IN THE COURT OF COMMON PLEAS
OF ERIE COUNTY, OHIO

JULIE GREGORY, etc., et al,
Plaintiffs, Case No.
vs. 98-CV-380
SANDUSKY OBSTETRICS and
GYNECOLOGY, INC., et ai.,
Defendants.

- - - - -

Deposition of WILLIAM D. BRUNER, D.O., called for examination under the statute, taken before me, Donnalee Cotone, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at Bayshore OB/GYN, Inc., 3004 South Hayes Avenue, Sandusky, Ohio, on Friday, March 17, 2000, at 3:06 o'clock p.m.

- - - - -

APPEARANCES:

On behalf of the Plaintiffs:
Hermann, Cahn & Schneider LLP, by
KENT B. SCHNEIDER, ESQ.
1301 East Ninth Street
Suite 500
Cleveland, Ohio 44114-1876
(216) 781-5515

On behalf of Defendant Providence Hospital:
Shumaker, Loop & Kendrick, LLP, by
JOHN C. BARRON, ESQ.
North Courthouse Square
1000 Jackson
Toledo, Ohio 43624
(419) 241-9000

APPEARANCES, Continued:

On behalf of Defendants William D. Bruner D.O., Brian Printy, M.D., Glenn McLaughlin, M.D., Sandusky Obstetrics & Gynecology, Inc.:
Bonezzi Switzer Murphy & Polito Co., L.P.A., by,
WILLIAM D. BONEZZI, ESQ.
Leader Building, Suite 1400
526 Superior Avenue
Cleveland, Ohio 44114-1491
(216) 875-2767

WILLIAM D. BRUNER, D.O., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF WILLIAM D. BRUNER, D.O.

BY MR. SCHNEIDER:

Q. State your name, please, doctor.
A. William Bruner.
Q. And what is your professional address?
A. 3004 South Hayes Avenue, Sandusky, Ohio.
Q. Are you married?
A. Yes.
Q. And what is your wife's name?
A. Rhonda, R H O N D A.
Q. How old are you, doctor? I'm sorry? I forgot to ask.
A. 48.
Q. How long have you been married to Rhonda?
A. 20 years.
Q. Is that the only wife you've ever had?

A. Yes.
Q. Did the two of you have children?
A. Yes. We have three daughters,
Q. What are their ages, please?
A. 19, 17 and 14.
Q. The five of you live together at one address?
A. Four now. One is away at school.
Q. Okay, The 19 year old?
A. Yes.
Q. And what is that address?
A. My home address?
Q. Yes.
A. 3712 Hull Road, H U L L, Road. Huron, Ohio.
Q. Where did you go to medical school?
A. Kansas City College of Osteopathic Medicine. Kansas City, Missouri.
Q. And when did you graduate from that?
A, 1977.
Q. You said that was an osteopathic school?
A. Yes, sir.
Q. What did you do upon graduation?

6

A. I did an internship, actually here in Sandusky at Memorial Hospital, and from there went to Garden City, Michigan to Garden City Hospital for a four year OB/GYN residency.
Q. When did you complete the four-year OB/GYN residency?
A. In August of 1982.
Q. Are you from the Sandusky area?
A. No.
Q. Where are you from?
A. Born and raised in Hobbs, New Mexico.
Q. What brought you to Sandusky?
A. I trained in this area, generally in the Detroit area in med school on out-rotations, and liked the staff and physicians here locally and opted to come back and train here.
Q. What did you do upon completion of your residency in August of 1982?
A. I moved back to Sandusky and started practice,
Q. Private practice?
A. Yes, sir.
Q. And that was a practice of

7

obstetrics and gynecology?
A. Yes, sir.
Q. Have you been in private practice in that specialty in the Sandusky area from 1982 up through the present?
A. Yes.
Q. Are you board certified?
A. Yes, I am.
Q. Okay. What are your certifications and when were they obtained?
A. Well, I'm certified by the American Osteopathic Board of Obstetricians and Gynecologists. That was in 1985.
Q. Anything else?
A. That's it.
Q. Are there, is there a written and an oral part for that test?
A. Yes.
Q. Did you pass them both the first time?
A. Yes, I did.
Q. What have been the names of the practices that you've had from 1982 up until now? Under what names have you practiced? I notice --

8

A. The first is Lake Wilmer.
Q. Lake Wilmer?
A. Wilmer, W I L M E R, OB/GYN.
Q. And that was from when to when?
A. That was from 1982 to, I believe, 1990, and there was then a name change to Physicians for Today's Women.
Q. Physicians for Today's Women?
A. Yes.
Q. When was that?
A. 1990 to 1995.
Q. Okay. And then what?
A. And then I changed groups in 1995 to Sandusky OB/GYN, and then in November of 1998, the area practices merged into Bayshore OB/GYN.
Q. That represented a merger of Sandusky OB/GYN and some other entity?
A. Physicians for Today's Women and Women's Clinic.
Q. Three practices merged?
A. Uh-huh.
MR. BONEZZI: You have to say yes as opposed to --
A. Yes. I'msorry.

9

Q. Have you practiced continually throughout that whole time period?
A. Yes, I have.
Q. Has there ever been a time when you took a leave of absence for any reason?
A. Yes, there was. In April of 1997 until, I believe, September of 1997.
Q. You did not practice in that time period?
A. Correct.
Q. Could you explain to me why you took a leave of absence, please?
A. My wife was diagnosed with terminal breast cancer.
Q. When was the diagnosis made, doctor?
A. In April of 97.
Q. And prior to that time, had there been, had she had any other serious health problems?
A. None.
Q. During that roughly six months, am I to assume that you devoted your time to assisting her with her problems and issues related to it?

10

A. Correct.
Q. Have you ever been a defendant in a medical malpractice suit before?
A. Yes.
Q. How many times?
MR. BONEZZI: Objection. Just a continuing objection.
MR. SCHNEIDER: Certainly. You can have a continuing objection to this line.
A. One time.
Q. Onetime?
A. Uh-huh. Yes.
Q. When was that, doctor?
A. A case from seven years ago, 1993, I believe.
Q. Is that case over with?
A. It's still pending.
Q. Who represents you in that case?
A. That's a good question.
MR. BONEZZI: Off the record.
(Discussion had off the record.)
MR. BONEZZI: Back on.
A. I'm sorry. The case was reassigned to another attorney, and if I heard the, if I heard the group, I would recognize it as from

11

Toledo.
Q. From Toledo. Who was representing you before it got reassigned, do you remember the guy's name or woman's name?
A. Actually, no, I don't.
Q. Where is the case pending?
A. I guess locally.
Q. In the Common Pleas Court here?
A. Uh-huh.
Q. What is the name of the person who's suing you will?
A. Lati Spencer, L A T I, S P **E** N C **E R,** I believe.
Q. And what are the nature of the allegations in that case?
A. She had come into labor and delivery earlier in the afternoon and was observed for a period of, I think, two or three hours, and it was felt that she was in, just having uterine irritability and there was no cervical change, so she was sent home, and then returned to the hospital about three and a half hours later, and after experiencing an onset of pain at home and had abrupted and came back with a stillborn.

12

Q. Have you been deposed in that case?
A. Yes, I have.
Q. About when was that?
A. About two months ago.
Q. Have you ever been deposed on any other occasion besides the one two months ago and the one we're doing now?
A. Yes.
Q. Under what circumstances?
A. There were cases from my residency training in Detroit.
Q. You were just simply asked questions about what had occurred there?
A. You know, my participation in the cases.
Q. Other than the ones in Detroit during your residency training and the one you told me about and this one, those are the only time you've ever been deposed?
A. I believe so. I just don't recall any others.
Q. Have you ever served as an expert witness in a medical malpractice case?
A. No.
Q. Have you been requested to do so?

13

A. No. You know, I'm trying to think. There was maybe another case. Oh, it had to have been 15 years ago, come to think of it that I had a deposition on.
Q. How many years ago?
A. About 15 years ago. I would say back in 19 -- in the mid 80s, I believe.
Q. Relating to what?
A. A girl had come to me after she had delivered twins in another hospital, came to me with persistent discharge after delivery, and I did a **D** & C on her, and she ended up with an Asherman's syndrome. She had retained placenta that was never given attention to and I did a D and C on her and she subsequently had Asherman's syndrome.
MR. SCHNEIDER: Could we go off the record for a minute, please?
(Discussion had off the record.)
Q. You remember Julie Gregory, doctor?
A. Yes, I do.
Q. When was the last time you saw her, do you know?
A. While she was in the hospital in 1997.

14

Q. Meaning around March?
A. At the time of this case, uh-huh.
Q. She has not been back to consult with you for any reason?
A. No, she hasn't.
Q. How about any of your partners?
A. Not to my knowledge.
Q. I thought I noticed in your file when I just looked through it some medical records relating to problems Julie experienced later in terms of abdominal pain of unknown etiology and things that were subsequent to the operative procedure you performed for removal of the sponge.
Do you know why that information would be in your file?
A. I don't know. I haven't looked at that file since this case.
Q. Okay. I'm going to show you what I'm talking about.
A. To my knowledge, she's not been back here, so I don't know why there's any information in there.
MR. BARRON: Kent, are you saying other information from other physicians --

15

MR. BONEZZI: This is off the record.
(Discussion had off the record.)
Q. Here's a for instance, We have a report here of a CT scan in July of 97, and --
A. That's Brian Printy's signature. I wouldn't know anything about that.
Q. And Dr. Printy is involved with this practice?
A. Yes.
Q. So it's possible that she did consult with somebody else in this practice, just not with you?
A. Correct.
Q. Did you, your group treated Julie throughout her pregnancy?
A. Yes.
Q. How would you describe Julie's pregnancy, would you describe it as uneventful or were there any problems of note that you could tell me about?
A. According to her prenatal chart, she had an uneventful pregnancy.
Q. Was there anything about her pregnancy other than her age that put her into a high risk category?
A. No, there was not.
MR. BONEZZI: Would you read that last question back, please.
(Record read.)
MR. BONEZZI: I'm going to object. I believe the record is not that she was at high risk, but that she was at risk.
Q. Other than her age, was there anything about her pregnancy that put her at risk?
A. No, sir.
Q. Have you reviewed the records in preparation for the deposition today?
A. Yes.
Q. Have you reviewed the fetal monitor strips?
A. Yes, I have.
Q. What else have you reviewed?
A. The -- her office chart, a copy of her office chart and her hospital chart, start to, you know, with all of the tracings in it.
Q. Have you reviewed any depositions?
A. I have looked through depositions. I haven't been through them completely.

