right.

MR. STEGE: Let me interrupt you. The first one was hypokalemia, and the second one was hypocalcemia?

THE WITNESS: Right.

BY MR. RHOA:

Q. Now, the baby was also diagnosed as having thrombocytopenia, too; is that correct?

A. Yes.

Q. Would you describe that for us, Doctor?

A. That's a low level of platelets.

Q. And what is the significance of that?

A. In this case, I don't know. It's a sign of possible blood clotting disorder.

Q. Coagulation and so forth?

A. Yes.

Q. In your opinion, that's not significant?

A. Oh, I don't know that it's not significant. I don't know the significance of it.

Q. All right. And then it says malnourishment?

A. Yes.

Q. And how was that ascertained, do you know?

A. I don't recall.

Q. Now, did you at all check for the measurements on this baby from the charts?

MR. STEGE: Objection, what measurements?

Q. Measurements of the head. length and so forth, in addition to the weight,

A. No.

Q. Did you think that might have been

significant?

A. I don't know. 1 wasn't interested in looking for that.

Q. Do you feel that the caesarean section should have gone forward without a pediatrician present?

A. Yes. I think, in the context of 1975 diagnosis of fetal distress, that Dr. Barrett responded properly when he discovered thick meconium at 8:15 a.m. It certainly would have been better to have a pediatrician physically present, but if that was not possible, I don't criticize him for proceeding to deliver the baby.

Q. Should Dr. Barrett have suctioned the baby?

A. No, he was occupied with the caesarean delivery, and it would have been wrong of him to redirect his attention to the baby under those circumstances.

Q. No, no, I'm not talking about after the baby was delivered; I meant at the time he was taking the baby, would it have been a proper procedure for him to suction the baby at that point?

MR. STEGE: Just so it's clear, are you talking about as the head was delivered?

Q. Well, as he was delivering the baby, himself, He has the baby then in his hands.

A. It's generally routine for the obstetrician --

Q. And he had an assistant there, right?

A. Yes, it's generally routine, and it certainly would have been appropriate for Dr. Barrett to use a bulb syringe to suction the mouth and nose of the baby as the baby delivered before he handed the baby to the nurse.

Q. That's normal procedure before he hands the baby to the nurse; isn't that true?

A. That's correct.

Q. Is there any indication in the record of that?

A. No, I don't recall.

Q. Well, you would have checked the record for that, wouldn't you?

A. Well, perhaps if someone has the mother's chart, I could look at the operative dictation. That would be the only place it might occur that -- I simply don't remember.

MR. STEGE: Off the record a second.

(Off the record.)

A. I just reviewed Dr. Barrett's dictated operative note, which does not indicate that a bulb syringe was used to suction the baby on the operating room table.

Q. All right. Now, did you review Dr. Kennedy's report, Charles Kennedy, one of the plaintiff's experts?

A. I don't recall the report, but I did read the deposition.

Q. His deposition?

A. Yes.

Q. I wasn't at his deposition either. So you and I are in about the same boat. I'm looking ai; his report which he submitted to Mr. Stege, and he states in that that he thinks the injury to the brain was attributable to conditions which prevailed before and approximately six hours following delivery.

MR. STEGE: That what he says, Al, or did he say shortly before?

MR. RHOA: Which prevailed just

before.

MR. STEGE: Just before. That's what I thought. All right.

BY MR. RNOA:

Q. Then he says that there was some asphyxia intrapartum which persisted, and it was aggravate by the hypoglycemia, which you have already testified to; is that right?

MR. STEGE: Note an objection.

A. Not specifically hypoglycemia aggravating the hypoxia. You were asking me questions about how it might have come about, and I indicated that, because of hypoxia, the baby probably became hypoglycemic.

Q. Well, and what do we mean hy hypoglycemic, again?

A. Low blood glucose.

Q. Okay. And is the fact that a baby does not have blood glucose lead to brain damage?

A. It can lead to seizure activity , which can produce further hypoxia and can certainly lead to brain damage. But I'm not a neurologist, so I'm not in any way trying to say that it was because of either hypoxia or blood glucose levels

that the baby has brain damage.

Q. Well, we're not getting into anything really esoteric here about the hypoglycemia, are we? This is not good for the brain, is it?

A. That's correct.

Q. And damages the brain; does it not?

A. It can.

Q. Is there any indication in here that this three hours with no apparent recordable dextrose did not damage this baby's brain?

A. No, there isn't.

Q. Now, Dr. Kennedy indicates that, on follow-up at five months, the head circumference was 69 centimeters. What's the significance of that?

MR. STEGE: Al, I'm going to object. Why is that -- why are you entitled to ask him about that?