16

17

Q. Which ones have you looked through?
A. Just all of them to a degree as they came in.
Q. Did you read Julie's?
A. Yes, I did.
Q. Do you recall --
A. Parts of it.
Q. Anything about that deposition that you did read that struck you as not comporting with your recollection of events?
MR. BARRON: I want to show an objection to the question given the voluminous nature of the deposition.
MR. BONEZZI: I'm going to join in that objection. Go ahead, please.
A. With what I read, I don't recall anything that I disagreed with.
Q. And I don't know if you remember her saying this in the deposition, that's why I'm going to tell you.
A. Okay.
Q. At one point she said that when you ruptured her membranes that, you said something to the effect that she had been in labor for a week.

18

Now, do you recall saying something like that?
A. I don't recall saying that. She hadn't been in labor for a week. She had been in labor or having contractions for two days, but she had, I think, had started into labor just prior to her admission. I don't recall her saying that. I think I saw that in her husband's deposition.
Q. The question was, do you recall if you said that? She said that you said it at the time which she ruptured her membranes. I'm not sure I made myself clear before.
A. No, I don't recall saying that.
Q. Julie was administered Prostaglandin Gel, correct?
A. Yes, sir.
Q. And that would have been starting on the 13th of March?
A. Yes.
Q. Was that per your order?
A. Yes, it was.
Q. Could you explain to me why you ordered the gel?
A. As I review the chart, I see that

19

the cervix was closed and she was at term and the head was high, and that is a concern for cephalopelvic disproportion, and since she was at term and would more than likely go past her dates with an unripe cervix, it was felt that Prostingel priming needed to be done to help the cervix along.
Q. Now, what was it about her condition that you felt might be indicative of CPD?
A. The baby's head was high, not engaged in the pelvis.
Q. If you're suspicious that there might be CPD, what's the point of gelling? How does that address the CPD issue?
A. Well, anytime that there's a high head at term, there's a concern for that.
Q. For CPD?
A. For CPD.
Q. Right.
A. And if she was going to be longer in the gestation, the baby was going to get big, be getting bigger.
Q. Okay. I see. So what you're saying is, you want to have her deliver before

20

the baby gets bigger and the likelihood of CPD becomes greater?
A. Correct.
Q. If the baby's head had not been in a high station, but the cervix was not ripe, do you then gel under that combination of circumstances?
A. We sometimes will, yes.
Q. Why? What's the reason for that?
A. Usually at term, we don't, we don't like to see baby's go too far past term, so in the 40 to 40th, somewhere around, the time that they're due, if the cervix is not ripe, then we will use gel or now we use Cytotec as part of ripening.
Q. Is that your custom, if they hit the 40th week?
A. No. No. I can't say that. In some cases we do. It depends on what the individual case is.
Q. Was there any other reason here besides your concern about CPD that you gelled her?
A. Her unripe cervix.
Q. And that's what I'm asking, if you

21

have -- if your patient, if your typical patient has an unripe cervix at the 40th week, do you typically gel?
A. No.
Q. Does it require some combination before you do that?
A. It could be a matter of patient preference, it could be whether there are any other medical indications to do it or it could be an elective circumstance, just an elective induction.
Q. Meaning what? What does that mean?
A. Meaning that you just want to control the circumstances. It's in mid January, and they're 39 and a half weeks or 40 and a half weeks and they live in Marblehead, Ohio, and there's supposed to be snow or, you know, and instead of the anxiety of trying to get across the bridge or, you know, you just -- you set up a circumstance there that is more predictable than if they went into spontaneous labor.
Q. What is the relationship between gelling and the onset of contractions, does the gel precipitate the contractions?

22

A. Usually, yes.
Q. So in addition to ripening the cervix, it tends to precipitate contractions?
A. Yes. You're stimulating the cervix and that stimulates contractions usually.
Q. How many times was Julie gelled?
A. Well, in reviewing this chart, I see that she was gelled on two occasions. I thought it was three, but I only see two.
Q. And why wasn't she gelled the third time, do you know?
A. Because upon review, I declined to give additional gel because she was contracting.
Q. So you mean, in essence, it had already done what you wanted it to do and there was no need?
A. Sometimes when you use gel, you get no response, and after one or two doses, I mean, you've gone as high as 15 doses of gel. If you're not getting a response within 24 to 48 hours, depending upon what the circumstance is, then usually we'll stop and wait 48 hours and then try again, which is what happened with Julie, except she went ahead into spontaneous

23

labor.
Q. So the plan would have been, come back in two days, if nothing has happened, then we'll do it again?
A. Yes.
Q. You mentioned that that minus 3 station that the baby was at caused you to think in terms of the potential for CPD, correct?
A. Yes, sir.
Q. Were you thinking at the time that you called for the C-section that, were you still thinking up to that point in time that you may very well have been right and that's why this baby is not moving because, in fact, she had CPD?
MR. BARRON: I'm going to object, Kent, unless you specify what C-section you're referring to.
Q. The first time you called for one at 15:30, was that part --
A. The indication initially was for failure to progress, and she was having decelerations as well, and she just wasn't progressing, and she had reached a point where

24

the cervix stopped its forward progression, became edematous and that's an end point of labor. That's an end point of a trial of labor.
Q. Is it that combination of circumstances that you just described that constitute the end point of the trial of labor, meaning the decelerations, the failure of the cervix to progress and the edematous cervix?
A. Yes.
Q. When that combination occurred and you called for the C-section at 15:30, were you thinking that it may very well have been that she failed to progress because of CPD, if you remember?
A. I'm sorry. Would you repeat your question?
Q. Yes. Do you recall if around 15:30, when you called for the C-section, that you were thinking that her failure to progress was a result of CPD? Was that in your thought process?
A. I won't say that it was the only thing. Failure to progress can include other things, and her cervix was not progressing.

25

She had a secondary arrest of dilation, and that could imply either cephalopelvic disproportion overtly or it could have been the position of the baby that was holding everything up.
Q. Were you suspicious that the baby was in a posterior position? Do you recall anytime during the labor?
A. Probably that -- that's almost a given with failure to progress, but I don't see anywhere in here that I put that it was posterior on exam.
Q. Was there anything about the monitor strips that you looked at that would give you a suspicion that the baby was posterior based on what appeared on the strips?
A. No. She didn't get that far in labor.
Q. What do you mean by that? Do you have to get further to see something on the strip that tells you that it's posterior?
A. Yes. Usually when the head is becoming well engaged, well deeply into the pelvis, there can be a pattern of decelerations that come about that would imply a posterior

26

presentation.
Q. So it's a decel pattern that gives you that information?
A. Usually.
Q. Anything to do with the length of time between contractions that gives you any insight into that?
A. Not in the active phase of labor.
Q. Did you consider her to have reached the active phase of labor?
A. That's why her labor trial was ample,
Q. What was it about, what was it that made her in the active phase?
A. When she had cervical change.
Q. From 2 to 4?
A. Yes. Yes.
Q. And then when you refer to a secondary arrest, are you referring to the fact that she stopped progressing at 4?
A. Yes.
Q. So what makes it secondary is that there had been some progress up to that point?
A. Yes, sir.
Q. You mentioned that you didn't see

27

anything in the chart in which you noted your thought about the fact that however you felt a posterior presentation. I didn't see any progress notes of yours for this labor or delivery.
Do you typically make progress notes?
A. No.
Q. Why not?
A. Usually the information that is important to me is on the monitor strip or I record it in the delivery note.
Q. The delivery note meaning the operative report?
A. Yes, or the delivery note.
Q. Is there a delivery note here? I want to make sure I'm thinking of the same thing you are. Is there a delivery note in there?
A. Yes, there is.
Q. Okay. Would you point it out to me, please?
MR. BARRON: Are you looking for the labor and delivery summary?
MR. SCHNEIDER: I don't know.

28

That's what I'm not sure.
A. Labor and delivery summary, yes.
Q. At the bottom there?
A. Yes.
Q. Okay. Let me just grab mine.
Okay. We're looking at the page entitled labor and delivery summary. I'm looking in the bottom lower-right hand.
A. Yes.
Q. Would you read that for me?
A. My remarks were, pregnancy at 40 weeks, Prostingel times 3, artificial rupture of membranes, meconium, failure to progress, bradycardia, emergency low transverse cervical cesarean section, male depressed --
(Short interruption.)
MR. SCHNEIDER: Back on the record.
Q. You were just about finished interpreting that for me down there, doctor, if you would. You said male, I think, depressed, and then --
A. Estimated blood loss was 800 CCs.
Q. And you wrote that after the birth on the 15th?
A. Yes.

29

Q. And am I correct that that's the only note that you made anywhere in the chart until you dictated your operative report, correct?
A. Yes.
Q. And you're telling me that that is your custom, that you will typically not make any progress notes through the labor and delivery, and then at the end you will make a delivery note if you deem it appropriate and then an operative report?
A. Yes.
Q. When do you normally dictate the operative report in relation to the time of the procedure?
A. It depends on how many other things that I have going. Sometimes I may not dictate an operative report for two days or three days afterwards. Sometimes it's the same way for the history and physical exam. I just carry note cards in my pocket with all of the pertinent data on it, and then whenever I get a chance to light somewhere, or I'll call outside dictation and dictate it in.
Q. You make notes on a note card?

30

A. Usually. In situations like this, I just refer to the chart.
Q. So you would not in a typical labor and delivery make a note on note cards to yourself that you use later?
A. For cesarian sections usually I use the chart.
Q. And you then just dictate off the top of your head what you did during the operative procedure?
A. Usually I have recollection.
Q. That's what I mean. I mean, there's nothing in the chart before you've dictated your operative note.
A. What, where information is noted, I usually will have information in my head as far as what the dilation was, what the indication was, you know, the pre and post operative diagnoses, and if there's any significant findings, like in this case, it was meconium, I will, you know, mark that. Usually I try to do it within 24 hours.
Q. You ruptured the membranes, according to the notes, at 7:40.
A. Yes.

31

Q. And at that time you observed meconium?
A. Yes.
Q. The record indicates that it was odorless, do you recall seeing that?
A. If that's what the record said. You mean where did the record say that?
Q. It said without odor.
A. You mean in my operative report?
MR. BONEZZI: No. Just let him go.
Q. No. If you look in the nurse's notes -- actually, I think it's in a couple of spots, but I have it here in front of me in the nurse's notes it says, 7:40, Dr. Bruner here, AROM, showed particulate meconium stained fluid. No odor noted.
MR. BONEZZI: It's right here right at the top.
A. Okay. I see.
Q. What, if any, significance does the absence of odor have?
A. That there's no infection present.
Q. Since I don't do this, this may not be a particularly articulate question, but try to help me through this. When you see

32

meconium, is it more often with or without odor?
A. There's usually no odor. I'm looking for something different.
Q. What do you mean?
A. Infection, and there's no odor, there's no infection.
Q. Does it tell you anything else in terms of your thinking, for instance, in relation to how long the meconium has been present?
A. No.
Q. Right underneath the note that I just read to you, there's an 8:00 note where it says, patient states she is exhausted because I've been contracting since Friday. This brings us back to that issue about whether you recall anything about you saying that she was in labor for a week.
This was a Saturday, the date of this delivery, by the way. Does that comport with your recollection?
A. I believe.
Q. You have to answer verbally.
A. Yes.

33

Q. Having seen this, does this refresh your recollection in any way about what anybody might have said about being in labor for a week?
A. I just can't imagine why I would have said that.
Q. Okay. The record that we have in front of us shows that you were in the room at 7:40, and then there's the next notation indicating you are present at 14:30.
Does that comport with your recollection that you were not in the room from 7:40 until 14:30?
A. You know, I seem to remember having been in there more frequently than that. I just -- it's hard since it's not recorded here. I don't know at what time that I would -- I just seem to recall that I was there somewhere around noon, but it's not down there.
Q. What is it that makes you think you were there about noon?
A. Usually I will come and review a strip within three to four hours of the time that they're admitted, but I just -- I don't know what it is. I just seem to recall having

34

been there, but...
Q. If you weren't there from 7:40 up until 14:30, is that a longer than usual time period for you to be absent?
A. Yes.
Q. Do you recall who the nurse was that was the labor nurse?
A. I see Holly down here, but I don't recall her.
Q. Do you remember her?
A. Vaguely.
Q. You think if she walked in the room, you would be able to recognize her?
A. No, I don't.
Q. Do you know if you had ever worked with her before that day?
A. I am sure that I had worked with her on other occasions.
Q. Do you remember if -- well, why do you say you're sure you had?
A. She was a labor and delivery nurse.
Q. How long had she been a labor and delivery nurse?
A. I would say probably several months.

35

Q. She was fairly new?
A. Yes.
Q. You were aware of that on March 15th, that she was a fairly new nurse?
A. I don't recall specifically bringing that to mind.
Q. Is it fair to say you did not have an understanding of her level of experience at that point in time?
MR. BONEZZI: At what point in time?
MR. SCHNEIDER: March 15th.
A. I may have, but I don't recall thinking about that.
Q. When you observe -- I'm sorry. Let me back up a little.
Do you recall the meconium being what you would describe as thick when you ruptured the membranes or thin or somewhere in between? How would you describe it?
A. Well, if it's described as thick, that means that it's more solid than fluid.
Q. Do you remember what your impression was?
A. At that time I don't. I remember

36

it at the time of delivery, from the time of delivery, but I don't remember when I ruptured membranes.
Q. Okay.
A. Sometimes that's deceiving because it may settle down at the very bottom part of the uterus and it may appear to be thicker than it really is.
Q. In other words, when you operate and deliver the baby and you observe what you describe as thick meconium, that doesn't necessarily tell you that that was the same thickness that you observed when you ruptured the membranes because of that settling affect that you just described?
A. Right.
Q. When you rupture the membranes and you observe meconium as you did in this instance, what, if anything, does that change in terms of your thinking about the delivery?
What element does that bring into play, if any, with respect to the labor and delivery?
MR. BONEZZI: Objection. Go ahead and answer.

37

A. Usually it doesn't change anything about labor. I mean, you just, you follow the labor the same, but it's to be prepared at the time of delivery for suctioning of the baby trying to prevent aspiration.
MR. BONEZZI: Would you read that question and answer back, please.
(Record read.)
Q. I'm sorry. Who made the decision at, on 3-15 of 97 as to what type of monitor should be placed on the mother and the baby? Who made those decisions?
A. Well, all patients are monitored, and the nurses have the authority to place an internal lead if they feel like there's a problem getting an ultrasound recording or reading.
Q. You didn't have any preference in this case as to whether or not there was an external or internal monitor on either the baby or the mother?
A. I just want the best tracing available.
Q. And it's within the nurse's discretion to make the judgment about how to go

38

about obtaining that?
A. If the monitor strip is unreadable or the patient is too big or moves too much to create a problem with the tracing, then we'll do a fetal EKG, place an internal lead so that we have a more continuous tracing.
Q. Do you learn more about short-term variability with a fetal electrode than you do with an external monitor?
A. Yes, you can.
Q. Is there, is it fair to say that in this case at no time did you tell the nurse that you wanted an internal monitor placed on either the mother or the baby?
A. I'm sorry. Ask that again.
Q. Yes. Is it fair to say then in this case at no time did you tell the nurse that you wanted an internal monitor placed on either the mother or the baby?
A. Yes. But what do you mean on the mother? You mean placing an internal fetal lead for EKG or --
Q. No. I'm talking about an internal monitor, an internal catheter for the mother's uterine contractions.

39

A. Pressure catheter?
Q. Correct.
A. I did not order that, no.
Q. Are there times when you do order internal monitors on the baby?
A. I think the standing order is that when you have a noninterpretable graph because of the toco or the ultrasound placement, to get a clearer reading, then you put an internal lead on. If I'm there, I'll put it in, if I'm not, then the nurse will put it in.
Q. Are there times when it's -- the monitoring of the contractions is less precise than you'd like it to be with an external monitor and therefore you want to use an internal pressure catheter?
A. There could be. I just don't use an internal catheter very often.
Q. Did this hospital have internal pressure catheters for the mother?
A. I believe they did.
Q. You're not sure?
A. I believe they did.
Q. But you just typically don't use them?

40

A. I'm thinking about three years ago. I don't know. I know they're there now and they probably were there or available then, but I don't know that for sure.
Q. Is it important to be able to get a good read on the mother's contractions so that you can compare their relationship to decelerations of the baby's heart rate and then get an accurate impression of how you would characterize those decelerations?
A. If you're having trouble discerning the beginning and the end of the contractions. But with the sophistication of today's monitors, the intrauterine pressure catheter, I just don't find I use them with any frequency.
Q. Is that true in 97 also?
A. Yes, sir, same monitors.
Q. I see that based on the nurse's notes that you came in the room at 14:30 and she indicates that you were advised of late and variable decelerations. Other than -- up to that point in time, do you have any way of knowing if you either looked at a strip or you were advised of anything about a strip from 7:40 until that time?

41

MR. BARRON: And that time you're referring to, Kent, is --
MR. SCHNEIDER: 14:30.
A. I don't see any recording here on the chart.
Q. You mean that you were told anything before that, you looked at anything?
A. Right.
Q. And as we sit here today, you have no way of telling me, for instance, that there's anything that causes you to recall specifically being advised or looking at a strip in that time period?
MR. BARRON: I'm going to object. I think there's been testimony about his recollection around noon, so I object to that.
MR. SCHNEIDER: Well, that had to do with him being in the room, first of all.
Q. And I'm narrowing the question now to specifically saying, is there any way that you could say that you were either advised by somebody about what was on those strips or that you personally observed what was on those strips from 7:40 to 14:30?
A. No, there isn't.

42

Q. At 14:30 the note indicates you were in the room. Do you recall her advising you of the late and variable decelerations?
A. Perhaps when we reviewed the monitor strip together, I would think, but she was telling me that. Do I specifically recall, no, I don't.
Q. All right. Is it fair to say that you don't have any recollection of what occurred at 14:30?
A. I don't have specific recollection.
Q. Is it fair to say that you don't know whether or not you personally looked at the strips at that time?
A. Oh, I'm sure I looked at the strips if I was there.
Q. And that's because what? Why are you sure you did?
A. If I came in the room to evaluate the patient, I would have reviewed the strips.
Q. Even if she told you already what was on them?
A. Oh, yes.
Q. You would still do it?
A. Absolutely.

43

Q. How far back would you go?
A. Usually back from, I have starting and stopping points in the strip. Usually they're torn off and we start all over again and I would review the entire strip.
Q. Okay. I'm confused about that. Could you explain to me what that means?
A. It could have been back as far as the early part of labor. If that's how much strip is still in the drawer, that's what I would have reviewed.
Q. And could it also have been much less than that?
A. Could have been much less than that, yes.
Q. What determines how much strip is left in the drawer?
A. Usually when, when a strip runs out and they change the paper, then they'll remove the paper from the drawer, so...
Q. Do you know if you examined -- let me strike that. Do you know when you performed vaginal examinations on Julie Gregory?
A. Well, I feel sure that I would have checked her, of course, initially at 2:30,

44

again at 3:30.
Q. You mean at 7:40, 2:30 and 3:30?
A. Uh-huh.
Q. You have to answer verbally.
A. Yes.
Q. Why are you so confident you would have done it at 2:30?
A. I always check the patients when I come into the room.
Q. Can we assume that you observed at 2:30 that her cervical dilation was still at 4 centimeters?
A. At 2:30 she would have been 4 centimeters.
Q. And my question is, since you're confident you examined her, can we assume that you would have been aware of that at that point, that her dilatation was still at 4 centimeters?
A. Yes.
Q. And I take it you would have been aware of the fact that she had not progress in some number of hours from 4 centimeters at that point in time, correct?
A. Yes.

45

MR. BONEZZI: Objection.
Q. And at that point in time, do you recall the nurse sharing with you any observation about the cervix being edematous?
MR. BARRON: I'm going to object to the question because I believe the witness has indicated he doesn't have a recollection of that visit.
A. No, I don't.
Q. You don't recall that. Can we assume that you observed or detected at the time of your 2:30 examination that the cervix was edematous?
A. No.
Q. Well, I noted in your operative note that you said -- let me back up.
Why can't you assume that?
A. I don't see it recorded.
Q. Well, it's not recorded at 3:30 either, is it, that the cervix was edematous?
A. No.
Q. But that was one of the reasons why you ordered the C-section, right?
A. Right.
Q. Well, how do you know then that was

46

one of the reasons that you ordered the C-section?
A. Her cervix became edematous between exams.
Q. Between the 2:30 and the 3:30?
A. No. Between her --the -- well, between the last two hours.
MR. BONEZZI: Here. Read your note so you have the information. It's right there.
A. Been in labor throughout the day, has been slowly progressive-- the examination over the last two hours have revealed increasing edema in the cervix.
Q. Now, when you say over the last two hours, does that meaning from 3:30 back? In other words, your last exam was 3:30 when you decided to have a C-section?
A. Right.
Q. So you said over the last two hours we had increasing edema. Now, looking at your operative note and putting it together with the fact that we know it was edematous at 3:30, you must have detected the edema at 2:30, since you pushed back the time of the progression of two hours?