MR. RWOA: Why not? It's at least discoverable information.

MR. STEGE: We're going to be here all day.

MR. RHOA: I'm not going to be here that long if you don't interrupt me. I'm going to

be out of here and catch my plane.

MR. STEGE: It's not reasonably related to the opinions that he's prepared to testify to that are represented in his report. I'm giving you some latitude.

MR. RHOA: I'm not sure what he's going to testify to because he indicated some criticism of my client early on without being an expert in that field.

BY MR. RHOA:

Q. Are you intending to testify in court as to the standards of an anesthesiologist, Doctor? Basically that's why I'm here.

A. As I've already indicated, I'm critical of the fact that he gave the Apgar score of three, as far as I can tell from the record was not otherwise occupied with the mother, and did not become involved in resuscitation of the baby.

Q. Well now, you're willing to state that, but you admit there's nothing in the record to indicate that he was asked to do anything?

A. That's correct.

Q. And the record does not indicate that the obstetrician suctioned the baby, which is

normal procedure under those circumstances, correct?

A. Yes.

Q. Now, -- So you're out of your field when you're talking about Dr. Depp; are you not?

A. I wouldn't be critical of Dr. Depp in any regard to how he gave the spinal anesthetic, what drug he used, actual anesthesia practice. But I feel that I am qualified to speak to what happens in the Delivery Room when the obstetrician is busy doing a caesarean section, and the anesthesiologist is present and needed to help in resuscitation of the baby.

Q. Well now, there's nothing indicating that anybody indicated to him he was needed, is there?

A. No.

Q. And isn't his -- Are you familiar with the standards for anesthesia care in an obstetrical situation, with the standards set by that group?

A. For resuscitation?

Q. No, no, for the duties of an anesthesiologist.

A. I don't understand the question.

Q. Are you at all familiar with the standards in the practice of anesthesiology as to the responsibilities of the anesthesiologist in the setting we have in this case; have you had read any of those standards or protocols?

A. Oh, yes.

Q. Can you quote any that says that Dr. Depp did not follow the standards of protocols?

A. Well, I can certainly quote Erom obstetrics policies that, over and over again, it's been stated that the resuscitation of a depressed baby should be done by the most qualified person in the Delivery Room that is available to provide that service.

Q. Is that is available?

A. And in this ease, it's my opinion that Dr. Depp was available and could have participated.

Q. It's your opinion then that: he should have left the mother?

A. Yes. Her condition was stable. She had a spinal anesthetic. Her vital sign:; were normal, I know of no reason that he could not have

walked a few steps from the mother's side to take care of the baby.

Q. So you're critical of him for that?

A. That's the reason that -- when it came up in the previous deposition --

Q. All right. I know what you said in the previous deposition.

MR. STEGE: Did you finish your answer?

THE WITNESS: No, I was interrupted.

BY MR. RHOA:

Q. Go ahead.

A. I started to say that I was critical of him in the previous deposition as a result of questions that were specifically directed at did I have criticism of him. I didn't bring it up of my on volition.

Q. Somebody else asked you a leading question along that line, one of the attorneys?

A. That's correct. As I recall, that's correct.

Q. Now, what was the second Apgar score, do you recall?

A. Seven.

Q. What does that indicate?

A. I don't know what it indicates because it was not detailed as to what the various points were awarded for.

Q. Could you tell from the record who made that evaluation?

A. Not from the record, no, From deposition testimony, it was indicated that the anesthesiologist was the person that was supposed to assign Apgar scores, and also there's Euclid Hospital policy that I reviewed in this matter that indicated that the anesthesiologist was responsible for the Apgar score at one and five minutes.

Q. And do you have a copy of that information?

A. Not with me.

Q. Would you make that available to me, that basis for that?

A. Certainly.

MR. RHQA: Would you see that I get that, Counsel?

MR. STEGE: Sure.

BY MR. RHQA:

Q. Okay. Now, was there anything in the record to indicate how long the baby was in the operating room?

A. Yes, the birth was recorded as 8:33 a.m., and the baby was apparently in the Nursery at 8:45 a.m. So it would appear that the baby was there for approximately 12 minutes,

Q. Is that normal, unusual or what?

A. I don't know what you mean by is it normal, for Euclid Hospital in 1975?

Q. How about your hospital in 1975?

A. I'd say that, considering the circumstances of the baby having an Apgar score of three at one minute, that would be unusual to move the baby from the resuscitation area that quickly.

Q. Did the record indicate how the baby got to the Nursery, or not?

A. No.

Q. Did the depositions?

A. I don't think that the parties involved remembered precisely. Nurse Nelson testified that she typically would carry the baby in her arms to the Nursery but didn't recall if that's what she did in this case.