47

A. I can't disagree with that.
Q. And we can also agree that at 2:30 you were aware of the decelerations that have preceded?
A. She was having decelerations, yes.
Q. Is the baby's head station still minus 3, if you know?
A. Whatever was recorded there.
Q. I don't see any recording about the baby's station.
A. As I recall, it still was, because it was still high in at the time of C-section.
Q. Well, at that point in time, doctor, since we have the combination of edematous cervix, we have the high head, we have the decelerations and we have the failure of the cervix to progress for some number of hours, at that point in time, is it fair to say that you're thinking C-section?
A. Usually.
MR. BONEZZI: No, his answer is, were you considering it, yes or no.
A. Uh-huh.
Q. Yes? You have to answer.
A. Yes.

48

MR. BARRON: Kent, your question is directed to the 14:30 time frame?
MR. SCHNEIDER: Correct.
Q. Were you aware that the baby was getting pitocin at the time?
A. Yes.
Q. Did you consider discontinuing the Pitocin at that time?
MR. BONEZZI: Objection to form. Go ahead and answer.
Q. At 14:30.
MR. BONEZZI: Objection. Go ahead and answer.
A. As I review this chart, I believe my thinking would have been that she -- this was time to make a move, either she made a progression in labor or the trial of labor was going to be done.
I knew that she was having decelerations, the variability was good in those decelerations.
Q. Baseline variable?
A. Yes. And I felt comfortable with that enough to give her another hour.
Q. Were you concerned at all about

49

allowing the Pitocin to continue, though, in the case of the decelerations?
A. Well, where are we at here on her strips?
Q. 14:30.
A. Why are you asking?
Q. I'm asking you if at 14:30 when you were in the room, you gave consideration to this discontinuation of the Pitocin?
A. As I look back on these tracings, she was having an average baseline variability. She had had episodic late decelerations with a satisfactory variability within those decelerations.
Q. Please tell me what strip you're referring to.
A. I'm looking at 74134.
Q. 746134, okay. Now, you're characterizing that as a late deceleration?
A. Yes.
Q. With what, did you say after that?
A. With satisfactory variability within the deceleration, coupled with a reactive deceleration.
Q. And that's about 2:18?

50

A. Uh-huh. I mean, I'm just looking back over the tracing. At 2:00 she had a spontaneous acceleration there.
MR. BONEZZI: What panel is that?
A. I'm sorry. 74129,74130, average variability. She's having two-minute contractions. She has, as we progress to 134, still has good variability starting to show and then the late, she has two significant late decelerations at 137 and 138.
Q. And that's right --
A. That's about the time that I saw her.
Q. Now, doctor, the two significant late decelerations you're saying?
A. Uh-huh.
Q. That's a yes?
A. Yes.
Q. Now, and this might be, brings us to my question which was at this point in time, were you considering discontinuing the Pitocin?
A. No.
Q. Nothing about these late decels is a contraindication to the continuation of Pitocin?

51

A. She's not hyperstimulated. Just because she has the decelerations in light of good variability, if we're going to keep an optimal labor pattern up, she's just on a very small dose of Pitocin. She's only on two milliunits of Pitocin.
Q. All right. So you, at this point in time, at 2:30, you are thinking that you're going to give her one more hour and then her trial of labor is over, unless there's significant progression?
(Short interruption.)
Q. Well, it's coming in here. I don't know what to do about that.
(Discussion had off the record.)
(Recess taken.)
(Record read.)
A. Yes.
Q. Was there any need for her to get oxygen at this point in time?
A. With having two decelerations within in light of the average variability, oxygen would be an option, sure.
Q. Do you know if you ordered it?
MR. BONEZZI: Are you asking him if

52

he ordered it at that time or was there a standing order for it?
MR. SCHNEIDER: Yes, either.
A. If you're looking at those two, I would say that that would have been an option and I did not order it.
Q. Does this facility have the equipment to do a fetal scalp pH?
A. No.
Q. Do you practice at other facilities where they do have them?
A. No, sir.
Q. No. Were you splitting your time between more than one facility that day?
A. If on the weekends I have, I would have been responsible for a call at both hospitals.
Q. Firelands and this hospital?
A. Yes.
Q. Do you know if you were, in fact, involved in another delivery at the same time as Julie's, one or more other deliveries?
A. I believe I was involved in one in the morning. I don't recall if I was involved in any others.

53

Q. Where was the one in the morning?
A. At Firelands Hospital. I think I was there when she came in to Providence.
Q. And then you would have come over and ruptured at membranes at Providence, and then you think you went back to Firelands?
A. Yes. At some point, yes.
Q. And did you complete the delivery of Firelands in the morning?
A. I believe I did.
Q. Do you recall whether it was an uneventful delivery or whether there were any issues or problems related to it?
A. I do not recall.
Q. You don't know if it was a C-section or a vaginal delivery or anything like that?
A. I do not recall.
Q. Would you have told the nurse when you left at 2:30 to notify you if the strips become more ominous or would you have had any discussion with her about such a subject, if you know?
MR. BONEZZI: Objection.
MR. BARRON: I'm going to object

54

due to the prior testimony regarding lack of recollection regarding this visit.
A. I will say that that's just part of protocol. I mean, they should, anytime there's any concern with a changing pattern, that they should call.
Q. Well, the reason I ask at this juncture is you indicated in your own mind at this point you had pretty much reached the conclusion that this trial was going to be over in one hour unless something happened?
A. She changed, correct.
Q. All right. Do you know if you shared that thinking with the nurse or if, in addition --
A. Usually I will tell them if I'm thinking that.
Q. Since you had already made a decision that it probably wasn't going to go more than an hour, do you know if you said anything to her or would it be your custom to say, and by the way, if in the meantime, if there's anything at all that is undesirable, let me know and let's just do it?
MR. BARRON: Same objection.

55

MR. BONEZZI: Objection.
A. No, I wouldn't say that.
Q. Would it be fair to say, doctor, that your thinking at 2:30 was that while you were going to give her another hour, it was not going to be likely that this lady was going to deliver vaginally, that you were going to have to intercede?
A. That wasn't my thinking at the time. At the time I was waiting for her to make a move off of 4 centimeters. If she would have been progressive, and depending upon what the fetal heart tracings were doing, then I would have allowed her to progress. But she had -- it was at the end of a generous trial of labor.
Q. And what I'm -- and maybe you answered it. If you did, I apologize for repeating it, but what I'm trying to get at, while I realize you were going to give her to chance to progress, is it fair to say that you didn't think that the odds of her progressing in that next hour to the point where she would end up being permitted to deliver vaginally were very high?

56

MR. BONEZZI: Objection.
MR. BARRON: Objection. Asked and answered.
A. No, I can't say that.
Q. You described it as a generous trial of labor that you terminated her. Why do you call it a generous trial of labor?
A. When a patient starts into labor with an unripe cervix, then you give them extra time to, extra hours to break the cervix down, but she had started on the progression and I think I gave her another hour to make the final change, and she just arrested at 4 centimeters and didn't go from that point.
Either at 4 centimeters, the cervix is either going to let loose and start moving or it's going to continue to remain 4 centimeters dilated and I --there's been countless times that I've had patients that just finally reach a point where they rapidly progress. And she had had a nice trial of labor through the day, regular contractions, and she would have been a candidate that would have possibly just let loose and moved on. But I had to draw a line in the sand.

57

Q. At 3:30 when you called for the C-section, was her condition roughly, her condition and -- I'm sorry. Let me start over.
Was there anything that was going on at 3:30 that was more concerning to you in terms of the mother or the baby than it was at 2:30, other than the fact that you'd now let another hour go by?
A. Well, her tracing began to show recurrent -- let's move on from 14:50, so that would be tracing 7143.
Q. Hold on a minute, please. 74143. Go ahead and comment on that.
A. Still had average variability. It's reassuring variability, but she is having late decelerations and she's having them persistently through the next several tracings. They're still mild. Heart tones are still in the normal range, the baseline variability is still average. 4374151.
Q. But they're still late, the decels?
A. She's still having mild late decelerations. The baseline variability at 4:10 or what is that, 3:10, this is tracing 74152, she still has average variability in the

58

baseline. She is having continued late decelerations.
On 74155, this is where the tracing, to me, begins to become significant. She's having deeper decelerations at that point and she switches from average variability to increased variability.
Q. And what's the significance of that?
A. That the baby is getting more hypoxic, he's getting more stressed, and as we move on towards the end, 74158, persistent variables are still there, but she still has variability within, and then --
Q. May I ask you a question?
A. Yes.
Q. Looking back at the ones that are getting worse, 74154 and 55 forward, are those the type of strips that you should be advised about by the nurse?
A. Yes.
MR. BARRON: I'm going to object to your characterization as to the nature of the strip.
Q. Those tracings that you see on

59

here, are those the types of tracings that should be brought to your attention by the nurse?
A. Yes.
Q. And you should be paged and advised of that?
A. Yes.
Q. Did you say something to the nurse about that when you came in the room at 15:30, about the fact that she should have notified you about those tracings?
MR. BONEZZI: Objection.
A. I don't recall that.
Q. Would that be your style to say something like that to a nurse, or are you the type of guy who would not say something?
A. I'm sure that something was said at the appropriate time.
Q. In other words, you might not have said it then --
A. Not in front of the patient.
Q. But you would have said something to her outside the patient's presence?
A. Oh, yes.
Q. Yes?

60

A. (Witness nodding head in the affirmative.)
Q. You have to answer verbally.
A. Yes.
Q. Okay. So now you're saying that these strips are telling you that the baby is becoming increasingly stressed and hypoxic, and that's -- is that the reason --
My initial question was, did anything change between 2:30 and 3:30, and is your answer that, yes, this picture was worse at 3:30 than what I saw at 2:30?
A. Yes.
Q. And so at that point in time, there was no question about whether you were going to call for a C-section, right?
A. Right, coupled with --
Q. Goahead.
A. Her cervical findings and other labor findings.
Q. The edematous cervix?
A. If the kid was on the perineum, I would have delivered the baby vaginally. It's time for delivery.
Q. In other words, you still got a

61

cervix that's 4 centimeters, you got a kid at minus 3 station?
A. Yes.
Q. And you got an edematous cervix and you have this picture on the tracing, that combination?
A. Yes.
Q. Now, and did you order the Pitocin stopped at this point in time?
A. If I ordered the C-section, yes.
Q. When you see this picture that we've just discussed and you know that there was meconium present, does that additional factor cause you to want to do anything to expedite the delivery more because you'd be concerned about the kid gasping and perhaps aspirating?
A. The timing of the delivery wouldn't alter that. It's just being able to suction the baby adequately. It doesn't make any difference whether you suction the baby five minutes from now or 25 minutes from now. You just need to suction the baby. The meconium doesn't dictate anything. I believe that's what you asked.

62

Q. Okay. At this point in time, why don't you call for a stat C-section? Let me back up.
You call for a C-section at 15:30. How long are you expecting it to take in the normal course of events which when you call for a regular C-section before this baby is delivered?
A. 25 to 30 minutes usually. She already had an epidural, so we just had to wait for the surgical nurses to come in. So when I said we'll do a C-section, that's the next thing that we do is a C-section. They immediately should start the prep and discontinue the IV, start a Foley catheter and on we go.
Q. At this point in time, you are concerned about the baby's oxygenation and the fact that he's appearing to be more hypoxic, right?
A. Yes.
Q. You call for a C-section and you told me that certain preparation has to occur, right?
A. Yes.

63

Q. What is the job of the nurse who's involved with the labor, Holly Cecil, at the moment that you say I want a C-section? What is she supposed to do?
A. She should notify all parties that the C-section is going to go forward. She should notify, I believe, the nursing supervisor, and the supervisor should notify the surgical nurses on call. She should notify anesthesia.
Q. Who is she at that point, the nursing supervise or Holly?
A. Holly. She should notify the supervisor who should notify the surgical nurses.
Q. Surgical nurses.
A. Holly should --
Q. Right.
A. -- notify anesthesia. They should notify pediatrics.
Q. Anesthesia notifies pediatrics, right?
A. Yes. No. I'm sorry. Holly notifies anesthesia. Holly notifies pediatrics.

64

Q. I'm sorry. Okay. Where does she do all this from?
A. At the desk.
Q. How long is all that supposed to take?
MR. BARRON: I'm going to object, unless you specify the nature of the procedure that's being ordered.
A. To make the phone calls, probably a couple of minutes, and to put the Foley catheter in, another several minutes.
Q. To put the Foley catheter in the patient?
A. Yes.
Q. And that can occur in the labor room, right?
A. Yes.
Q. So when you say prep for C-section, she needs to leave the room momentarily to go out to the desk?
A. Right.
Q. And make the notification you just described, which should take a couple of minutes?
A. Correct.

65

Q. She should then return to the room immediately, is that right?
A. Well, just -- I mean, in the course of the event, she needs to come back in the room to get things going.
Q. Put the Foley catheter in?
A. Yes.
Q. Do the abdominal prep?
A. Correct.
Q. Is that her job?
A. Yes, it is.
Q. Does she put Betadine prep?
A. Just the prep, to do a shave prep.
Q. Shave and then the Betadine goes on in the operating room?
A. If we use it, yes.
Q. In this case, Holly left the room and we know that there was bradycardia that began, correct?
A. Correct. Yes.
Q. And continued for, perhaps, seven minutes, seven to eight minutes?
A. Yes.
Q. And was not detected for, perhaps, six minutes, six or eight minutes, does that

66

sound right to you?
A. I -- you know, I was with another patient, so I'm not exactly sure when it was recognized. I know that she came in the other patient's room and notified me and that she had tried the maneuvers to try to get the heart tones back up again, and so I came back down and I walked in about two seconds before the end of the strip and I looked at the strip, pulled all the plugs and off we went.
Q. I take it you were alarmed when you looked at the strip?
A. Yes.
Q. Did you ask her, you know, how this was allowed to continue for this length of time without somebody knowing about it?
A. Honestly, I -- as I recall, I think she was doing maneuvers in the meantime to, shifting the patient back and forth trying to get the heart tones up. I don't -- I'm not sure of the exact times.
Q. Is it fair to say that when a baby was in the condition that the baby was in when you left, based on what you observed on the monitor strips, that that mother should not go

67

unobserved for a period of six or seven minutes?
A. Yes, I would agree with that.
Q. And it's just because of a situation that can develop just like this where suddenly you get this serious bradycardia that requires immediate action, right?
A. Yes.
Q. And you would have expected if the nurse had been in the room that you would have been notified immediately of this type of bradycardia?
A. Called a stat, sure.
Q. At this hospital, is there a central monitoring station?
A. No, there is not.
Q. Is there at any other hospital that you work at?
A. Yes, there is.
Q. Where?
A. At Firelands Hospital.
Q. Did Firelands have one at that time?
A. Yes.
Q. So is it fair to say that

68

Providence, if you weren't in the room with the monitor, there was no way for anybody else to know what was occurring?
A. That's true.
Q. Is there any reason, doctor, why Holly had to be the person to do the notifying of the anesthesia and the supervisor? Is there any reason why she couldn't have stayed in the room and had somebody else do that?
MR. BARRON: Objection.
Q. Either per your instruction or on her own?
A. I don't know how many nurses were on that day, but there's usually a nurse assigned to a patient, and they're responsible for the total care of that. In other words, there may have been another nurse or even two nurses, you know, that were available or not available, but were taking care of other patients and have responsibilities with those other patients.
Q. Couldn't she -- is there a phone in which she could use to call the desk?
A. Well, she was ten feet from the desk, so she was immediately...

69

Q. So invariably she could have walked out, said to the supervisor, we have a C-section, make the proper notifications, but I want to make sure I'm staying in the room.
MR. BARRON: Objection. Calls for speculation.
Q. Would there be --
A. Well, the supervisor wouldn't necessarily be there.
Q. So she has to find a supervisor?
A. Right. She has to call the supervisor, wait for the supervisor to call her, relay the situation.
Q. So she has to go out to the desk, make the call and then stay at the desk until the call comes back?
A. Well, I mean, she doesn't have to. I mean, just if they're going to communicate, somebody has got to answer the phone, and there is nobody else out there.
Q. They don't have somebody manning the phones at the desk?
A. No.
Q. Just a staffing issue?
A. Usually not.

70

Q. Are there less people there on the weekends?
A. I can't remember three years ago. Usually, I think at any places --
MR. BONEZZI: Don't guess, doctor.
Q. Usually there are less people on the weekends?
A. Less people on the weekends.
Q. Are there times that that desk is manned with personnel that you've observed?
A. Oh, yes, and I can't recall if there was someone there that day.
Q. You say that when you saw the prolonged bradycardia you became alarmed and you called a stat C-section, right?
A. Well, the C-section was going. All I did was pull everything and move the patient immediately so that we could immediately move instead of waiting for the crew to come and tell us that they were there. Then we can move the patient. I wanted the patient over there immediately.
Q. And you did become alarmed when you saw that prolonged bradycardia?
A. Yes. I did.

71

Q. Now, from the time you called the stat C-section, how long would you expect it to take before you could get that baby out?
A. 20 to 30 minutes.
Q. Same amount of time as a regular C-section?
A. Well, it was dependent on when the nurses got there. See, there's not an in-house --the surgical nurses were not in-house.
Q. So at this hospital, you knew that it was going to take you 20 to 30 minutes to round up the personnel to do an emergency C-section, essentially the same amount of time that it would take you to do a nonemergency C-section, right?
A. Correct.
Q. For all intents and purposes, at this facility at this time, the concept of a stat C-section was meaningless?
MR. BARRON: Objection.
Q. In reality, it was the same as a nonemergent one?
MR. BARRON: Objection.
A. I disagree with that. It -- when

72

you want to move -- an urgent -- any patient in labor is in an urgent circumstance. I don't care if it is just failure to progress. If they've been in labor and you've decided to do the surgery, then you move along expeditiously.
In this case, the -- it was urgent from the beginning, stat, if you will, from the time that I pulled the plugs, but it didn't change anything. It was still as quickly as we can do this.
Q. You're telling me it was urgent at 3:30, right?
A. Yes.
Q. And --
A. As in any patient that you make a decision, you know, you're not going to take a laboring patient an hour later for cesarian section if you can accomplish it quicker than that.
Q. But here you just -- the fact of the matter is, call it what you will, you can't accomplish it any faster if you call it a stat or if you don't call it a stat, that was a reality?
A. Yes. Yes.

73

Q. And you, of course, knew that all through Julie's labor that if, in fact, she needed a C-section, it wasn't going to happen any quicker, no matter what you called it?
A. It would happen, you know, in 30 minutes or less. I mean, that's what we're usually able to do them in.
Q. You've worked in hospitals, haven't you, where a stat C-section occurs a lot quicker than that, right, when they have the personnel on the premises?
A. Yes. Right. When the personnel are on the premises and, you know, you have an indepartment surgical team, and, of course, those are usually in level two or level three centers. We're a community hospital.
Q. Now, knowing -- let me back up for a second.
I don't see anyplace in the record where it indicates that the baby's heart rate was monitored after the end of that strip that you and I have been looking at up until the time of delivery.
Do you know if, in fact, the baby's heart rate was monitored during that time

74

period, from the time you pulled the plugs?
A. It probably was intermittently.
Q. Probably by who?
A. By the Holly or if there was another nurse available.
Q. Okay. Holly says she didn't do it.
MR. BARRON: Objection.
Q. Do you know of anybody else who did?
MR. BARRON: Just place my objection on the record.
A. I don't recall who all was in the room.
Q. You never saw -- you don't have any clear recollection of somebody doing it, right?
MR. BARRON: Objection.
A. In that specific case, no, I can't say that I specifically recall that. It is usually done intermittently.
Q. You don't have any recollection of ordering that it be done?
A. It's always done if a patient is taking over in labor, then usually there is intermittent oscilltation that is done. In this case, it didn't make any difference.

75

Q. In other words, it was going to take you however long it was going to take you, no matter whether you knew what the heart rate was or wasn't, right?
A. Exactly. And I assumed that the heart rate was 60 the whole time.
Q. So your assumption is that essentially from 15:30 until the time of delivery, that baby's heart rate was in the 60s?
A. I don't know that it was. If we don't have a record of intermittent oscilltation, but from the way that it started out in the labor room, you know, you just, you get the baby out as quick as you can. There's nothing else to do.
Q. I guess what I'm saying is, I thought you said to me that your assumption was that, you know, this baby's heart rate is likely staying down in that area throughout this entire procedure?
A. Yes. Yes.
Q. And of course, you realize --
A. Meaning that I would want to just get the baby delivered as soon as possible.