Q. All right. At the present time are you performing caesarean sections, Doctor?

A. Yes.

Q. All right. What's your procedure in that regard?

A. What regard?

Q. Regard to who you have present.

MR. STEGE: Note an objection. But go ahead.

Q. Let's say first when there's not a high risk, and then where there is a high risk?

MR. STEGE: You're talking about 1991, Al?

Q. Well, 1975. Is there a big change?

A. Not in terms of my practice, no.

Q. I wouldn't think. All right.

A. I would do the procedure with a resident physician assistant, and there would be a scrub nurse; there would be circulating nurse, and there would be a group of pediatricians present in the Delivery Room at the time that the baby was born.

Q. A91 right. Would that be for a high risk or any caesarean section?

A. Any caesarean section.

Q. Now, was there anything in the record to indicate that there wasn't anybody available by way of a pediatrician at the time this operation was done?

A. No.

Q. Did the record indicate that there was a pediatrician present at least shortly thereafter?

A. Yes.

Q. Was this baby properly resuscitated in the Nursery?

A. I don't know.

Q. Formed no opinion on that?

A. Well, think the fact that the baby had Dextrostix of zero and was not given glucose solution until three hours later indicates that she was not well cared for.

Q. What about the oxygen therapy?

A. I didn't review that in detail to comment on it.

Q. Do you think she was properly suctioned and -- in the Nursery?

A. I didn't review it in -- as an expert

to comment on that.

Q. Do you know what the baby's -- Do you recall, after reviewing the baby's charts both at Euclid and at B&C, where she was transferred at age six hours, what the condition was when the baby arrived at B&C?

A. Not precisely, no.

Q. Did you ever review the report by Dr. Horwitz, Samuel Horwitz, the neurologist, or not?

A. I don't recall.

Q. Pardon?

A. I don't recall.

Q. Is it listed on your list there?

A. No.

Q. You don't recall anything that he stated in his report?

A. NO.

Q. Did you review the report by Dr. Clause, Marshall Clause, at Baby's And Children's Hospital?

A. I don't believe so.

Q. Where do you practice obstetrics, Doctor, what hospital?

A. University of Cincinnati Hospital.

Q. And do they have written protocols there regarding obstetrics care on a caesarean section published?

A. I don't know specifically --

Q. Have you ever seen one?

A. No, there may be some in existence. I know there are many nursing policies that are in a manual, but I don't know specifically what it says about caesarean section deliveries.

Q. The only thing you're familiar with is a nursing manual?

A. Yes.

Q. And that has to do with the duties of a nurse, right?

A. Yes.

Q. That does not differentiate between the various members of the medical profession?

A. No.

Q. You're not familiar with any written protocols for the hospital you practice at?

A. Not in respect to the physician,

Q. Physicians and anesthesiologists and so forth?

MR. STEGE: Wait a second, note an

objection to the "and so forth." What are you asking?

MR. RHOA: Well, I don't know. He says he hasn't seen any apparently.

BY MR. RHOA:

Q. Is that correct?

A. I'm not aware of a policy, a manual of policies, regarding specific obstetrics management of patients in our hospital.

Q. All right. So, there's no manual setting forth the duties of the obstetrician, the anesthesiologist, the circulating nurse and the pediatrician under those circumstances; is that what you're saying?

A. Not that I am aware.

Q. And you've never seen one?

A. Not that I recall.

Q. Did you say you saw one from Euclid General?

A. Yes.

Q. Was that a nursing manual or something else?

A. I don't know how to characterize it. It simply was about an inch thick compilation of

various policies.

Q. Could that have been from a nursing manual?

A. It might have. I don't know.

Q. Mad nothing to do with the doctors, themselves, then?

A. Well, I do recall that there were at least two entries that related to anesthesia care. One had something to do with the anesthesiologist was responsible for the suction equipment in the delivery --

Q. Wasn't there anything about the nurse being responsible?

A. Not that I recall.

Q. And this was from the nursing manual?

A. I don't know what the -- as I said, I don't know what type of manual it was that was sent to me.

Q. Well, in your experience, have you ever seen anything like this other than in a nursing manual where you practice?

MR. STEGE: Objection.

Q. I assume you haven't seen anything other than a nursing manual where you're practicing

now; is that correct?

A. I'm not aware of a manual directed to physician management of patients, at least in our hospital.

Q. Okay. Are you aware of it in any hospital?

A. Well, there certainly are situations where medical policies are published in hospitals that I have seen. I just don't believe we have one.

Q. None has ever been published in your hospital to your knowledge?

A. No, we have certain memoranda that are circulated among the physicians regarding specific management principles, but I'm not aware of it being formally put together as a manual.

Q. Okay.

MR. RHOA: Okay. That's all I have at this time.

MS. GARDNER: I have a few questions, Doctor.

CROSS EXAMINATION

BY MS. GARDNER:

Q. When is it you can assert the baby

was first suctioned?

A. In the mother's chart, there's an entry that the baby was suctioned and resuscitated, as I recall. But it's not timed. So I don't know what it has reference to.

Q. That was in the mother's chart?

A. Yes.

Q. And do you know who did that?

A. No, I think Nurse Melson testified that the entries were hers as the circulating nurse.

Q. So you don't know if that was done in the Operating Room or elsewhere?

A. This was in the obstetrics maternal record, so --

Q. It would be in the Operating Room?

A. It would be in the Operating Room.

Q. And again, there's no time on that?

A. NO.

Q. Did you read your prior deposition before today, Doctor?

A: Yes.

Q. Mark Groedel, who represents Dr. Barrett along with me, asked you a pointed question

as to whether or not you had voiced all of your criticisms of Dr. Barrett, and I believe you had at that point. And I'm concerned because you raised an additional one today, that being failure of Dr. Barrett to suction the baby with the bulb syringe. I believe --

A. Perhaps that wasn't described in my first list. I don't know if he did or not. It's just simply not mentioned in the dictated operative note. And as I testified, it is routine for the obstetrician at birth of the baby to initially suction the baby's mouth and nose. And I'll assume that he did. But it's not recorded.

Q. Okay. Maybe I misunderstood your earlier testimony. I had taken your testimony to be that he did not do it?

A. No, I don't know.

Q. You don't know. Would the failure to do that be a deviation from the standards of care in 1975?

A. Yes.

Q. Okay. And what's your authority for that?

A. Particularly in a situation where

there is meconium, thick meconium, present, I think it was well established in 1975 that one needs to establish a clear airway so the baby would not aspirate the meconium into its lung as it established breathing and crying, so that the obstetrician had an obligation in 1975, as he does now, to make an effort to clear the airway before the baby is passed off the operating table to the person that will provide further resuscitation.

Q. You have commented on the standards of care basically of an anesthesiologist in these circumstances as to the resuscitation of this baby, correct?

A. Yes, I think that the anesthesiologist --

MR. RHOA: Well, I'm going to object to this.

MR. STEGE: I think she's only asking you, not to recount your --

MS. GARDNER: No, I understand your criticism.

BY MS. CARDNER:

A. Yes, I have.

Q. In view of the fact that a

pediatrician was not available, and he weuld have been the best qualified in the room to have resuscitated the baby?

MR. RHOA: Objection to that.

A. The pediatrician?

Q. The anesthesiologist.

A. Yes.

Q. In your opinion, Doctor, does that responsibility only fall upon him when asked to do so by someone else in the room?

MR. RHOA: I'm going to object to that. He's not qualified to give an opinion on that. Now, you're either coming in as an obstetrician, or you're coming in as an anesthesiologist, or you're coming in as both. I assume you told me you were not coming in as anything but an obstetrician, and she's asking you for some standards, which I'm objecting to.

MS, GARDNER: He's already voiced opinions on it, Al.

MR. RHOA: That may well be.

MR. STEGE: His objection is for the record. Do you have the question fresh in your mind?

THE WITNESS: I need the question again, please.

(The record was read back by the court reporter.)

MR. RHOA: Same objection.

BY MS. GARDNER:

A. No, I think he has an independent obligation to become involved.

Q. Doctor, in your opinion, should this baby have been intubated in the Operating Room?

A. Yes.

Q. I understand the plaintiff is not offering you on issues of proximate cause; is that your understanding?

A. Yes.

Q. So you're not able to say today how her condition would have been any different had she be intubated immediately?

A. No, except to say better.

Q. Now, you've talked to Mr. Stege, I think, two or three times since your last deposition; you met with him yesterday; you met with him just prior to today?

A. I believe two or three telephone conversations.

Q. Are there any additional criticisms that you have of Dr. Barrett in this cane?

A. No.

Q. Mrs. Alikhan's condition on July 17th or July 18, you referred to earlier, I believe your opinion is she should have been induced by the latest either the 17th or the 18th?

A. Yes, I think, given the circumstances, induction of labor due to post-term gestation was indicated at that time.

Q. And I think your earlier testimony today was that a pediatrician should have been notified on that day to be available for the delivery; is that correct?

A. Yes, the way the question was -- led my thought process was -- if she had come in at 42 weeks and been induced, it would have been prudent to involve a pediatrician in her care because, even then, there was high risk involved.