76

Q. Right. But also, obviously meaning and you recognizing that that period of time where the baby's heart rate would be in the 60s could represent a serious threat of neurological injury to the baby?
A. It possibly could, yes.
Q. I mean, you were thinking that at the time, weren't you? That was going through your mind in some fashion or another?
A. I was just thinking in terms of a depressed baby. I don't think in terms of a neurologically impaired baby.
Q. Obviously you'd recognize that's a potential sequela?
A. If you stop and think about it you're thinking of a depressed baby and trying to get the baby out as soon as possible.
Q. Is it fair to say, though, doctor, that once you saw this bradycardia, and you know the baby's heart rate is down in the 60s, you became much more concerned for his overall well-being than you were at 3:30 when you called for the general C-section based on what you had seen on the strips?
A. Yes.

77

Q. It indicates in the record that Dr. Nimmagadda or anesthesia begins at 16:00. Do you recall seeing that?
A. No. If you can point that out,
Q. I'm looking at the surgery record of operation, which I'd be happy to show you.
MR. SCHNEIDER: Are you with me, Bill? Do you got the pages?
MR. BONEZZI: Uh-huh.
A. Oh, it wouldn't be in the same place in yours, would it?
Q. Mine was set up differently than yours, but that's the record.
MR. BONEZZI: Here. Which one do you want?
Q. This one.
THE WITNESS: Thank you.
Q. We know you called for the stat C-section at 15:38. Now, if you would, tell me exactly what has to happen from that moment until the time of delivery? Well, actually, you called for a C-section at 15:30. So the ball should have been rolling already, right?
A. Excuse me one minute.
Q. Take your time.

78

THE WITNESS: I'm sorry. Bill, I lost the page.
MR. BONEZZI: I'll get it.
A. I'm sorry. Your question?
Q. My question was, we know you called for the C. at 15:30, 3:30 in the afternoon. So the ball should have been rolling at that point in time, right?
A. Yes.
Q. All right. Now, tell me what is supposed to occur then to bring about the C-section? You told me that the supervising nurse is supposed to be called, advised, and she gets the surgical nurses, and the nurse calls anesthesia and the nurse is supposed to call pediatrics as well?
A. Correct.
Q. Then what happens?
A. The patient is prepped and a Foley placed, and they're essentially ready to go.
Q. How long does the prep of the patient and the Foley catheter take, if you're hustling?
A. If you're hustling, no more than four or five minutes.

79

Q. And in this case we got an epidural already in place, right?
A. Yes.
Q. So once you've got the prep done, you move the patient to the OR --
A. Yes.
Q. -- is that right?
Who sets up the OR?
A. The circulating nurse.
Q. So those surgical nurses have to get there first in order to do it?
A. Yes.
Q. And they're not on the premises, they have to come from home or wherever they may be?
A. Yes.
Q. They get beeped, I take it?
A. Yes.
Q. And they're told, appear?
A. Yes.
Q. And what's the general time in your experience at that hospital at that time before the surgical nurses show up?
A. I would say 15 to 20 minutes.
Q. And what's the typical time before

80

anesthesia shows up?
A. Well, they should be there. I mean, if the epidural is going, they're on-site or on premise, so they should be there.
Q. So since there was an epidural in place, we can assume that there was an anesthesiologist on the premises?
A. Yes.
Q. They're required to be there if there's an epidural going, right?
A. Yes.
Q. Do you know if Dr. Nimmagadda was on the premises?
A. To my knowledge, he was.
Q. And so the prep is done, the patient is taken to the OR, as soon as the personnel is there, how long does it take those nurses to set up the operating room?
MR. BARRON: Are you talking about after arrival?
MR. SCHNEIDER: After arrival.
A. I would think five to ten minutes. They just have to open packs.
Q. So it might take them 15 to 20 minutes to get there and another five to ten

81

minutes, right?
A. Right.
Q. And then the operation itself takes how long?
A. Usually just a few minutes.
Q. A few minutes?
A. Total procedure or you mean to deliver the baby?
Q. Yes, to deliver the baby.
A. Usually a few minutes.
Q. Yes. What -- when you came into the room and you saw the bradycardia and you switched it to a stat C-section, what did you do from then until the time you went into the operating room or did you go straight to the operating room?
A. We went straight to the operating room.
Q. So you went right from her room and after you unplugged her and walked into the operating room?
A. I walked into her room, saw the strip, pulled the plugs and immediately started taking her down the hall.
Q. Okay. And that would, the notes

82

indicate that she was taken to the operating room at 15:42, I don't know if you recall that, but that's what it says on the chart.
A, Okay.
Q. So that's 15:42 and it's just a few feet down the hall from the operating room?
A. Yes.
Q. Dr. Nimmagadda, according to the record that you have in front of you, starts the anesthesia at 16:00. What are you doing during that 18 minutes that you're standing there in the operating room?
A. Just trying to keep the uterine fundus over to the left side of the abdomen just to optimize blood return to the heart.
Q. So are you literally just standing there?
A. Literally standing there.
Q. Do you remember it?
A. Oh, yes.
Q. You say oh, yes as though it's a clear picture in your head.
A. It's a clear picture.
Q. And is it something that the recollection of which you've retained because

83

it was very stressful?
A. Yes.
Q. Much more stressful than you're used to?
MR. BONEZZI: Objection.
Q. Maybe I put that improperly. What I mean is you were becoming very, very concerned about the welfare of the baby, weren't you?
A. Yes.
Q. And so your stress level is rising?
A. Yes,
Q. And I take it that under those circumstances, that 18 minutes seemed like an awful long time?
A. And that was the hardest part.
Q. Were you talking --
A. There's just nothing to do. You're just waiting.
Q. Except worry?
A. Just waiting for the team to get there so you can get the baby out.
Q. Did Dr. Nimmagadda give you an explanation of why he didn't get there until 16:00? Let me back up. I'm sorry.

84

You recall sitting there waiting for Dr. Nimmagadda to get there?
A. No, I don't. I don't know. I don't know times. I'm sorry. I just don't know times.
Q. Well, is it fair to say that that time where you were sitting there stressed out, as you described to me, waiting, he wasn't in the room at that point?
A. I don't know when he came in the room.
Q. Well, isn't it fair to say that he would have started anesthesia immediately upon entering the room?
MR. BARRON: If you know.
A. You know, I -- anesthesia start time doesn't mean that he wasn't in the room for the ten minutes before. I don't know what that means. Maybe it means that he injected an additional dose at 16:00.
Q. Well, my point is, you were concerned about expediting this, right?
A. Yes.
Q. So you would have insisted that anesthesia get to work as soon as they get in

85

the room to make sure that as soon as the rest of the team was assembled, you could make the incision and take the baby, right?
A. Yes.
Q. You would not have permitted a situation where anesthesia stood around with you not getting the patient ready for the procedure, you would have had him start it as soon as they enter the room, wouldn't you?
A. She already had anesthetic. I'm not sure what that means. I should say I just don't know because I don't -- I believe that's when he doses her again.
Q. Well, my point is, I mean, we see anesthesia start at 16:00, surgery start at 16:05. Isn't it true that the reason there's a five minute gap is that you're standing there waiting for the anesthesia to take affect so you can cut her?
A. I don't know that.
MR. BONEZZI: Hang on. I'm going to object. Those questions can be answered by the anesthesiologist better than this individual given the fact that he has said he just doesn't recall. The anesthesia record

86

also lays everything out and only anesthesiologistscan interpret it, other than myself. But he is not in the position that he is going to understand those times, because he said that, Kent.

Q. Well, okay. If you don't remember, you can tell me, but I guess my question to you is, do you have any recollection of there being a time frame in which anesthesia administered a dosage of something and you were waiting there for it to take effect so that you could then perform the procedure?

A. No, I don't recall that.

Q. Okay. Is that the normal course of events in your business, that when you perform an operation, anesthesia does their job, you wait for it to take effect and then you operate?

A. Yes.

Q. But you just don't recall in this instance if that's what occurred?

A. I don't recall waiting for anesthesia to take effect.

Q. Okay.

A. I think we started this case as soon as it could possibly be started.

Q. When you -- where else do you operate besides Firelands and Providence?

A. No where.

Q. How long has that been the case?

A. 18 years.

Q. You've told me that when you operate at Providence, that when you call for a C-section they have to notify the nurses and bring them in off the premises at times?

A. Yes.

Q. And the same could also be true of the anesthesiologist?

A. That's true.

Q. Is it the same setup at Firelands?

A. No, it is not.

Q. Okay. At Firelands, are the surgical nurses on the premises?

A. They're --

MR. BARRON: Are you asking 24 hours a day, seven days a week?

Q. Okay. Let's start with that. Are they always on the premises?

A. Yes.

Q. So you don't run into the situation

88

there where they have to call them up at home and bring them in if you need them, correct?

A. Yes.

Q. How about anesthesia, is anesthesia on the premises then?

A. Yes.

Q. All the time?

A. 24 hours.

Q. So a stat C-section at Firelands can be done considerably quicker than it can at Providence, right?

A. Yes, unless everyone is in-house at Providence.

Q. Unless they happen to be there?

A. Yes.

Q. But in the circumstance like we had on a weekend, for instance, you don't expect them to be there, do you?

A. Correct.

Q. I should have asked you that. Actually, it's fair to say that on the weekends at Providence, you're pretty certain they're not going to be around, aren't they?

A. No. Usually Saturdays they will run upwards of maybe a half a day.

89

Q. Okay. So once you hit Saturday afternoon, though, or Saturday evening, it's a pretty good bet they're not going to be there?

A. Usually they're not there.

Q. My question, doctor, is with that knowledge that you had about their capacities, when you have a mother like Julie Gregory who has the picture she has at 2:30 in the afternoon, at which time you say, well, I'm going to give her a little more time and we end up in the type of scenario we're in here, are you thinking to yourself, you know, when I'm at Providence, I can't let the situation deteriorate to the point where it is emergent, I need to be more mindful of the fact that if this baby needs to come out quickly, it's not going to happen at Providence?

Is that thought process something that you employ in your practice over there?

A. It has. But this was an unusual case.

Q. What was so unusual?

A. Well, the heart tones dropping as they did was of very much a surprise.

Q. But we did have a deteriorating

90

picture over that last hour, though, didn't we?
A. Yes, you did.
Q. And if the nurse had told you sooner when she saw those decelerations that you described, you would have called the C-section sooner, wouldn't you?
MR. BARRON: Objection. Calls for speculation.
MR. BONEZZI: Objection.
A. I may have, yes.
MR. BARRON: Move to strike as deals with possibilities.
Q. And I guess -- have you encountered an unexpected bradycardia like this one in your practice before?
A. Yes.
Q. Do they usually follow a period of deterioration on the strips?
A. No, not always, not at all.
Q. Sometimes, yes, sometimes no?
A. Sometimes.
Q. Sometimes they just happen?
A. Just spontaneously.
Q. Do you know why there was no pediatrician present at the birth?