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

MR. STEGE: Margaret, just so it's clear, I don't know -- I just want to make sure you have a chance to inquire on a subject which I think

is implicit in his testimony. And that is that, if Depp had an independent obligation to --

MR. RHOA: I'm objecting to this. She's asking her own questions, and you have no responsibility for any questions at this deposition.

MR. STEGE: I don't want to be accused of not giving people a chance to take shots at the witness later on.

MR. RHQA: People are taking all the shots they want. You do not have to suggest any.

MR. STEGE: 1 don't want you all to object --

MR. RHOA: I wasn't objecting.

MR. STEGE: Implicit in his criticism of Dr. Depp for not being independently involved is that Barrett should have said, "Depp, get involved with this baby," right after delivery. And I suspect he has an opinion on that, and I don't know that.

MS. GARDNER: Oh, I don't know it was that implicit.

MR. STEGE: All right. Well, I want to give *you* chance.

MR. RHOA: Do you want to ask the questions for her, or what?

MS. GARDNER: I appreciate, I think, what you're saying.

BY MS. GARDNER:

Q. Maybe I didn't touch on it precisely enough. But do you have an additional criticism of my client, Dr. Barrett, for not eliciting the assistance of Dr. Depp?

A. Yes.

Q. Okay. Why is it you feel it was his obligation to do so?

A. The obstetrician has a responsibility to make as certain as possible that there's adequate resuscitation of the newborn. The first step is to make an effort to have a pediatrician present under these circumstances of caesarean delivery. And if that's not possible, then it certainly would be appropriate for Dr. Barrett to ask Dr. Degp to become involved because he's literally a few inches away, and the baby's condition should have been apparent to Dr. Barrett as well as it was to Dr. Depp.

I know Dr. Barrett was quite busy

with the repair of the uterus at that point in time; therefore, there's no reasonable expectation of him to provide the resuscitation of this baby, or for his assistant to provide resuscitation. And because, as far as I know, nurses are not capable of, or trained to provide resuscitation that involves intubation, the only person left was Dr. Depp.

Q. Okay. Are you assuming that criticism; that Dr. Barrett did not ask €or his assistance?

A. I don't know.

Q. You don't know?

A. And it appears from the deposition testimony -- Did any of the people that were present remember? It isn't in the record, and the recall of --

Q. So is that something that would be in the record, Doctor; would you expect that to be in the record?

A. No, that's not the sort of comment that you would record or expect to be recorded, that Doctor A asked Doctor B.

Q. Your earlier testimony was that the

'policymanual at Euclid General Hospital required the anesthesiologist to do the Apgar assessment?

A. Yes.

MR. RHOA: I'm going to object to that. I don't know what --

MS. GARDNER: I'm getting there, Al.

MR. RHOA: Your criteria is, and I suspect that he's quoting from a nurses manual, which is why you're going to forward me whatever it is.

MR. STEGE: You've got it already.

MR. RHOA: It's a nursing manual. Then go ahead. I just don't want anybody confused any more than you do.

MR. STEGE: I think it's a policy that appears in the nursing protocols.

MR. RHOA: Wait a minute. What you think and what I think are something we're not here about at this point. We'll argue your case when the time comes. We're here to question the doctor.

BY MS. GARDNER:

Q. I want to you assume Dr. Barrett did not ask for assistant from Dr. Depp. Is it still

your opinion that Dr. Depp had an independent obligation to attend to this baby?

MR. RHOA: Objection.

A. Yes.

MS. GARDNER: That's all I have.

CROSS-EXAMINATION

BY MR. WALTERS:

Q. Doctor, I represent the hospital. We met before. I want to carry this a little bit further, this conversation we just had. And I'm assuming you're indicating the need for intubation based on the baby's appearance; is that correct; in other words, the baby was meconium stained, post-mature and appeared to have gone through an asphyxic event; is that correct?

A. Yes.

Q. And you're then saying that, based on that, a trained professional should have taken notice of the baby's condition, determined the need for intubation and done the intubation if qualified, correct?

MR. RHOA: Objection.

A. Yes.

Q. Consequently, when the baby was off

to the Nursery, would you also agree that a trained professional who was qualified to do intubation, if faced with that same baby, should have done the intubation?

A. Not necessarily.

Q. And why is that?

A. Because at one minute, the baby's Apgar was recorded at three. As admittedly I don't know what constituted three points because it's not recorded, but the general approach to babies with Apgars of three or less in 1975 was to proceed to establish the airway by intubation before proceeding with the rest of the resuscitation.

And therefore, it was indicated for that reason, number one; number two, it was indicated because the baby had thick meconium around it, and we can all presume in its mouth. And it was established in 1975 that the baby, therefore, was at risk of meconium aspiration.

So the second reason to do the intubation was to get as much of the stuff out of the baby's pharynx, and if it was below the vocal cords, the larynx, as possible before respirations were established.

Now, the condition was different when the baby arrived in the Nursery twelve ninutes later in that the baby probably was breathing and had cried and whatever, but I don't know the details of the condition at that point.

Q. Fair enough. Let me follow up on what you just said. The need to intubate on a baby who has a severe meconium or heavy meconium staining is the need to remove and clear the airway of the meconium deep down into the airway; is that correct?

A. Yes.

Q. Assuming that intubation is not done, can we say with any certainty whether the meconium is deep out of the airway; in other words, even if the baby is breathing, can the meconium still be deep in the airway if the intubation is not done?

A. I'm not sure I understand what you mean, deep in the airway. Once the baby begins to breathe and to cry, there can still be some meconium in the pharynx and larynx that can be sucked out. But with the establishment of breathing, the baby may have sucked some of the meconium into the more peripheral lung, which is

beyond reach.

Q. Okay.

A. So some of the damage is done.

Q. And may there still also be meconium in the airway?

A. Yes, therefore, it was reason to give the baby -- if the baby hasn't been intubated or at least the cords visualized by laryngoscopy on arrival in the Nursery, that would have been a reasonable thing to do. But I've already testified today 1 don't want to be an expert in testimony against the pediatric care of the baby.

Q. Doctor, and I just want to follow up on what you have earlier said, and you've testified as to what you would do in the Delivery Room, and that would be to intubate the child?

A. Yes.

Q. My question is very simple: A professional who could intubate the child, faced with the same circumstances, however twelve minutes later, do you have an opinion within a reasonable degree of medical probability whether this baby should have been intubated?

A. No, at that point I don't know the

condition of the baby, so I'd rather not comment.

Q. Fair enough. Assuming -- let me ask you, take it one more step -- Assuming the condition is similar, do you think the baby should have been intubated?

MR. STEGE: Similar again to that the three at one-minute?

Q. (Mr. Walters nodding head.)

A. Yes, at the time the baby arrived in the Nursery, and the Apgar score was still three, it would be definitely indicated that the baby should be intubated, the airway established and meconium aspirated.

Q. Was this baby ultimately intubated, do you know?

A, I don't recall,

Q. Doctor, did you review the prenatal care --

A. Yes.

Q. __ for the mother?

A. Yes.

Q. Was there an indication of spotting on the five months?

A. I don't recall.

Q. Did the mother have hypertension?

A. I was not impressed in the prenatal record that there was any indication of elevated blood pressures.

Q. Okay. Would you agree with this general statement: That hypertension is the most frequently identified maternal problem associated with intrauterine growth retardation? That's a general statement.

MR. STEGE: Note an objection. But go ahead.

A. Well, that's --

Q. I tie it, just so you're clear, I tie it right out of -- I just wrote it down while we were sitting here right out of public health -- National Institutes of Health study.

MR. STEGE: Just so it's clear, I don't think there's any indication that this baby had either intrauterine growth retardation or hypertension

BY MR. WALTERS:

Q. I'm not asking if the baby had hypertension.

A. The reason that's a tough question is

that there are different types of intracterine growth retardation. There's what's so-called symmetric **IUGR**, which often occurs from an insult early in pregnancy, and the baby just grows at a slower rate than normal. And that's not due to hypertension generally, but rather to some type of metabolic, or infection, or even chromosomal defect.

And then there's asymmetric **IUGR**, which in fact often is the result of pregnancy induced hypertension. But it can also result from any number of other things; poor nutrition, excessive smoking, drugs of one kind or another. So there are other etiologies.

Q. Just so **I'm** clear, you're not aware, based on the prenatal record, that the mother had hypertension; is that correct?

A. That's correct.

Q. And do you remember in the prenatal record any reference to spotting for the mother?

A. No, as I said, **I** don't recall that offhand,

Q. **Is** there any, based on your opinion, any -- What does spotting indicate, generally?

A. At what gestation?

Q. At approximately 18 weeks.

A. Most likely due to a local cause, such as cervical erosion. It could be due to some partial separation of the placenta.

Q. Does it hav any adverse signs to it, or something that the obstetrician should attend to when that is noticed?

A. Yes, if the patient complains of bleeding at any time during pregnancy, it's the obligation of the obstetrician to try to discover what caused it.

Q. And you don't recall that in this record?

A. No.

MR. STEGE: Let the record of this deposition show that he doesn't have the record of her prenatal care in front of him.