91

A. No, I don't.
Q. I take it that based on your earlier testimony that you certainly anticipated the need for one?
A. Yes.
Q. Did you ask the people that were part of the surgical team if somebody had made contact with a pediatrician?
A. I don't recall that.
Q. Did anybody say anything about the fact that, you know, there's no pediatrician here?
A. You know, I don't know when the pediatrician was called. I can tell there was a few minutes there between the time that the C-section was originally called and I don't know if that call was made before the nurse came back into the room and had kind of preempted everything. I don't know. I don't know when -- I don't know when or if pediatrics was called from labor and delivery.
Q. They're supposed to be, you're just not sure if it happened?
A. Right, and there was not a pediatrician there.

92

Q. Okay. And there wasn't one for some time afterwards, is that your recollection?
A. Yes. I don't recall.
Q. Was that something you were concerned about after the birth?
A. Yes.
Q. Did you voice that concern to anybody there?
A. I'm sure I did. I'm sure I asked where the pediatrician was.
Q. What pediatrician were you expecting?
A. The -- I didn't know. I mean, just the pediatrician on call, which I believe was Dr. Isphording, as I see here.
Q. And do you know Dr. Isphording?
A. Yes.
Q. When the baby was born, I take it that you, you suctioned the baby?
A. Yes, I did.
Q. Could you describe for me how you did the suctioning?
A. As soon as I delivered the baby, I suctioned the mouth with the surgical sucker,

93

I sucker with the wall suction, and I cleaned the nasal, oral pharynx as best I could, delivered the baby, suctioned the baby again with the wall sucker to clean out all of the mouth that I could, and the baby was significantly depressed and so I just clamped the cord and took the baby over to the warmer myself.
Q. Did you suction the baby below the vocal cords?
A. Not on the table.
Q. Do you know if anybody did?
A. No, not on the table.
Q. How do you do that?
A. With great difficulty on the table. You usually wait until you get them in the incubator and can visualize the cord. You just have to be about standing on your head to do it.
Q. Did somebody suction him below the cords in the incubator?
A. Yes. They were -- the baby was intubated on multiple occasions and suctioned immediately after birth, so...
Q. That was Dr. Nimmagadda?
A. Well, that was Dr. Nimmagadda and

94

myself.
Q. You said the baby was significantly depressed, that was obvious?
A. Yes.
Q. Did you look at the Apgar scores on the baby?
A. Yes.
Q. Do you agree with what they put down?
A. Yes.
Q. They give the baby a point for color in the Apgar scores. Did you agree with that?
A. Yes. The baby was pink. When the baby came out, the baby was pink.
Q. Does Providence Hospital have the ability to give you cord blood gas readings?
A. Yes.
Q. Do you occasionally -- how does it come about that you get those, do you have to ask for them?
A. Yes.
Q. And if you don't ask for them, what happens?
A. You don't get them.

95

Q. When do you ask for them?
A. Usually in cases like this, in significant depression.
Q. And you want a cord blood pH?
A. A cord blood pH.
Q. Did you get one in this case?
A. No, I didn't.
Q. Why not?
A. As I recall, when I clamped the cord, it cut through the cord and I wasn't -- the cord drained, so...
Q. Is that your -- yes. Oh, I see that cord blood was obtained, but --
A. Yes.
Q. That's different from --
A. But for gases, right. It had clamped through the cord or the clamp had cut through the cord and the cord basically had drained, so I really didn't have any pressure or anything else. I just -- I compressed the placenta as best as possible to get what blood I could for just the blood typing, but I did not do cord blood gas studies.
Q. You would have liked to, but because of what you just described it wasn't

96

feasible?
A. Uh-huh.
MR. BARRON: I think you need to have a verbal on that.
Q. Yes. You have to answer verbally.
A. Yes.
Q. Doctor, is an edematous cervix a contraindication to placing an internal lead electrode?
A. No.
Q. Do you remember when the surgical nurses showed up in this case in relation to the time of the surgery start?
MR. BARRON: You mean a specific time?
Q. Or, you know, how much before or whatever. Do you remember them showing up?
A. I was really pushing them, so it was only a few minutes.
Q. So when they got there, you were telling them, do it fast?
A. Yes.
Q. And it mentions in the record that there was no sponge count before.
A. Uh-huh,

97

Q. Do these sponges come in a pack?
A. Yes.
Q. How many in a pack?
A. Five usually.
Q. Was there more than one pack used?
A. I don't -- I'm sure there was. I'm sure there was probably multiple.
MR. BONEZZI: Don't guess. Doctor, don't guess.
Q. And since I don't operate, I don't know the answer to this, and, again, this may not seem very informed, but can't, at the end of the operation, can't you just look and see how many packs were out and count to see where all the sponges are?
A. Yes, you can.
Q. So how does it happen that we lose one in circumstances like this?
A. Well, as I recall this, I put a sponge in the, on the left side of her uterus because of the thickness of the meconium and to keep the meconium from getting in and coating the bowel because that can create a problem with ileus after delivery. You know, I took the baby away from the table and I broke my

98

focus. I was flustered. I lost my concentration. I came back, and when you check for sponges and you're not thinking that one is there, you go right over them. They just blend right in, and --
Q. Explain that to me.
A. When they get soaked, they --
Q. Blend inside, you mean?
A. Yes. I mean, they feel like -- I mean, it's up inside.
Q. I see.
A. And you can't, you can't feel it. And I really was just going through the motions, getting the C-section completed. I left the sponge in.
Q. When you say you were flustered, you mean by this whole series of events that were becoming more and more stressful?
A. Yes. Yes.
Q. Isn't the nurse, though, before you close supposed to look at those packs and count them up and see where they all are? Aren't the nurses supposed to do that?
A. Yes.
Q. I mean, that's their job, isn't it?

99

And I realize you're not supposed to leave one, but it's their job to count them before you close, right?
A. Yes.
Q. Did you ever discuss with any of them what happened?
A. Not much to discuss.
Q. Well, I mean, did you talk to anybody? Did any of them say anything to you about it?
A. No. I didn't know anything until three days later.
Q. At that point, did you ever talk with any of those nurses or did any of them apologize to you or say anything about it?
A. You know, I don't recall. I know that they were very upset about it.
Q. Who was upset?
A. The nurses.
Q. Both of them?
A. That were there. I don't even recall who they were, but I know that they were upset. They were in the department when I came to see Julie, when I came up from radiology.
Q. Have you ever had that happen to

100

you before in your practice?
A. No, sir, I haven't.
MR. BARRON: I'm sorry. What was that answer?
THE WITNESS: No, sir.
Q. Would you agree with me, doctor, that leaving the sponge in is a deviation from the standard of care?
A. Yes, it is.
Q. Who was the medical student with you, doctor?
A. I don't recall.
Q. Okay. Do you know if there have been any changes that have occurred at Providence Hospital with respect to any of their policies after this, that resulted from this delivery?
MR. BONEZZI: Objection.
MR. BARRON: Objection.
MR. BONEZZI: I'm not going to let him answer that.
MR. SCHNEIDER: We can take it up another time.
MR. BONEZZI: (Nodding.)
Q. Do you know if the regulations of

101

Providence Hospital require you to be on the premises if you are administering Pitocin to a patient?
A. I know it doesn't at Firelands, but at Providence, I don't know the answer to that.
Q. Does not at Firelands, but you don't know about Providence?
A. Correct.
Q. How can you tell if a mother is experiencing titanic contractions?
A. Usually the monitor would show no relaxation between contractions.
Q. Did you, in your review of the strips here, observe anything that you would consider to be anything at titanic in contractions?
A. No, at no point.
Q. At the time of the, around the time of this delivery, was there any new construction at Providence Hospital? Was this a new wing or was the new wing built or something there, do you remember?
A. I'm not sure what you're asking.
Q. Was any part of the facility new, as you recall, around this time?

102

MR. BARRON: Are you talking about new construction?
MR. SCHNEIDER: Yes.
Q. Let's start with new construction.
A. Not that I recall. You mean, dealing with the hospital?
Q. Yes.
A. Not that I recall.
Q. Was any portion of it under construction, if you remember?
A. Not that I recall.
MR. SCHNEIDER: Can I have a couple of minutes to go over my notes, gentlemen?
MR. BONEZZI: John, do you have any questions?
MR. BARRON: Yes, I do.
EXAMINATION OF WILLIAM D. BRUNER, D.O.
BY MR. BARRON:
Q. Doctor, my name is John Barron, if I can avoid the sun, and I have few questions for you.
At 3:30 in the afternoon on this March 15, 1997, you ordered a cesarean section, correct, for Julie Gregory?
A. Yes.

103

Q. Okay. And there are within the medical world different kinds or urgencies associated with cesarean section, correct?
A. Yes.
Q. And the cesarean section that you ordered at 3:30 p.m. was of a non, what doctors refer to as a nonstat or a nonemergency C-section, correct?
A. Yes.
Q. And at approximately 3:38 p.m., based on developments that occurred between 3:30 and 3:38, you made a judgment that you now wanted to pursue an emergency stat C-section, correct?
A. Yes.
Q. And that set of developments at 3:30, and then what transpired between 3:30 and 3:38 and reflects that at 3:30 while you decided that you wanted to have Mrs. Gregory deliver by C-section rather than vaginally, you did not at 3:30 deem Mrs. Gregory and her child to be in an emergency situation, correct?
A. Correct.
Q. You simply wanted at that time to have her deliver by C-section as opposed to

104

waiting for more progress and a vaginal delivery, correct?
A. Correct.
Q. I believe when Mr. Schneider was asking you some questions about the monitoring strip between 2:30 p.m. and 3:30 p.m., you referenced various observations about the strip, and I think one of them was that at strip 74152, and feel free to turn to that, I believe that you described that strip at 74152 as still showing average variability, is that correct?
A. Yes, sir.
Q. Okay. And do you see any evidence of average variability in any of the other strips between 74152 and 74158?
A. 53 and 54.
Q. And 74154 would be at approximately what time?
A. 15:17.
Q. 3:17 p.m.?
A. Yes, sir.
Q. And these findings of average variability as late as 3:17 p.m. were the same kind of findings of average variability that

105

you made at 2:30 p.m. regarding the monitoring strip as of 2:30 p.m., correct?
A. That's correct.
Q. And --
MR. SCHNEIDER: I'm sorry, John, could you repeat that or read it back? I wasn't sure if I heard that correctly.
MR. BARRON: Would you like to have the court reporter read it back.
(Record read.)
MR. SCHNEIDER: Thank you.
Q. And if I understand your viewpoint, it's that the average variability, which you were noting in the monitor strip as of 2:30 p.m., was one of the factors that made you comfortable with proceeding for another hour to see how she would progress rather than do something in terms of a C-section at 2:30, is that correct?
A. That's correct.
Q. Now, in light of the fact that you're seeing an average variability as late as 3:17 p.m., isn't it likely that if by some mechanism you had been given minute to minute updates by the nurse between 2:30 and 3:30,