MR. RHOA: Do you want to give it to him?

MR. STEGE: No, not unless Steve does.

MR. WALTERS: I don't have the record either. I just have it in my notes.

BY MR. WALTERS:

Q. Doctor, if she did have spotting, would that be something that you would note in something of this nature?

A. I obviously wasn't impressed by it, or I would have commented on it in my report, and I would have remembered it more specifically.

Q. Now, you've expressed some opinions about having a pediatrician available at a caesarean section, and I'm not sure as to what your opinion is in 1975. What is the obstetrician's duty as it relates to having a pediatrician available at a caesarean section delivery in 1975?

MS. GARDNER: Objection.

A. To make an effort wherever possible to have a pediatrician present, but in this case, I certainly acknowledge that Dr. Barrett thought this was important to quickly deliver this baby because of the diagnosis of fetal distress that he diagnosed from the thick meconium being present. And so I have previously testified that I'm not critical of him for proceeding to do the delivery in the time frame that it occurred,

Q. What are his obligations in follow-up

in that regard?

A. In follow-up of getting the pediatrician there?

Q. Yes.

A. He should make an honest effort to get a pediatrician there.

Q. Even after delivery?

A. Yes.

Q. Doctor, I'm going to ask you a question, a question and answer that were put to you at your previous deposition, because I'm not clear, and at the time that we were doing it, I didn't have the printed record, and that's the value of coming back a second time.

MR. WALTERS: It's an open-ended answer.

MR. RHOA: Ask the question, and let's --

MR. STEGE: Steve, just, I'm not going to -- I'm not going to block this one, but as I understand the ground rules of this deposition, it's not open season on the doctor again for everything that was discussed during the first deposition; it was open season for all -- he's

, raised things. It seems to me that all three of you are entitled to follow up on these things. But if it is a follow-up to something that Al raised or Margaret raised, fine, but if you're taking another crack at him --

MR. WALTERS: It is because it's follow-up by the obstetrician to have a pediatrician attendant to the baby. That's what it is about.

MR. STEGE: Right.

MR. WALTERS: And that's why I want to ask him a question.

MR. STEGE: Go ahead.

BY MR. WALTERS:

Q. And I asked you that same question earlier, Doctor, and you talked about Dr. Fanney and you said "whether the hospital contracted for that care," and you're talking about pediatric care, "or whether it was private practitioners were on the staff of the hospital or whatever, I don't look into that, nor I do read anything that clarified that for me." If you want to read the whole --

A. No, I don't have to.

Q. Do you recall that?

A. Yes. What's you question?

Q. What is the delineation that you're making there?

MR. STEGE: Just note an objection because I don't see how that relates -- I don't see anything about Dr. Fanney in there.

MR. WALTERS: Well, excuse me --

MR. RHOA: It goes to Dr. Fanney, who was on the periphery.

MR. WALTERS: It goes to a pediatrician.

BY **MR. WALTERS:**

A. I believe that I was simply explaining that I didn't know if the pediatricians were hospital employees, or whether they were in any way on a schedule that would provide one of them on call for emergency obstetrics situations or any of the other details regarding how they normally covered such a situation.

Q. Assuming they're not employees of the hospital, and they're staff physicians with privileges at the hospital who have patients in the hospital, what are their obligations?

A. Their obligations regarding what?

Q. Regarding being attendant at a delivery.

A. They, when requested by either the obstetrician or by a nurse on behalf of the obstetrician to attend a delivery, they should make an effort to be there.

Q. And assuming it's a caesarean section of a post-mature infant, what is the time frame you would expect them to be there?

A. I think, in another part of the deposition, I indicated I didn't know how far the pediatricians were --

Q. Assuming these were --

A. -- were from the Delivery Room; whether at 8:30 in the morning they would tend to be already present in the Nursery. I don't know the distance from the Nursery to the Delivery Room and many other details that certainly could influence why a pediatrician wasn't in the Delivery Room.

Q. Would you agree that the pediatrician should get there as quickly as possible?

A. Yes.

Q. And Doctor, I have one more follow-up in that regard. In the earlier deposition, it was asked of you that Dr. Fanney, you're aware that Dr. Fanney was available in th'e Nursery after the baby was born, correct?

A. Yes.

Q. And you answered in response to a question like that earlier, and this is what I need some clarification on, and I'll read your entire answer to this question. Well, my understanding is that at 8:45 he was there and suctioned or aspirated the baby and says that the baby thereafter had established respirations. And the same note in the nursing notes goes on to describe the Dextrostix of zero. So it was apparently done about the time he was there, and why that wasn't transmitted to him, and he didn't stay engaged in the care of this baby, I don't know. The point he did is a mystery to me.

Are you critical in that, or are you critical of Dr. Fanney for not staying with this baby longer?

MR. STEGE: Note an objection because I think this is way outside the scope of

this deposition. But I'm not going to prevent the witness from answering.

A. I remember that answer, and somehow in reading the additional material that I have read or in conversations with Ms. Stege --

Q. I want to you disregard those conversations, and I want to you to concentrate on what the record or material is. Mr. Stege's opinions are irrelevant?

A. But I can't disconnect them because I don't recall the source. It's my understanding that Dr. Fanney had left the care of the baby by the time the Dextrostix of zero was obtained. And I don't remember the way that this came to my attention.

Q. You're not aware of any record that indicates that?

A. No.

Q. Doctor, are you familiar with the condition microcephaly?

A. I know what the term means generally, but I wouldn't be able to define it specifically.

Q. And you don't do actual measurements on babies as it relates to that condition; is that

correct?

A. Not of numbers. We certainly many time a day basis are looking at heads of fetuses by ultrasound now.

Q. I think you've indicated your criticisms of the hospital to be, and let me go back over this. This is both including your first deposition and today. And that's the failure of the nurses at 6:30 to notify a physician of the greenish brown show, and secondly the failure of the nurses to notify the physician of the deceleration at 80 at 6:50 a.m.; is that correct?

A. Yes.

Q. Do you have any other criticisms of the hospital personnel, Doctor?

A. No.

Q. As I understand it, it's your testimony that the general responsibility for the baby in the Delivery Room goes to both Dr. Barrett and Depp and the nurse; is that correct?

MR. RHOA: I'll object to the form of that. Go ahead.

MR. STEGE: Are you talking about the circulating nurse?

Q. Yes.
A. For care, immediate care of the newborn?
Q. Uh-huh.
A. Yes.
Q. And all three of those -- you would expect all three of those to provide what they could provide in that situation; is that: correct?
MR. RHOA: Object.
A. Yes.
Q. And in the Nursery, you don't have any opinions as to who's responsible for the care of the baby; is that correct?
A. That's correct,
MR. WALTERS: I don't have anything further. Thanks.
MR. VAN WAGNER: Doctor, I just have a couple questions for you

CROSS-EXAMINATION

BY MR. VAN WAGNER:
Q. You indicated this was a high risk delivery for a variety of reasons, but one of these reasons was it was a post-term situation?
A. Yes.

Q. What was Mrs. Alikhan's estimated date of confinement?

A. It was July 3, 1975.

Q. Do you know how that date was derived?

A. Yes, I think it was -- I believe it was from the first day of her last menstrual period.

Q. What is the calculation from the first day of the last menstrual period to the date of confinement?

A. You add 280 days, 279 days, or you can do it various other ways.

Q. What are some of the other ways?

A. Add seven days and subtract three months, or you can use a gestational wheel which accomplished the same thing.

Q. Do you recall offhand when the date of her last menstrual period was?

A. Not without referring to the chart.

MR. VAN WAGNER: I don't have any other questions for you.

MR. RHOA: I have one question, doctor.

CROSS-EXAMINATION (CONTINUED)

BY MR. RHOA:

Q. Do you recall if the baby was ever intubated?

A. No.

Q. What does that mean; you don't recall, or she never was?

A. That I don't recall.

MR. RHOA: Okay. That's a safe answer.

MR. STEGE: That's it.

(SIGNATURE WAIVED.)

TOM P. BRADEN, M.D.

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DEPOSITION CONCLUDED AT 5:45 P.M.

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C E R T I F I C A T E

STATE OF OHIO :

: SS

COUNTY OF HAMILTON :

I, KATHERINE L. WARREN, 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 TOM P. BARDEN, M.D., was by me first duly sworn to depose the truth, the whole truth and nothing but the truth; that the foregoing is the deposition given at said time and place by the said TOM P. BARDEN, M.D.; that said deposition was taken in all respects pursuant to agreement to take deposition; that said deposition was taken by me in stenotypy and transcribed by computer-aided transcription under my supervision; that the submission of the transcribed deposition to the witness for his examination and signature was expressly waived; that I am neither a relative or nor attorney for any of the parties to this cause, nor relative of nor employee for any of their counsel, and have no interest whatever in the result of the action.

IN WITNESS WHEREOF, I hereunto set my hand and official seal of office at Cincinnati, Ohio, this

day of , 1991.

MY COMMISSION EXPIRES: KATHERINE L. WARREN
AUGUST 28, 1991. NOTARY PUBLIC-STATE OF OHIO