106

that you would have come to the same conclusion that you came to at 3:30, which is that was then the time to proceed with a regular, rather than stat C-section?
MR. SCHNEIDER: Objection. You mean, assuming that she described to him every contraction that exists on that strip up until 3:30?
Q. I'm asking the doctor that given what he is seeing regarding the average variability as late as 3:17 p.m., isn't it likely that if by some mechanism you had been receiving minute-to-minute updates by the nurse in terms of what the strip was printing out, that after all was said and done, that you probably would have reached the same decision at 3:30, which was to order a C-section at that time on a nonemergency basis.
MR. BONEZZI: Objection. Go ahead and answer.
MR. SCHNEIDER: Objection.
A. I don't understand the question.
Q. Let me ask it this way, doctor. Given the continued presence of average variability after 2:30 p.m. --

107

MR. SCHNEIDER: Up until when?
A. With the last minute update at what time?
Q. Okay.
A. Sorry.
Q. Let me ask the question this way: Given the continued presence of average variability after 2:30 p.m., isn't it speculative for you to say that even if you had gotten minute-to-minute updates by the nurse, that your management of the patient would have changed in terms of your decision at 3:30 to order a nonstat C-section?
MR. SCHNEIDER: Objection.
MR. BONEZZI: Objection.
A. Sir, would you mind -- I hate to be so dense, but there's got to be a simpler way to ask that question.
Q. Let me ask it this way.
A. In English.
MR. BONEZZI: John, let me just interrupt and ask you, are you asking him whether or not it's the rhythm tracings and the information on the rhythm tracings that directed and guided his decision to do the

108

section, and if so, are you asking that even though there was information available between 2:30 and 3:30, and had it been provided to him, that he would not have done the section any quicker, or he would not have ordered it any quicker than what he did?
Because see, that fails to take into account that had he come in earlier, he would have examined the patient also, and that's really the basis of my objection, not your question. But it leaves out, I think, some important data, and that is that he would have come in and examined the patient, and if he would have, that would have provided him information also as to what he was going to do.
Q. Let me ask it this way, doctor. When you came in at 3:30, you had an opportunity and, in fact, reviewed the strip as it had progressed between 2:30 and 3:30, correct?
A. Yes.
Q. You also had an opportunity to, and did, in fact, examine the patient, correct?
A. Yes.
Q. And based upon all of that data,

109

you did not believe that there was a necessity for an immediate emergency C-section, correct?
A. That's correct.
Q. It's not your claim, doctor, is it, that if you had come into the hospital at 3:00 p.m. or at 3:10 p.m. or at 3:15 p.m. or at 3:20 p.m. or at 3:25 p.m., you would have ordered an emergency C-section, is it?
A. Correct.
Q. Now, once you gave the order for a regular nonemergency C-section, you acknowledge, I believe, in response to one of Mr. Schneider's questions, that that was to put into affect a chain of events, one of which would have required the labor room nurse to leave the labor room for a period of time to carry out your order, correct?
A. Yes.
Q. Okay. You, yourself, don't have any knowledge as to the precise amount of time that elapsed between when the labor room nurse left the room following your order and the time that she returned to the room and discovered a fetal bradycardia, correct?
A. Correct.

110

Q. There are certain steps that a nurse can sometimes take to attempt to, from a nursing perspective, help with fetal bradycardia, correct, like repositioning the patient?
A. Yes.
Q. Okay. And if that took place in this case, you wouldn't fault the nurse for repositioning the patient, correct?
A. Not at all.
Q. Okay. Is oxygen sometimes given by a nurse to deal with fetal bradycardia from a nursing perspective?
A. Yes, that's part of the protocol.
Q. Okay. And if that was done in this case by the labor nurse, you would not fault that?
A. No.
Q. Do you, yourself, have any knowledge regarding the amount of time that elapsed between the time the nurse became aware of this fetal bradycardia, which developed after 3:30 p.m. and the time the nurse summoned you regarding that in terms of specific seconds or minutes?

111

A. I don't recall that.
Q. Okay. Mr. Schneider asked you a number of questions about how, what you knew about arrangements at Providence Hospital and at Firelands Hospital for staffing for emergency cesarean section, and I'd like to ask a couple of questions about that.
If I understand your testimony, correct me if I'm wrong, that Providence Hospital was considered to be a community hospital?
A. It's a level one hospital.
Q. Level one hospital. What is the designation for Firelands Hospital, at least as regards obstetrics?
A. Level one.
Q. Am I right that it is fairly common for level one hospitals on the weekends not to have in-house anesthesia and in-house surgical team for cesarean section purposes?
A. That's correct.
Q. Okay. And whereas, that is the situation at Firelands, there are many community hospitals throughout Ohio and throughout the country who are staffed in

112

exactly the same way; that is, needing to call in the surgical team and, perhaps, even call in anesthesia for the purposes of doing an emergency C-section on a weekend, is that correct?
A. That's correct.
Q. And that type of arrangement or standby capability for a cesarean section was something that you were prepared to deal with insofar as you have chosen to do obstetrical practice at Providence, correct?
A. That's correct.
Q. Doctor, I'd like to ask you a few questions now about the resuscitation efforts and care provided to Trent Gregory, the male infant, after his birth.
My understanding is from an earlier answer of Mr. Schneider, that upon delivery of the head, you immediately suctioned the mouth and the oral pharynx?
A. That's correct.
Q. Okay. And tried to remove as best you could within that technique all of the fluid or meconium that was in those areas of his airway, correct?

113

A. Correct.
Q. Okay. If I'm understanding you, and correct me if I'm wrong, that after the whole body was delivered, you, again, attempted to suction the mouth and the, what's called the oral pharynx area of whatever meconium you could?
A. Yes.
Q. Okay. Immediately after those steps were accomplished by you, the baby was taken where?
A. I took the baby around the table over to the incubator.
Q. Okay. And at that point, Dr. Nimmagadda came forward to provide resuscitative care to the infant, correct?
A. Correct.
Q. And his care included intubating the baby?
A. Correct.
Q. And from your observation, would it not be fair to say that Dr. Nimmagadda provided excellent resuscitative care for this infant?
A. Yes.
Q. And there is no reason to believe

114

that the resuscitation efforts could have been any better provided by the pediatrician than what was, in fact, carried out by Dr. Nimmagadda, is that correct?
MR. SCHNEIDER: Objection.
A. I agree.
Q. If you don't know, just tell me. It's my impression from reading the chart, but I'd like to know whether or not you know from your own knowledge that Dr. Nimmagadda after suctioning, after intubating the baby, suctioned the airway beneath the level of the vocal cords?
A. Yes, he did.
Q. You observed that?
A. Yes.
Q. Am I right that in the time period running up to your performance of the cesarean section, because of your desire to speed up the process of delivery as quickly as possible, you directed the nursing staff not to do a sponge count prior to the performance of the cesarean section, is that correct?
A. That's true. That's true. Yes.
Q. And this was something that you

115

ordered them not to do because you wanted to have them focus their efforts on assisting you in getting the child delivered as quickly as possible, correct?
A. Correct.
Q. And under normal circumstances, absent your direction, the nurses would have carried out a sponge count, correct?
A. Correct.
Q. And in the absence of a sponge count going in, it is more difficult to determine by the nurses after the procedure the exact status of whether or not all the sponges have been removed, correct?
MR. BONEZZI: I'm going to object. Go ahead and answer.
A. It would be highly unusual that there were an abnormal number of sponges. Those are -- I mean, they're --
Q. It can happen?
A. If they open five packs, that should be 25 sponges there. But it could happen, yes.
Q. The most accurate way of being able to determine the status of the sponges and

116

whether or not there are any sponges that are left in the patient is to have a sponge count from going in at the start of the procedure, correct?
A. That would be the best, yes.
Q. Did you at any time, doctor, after the performance of the cesarean section order an x-ray of the abdomen to determine the presence or absence of a sponge?
A. No, I didn't.
Q. That's something that you could have ordered?
A. I could have.
MR. BONEZZI: Objection.
Q. Is there some reason why you did not?
MR. BONEZZI: Objection.
A. There are many times that sponge counts are done after procedures. If you were to ask me of all of the cases that I did in 1997, how many of my sponge counts were correct, and I was told that they were correct, I just don't have a very good recollection. They usually will stop the procedure or throw a fit or something like

117

that. I mean, sponges get misplaced very often. That's why sponge counts are done.
Q. But it's not usual -- I mean, in this situation, we weren't dealing with the routine situation, right, because in a routine situation you don't direct the nurses to not do a sponge count, correct?
A. Yes, sir.
Q. Is that correct?
A. Yes.
Q. From your perspective, the fact that this child was -- or I'm sorry. The fact that this mother was admitted to Providence Hospital on March 15, 1997, rather than Firelands Hospital, how did that come about?
A. Her preference.
Q. Am I correct, doctor, that when you go in to see a patient who's in labor who's being monitored, that it's your routine on every occasion when you go into the room to look at the electronic fetal monitor strip, correct?
A. Yes.
Q. And you will review the entirety of the strip that is part, since the last time you

118

looked at it?
A. That's available, correct.
Q. And when you say that's available, you mean that unless someone has actually physically removed some earlier portion of the strip from the room, you'll look at the entirety of the strip?
A. Yes.
Q. Do you have any knowledge in terms of this labor on this date that at any time any part of the strip was removed from the room?
A. Not to my recollection.
Q. I believe there's been some testimony by Mr. and Mrs. Gregory that you came to see her in her labor room sometime around noon. Do you have any recollection of that?
MR. SCHNEIDER: Objection.
A. I believe I did, but it's not down on paper, so I don't have a --
Q. Did you note that portion -- let me back up. Did you read that portion of Julie Gregory's deposition?
A. No.
MR. BARRON: Thank you. That's all the questions I have at this time.

119

MR. SCHNEIDER: I just have a couple follow-ups, doctor.
EXAMINATION OF WILLIAM D. BRUNER, D.O.
BY MR. SCHNEIDER:
Q. In the course of your many years of practice, I take it that you have become familiar, very familiar with the obligations of obstetrical nurses as it relates to keeping obstetricians like yourself informed during labors and deliveries, is that a fair statement?
A. Yes.
Q. And would you agree with me that the nurses' failure to inform you of what was appearing on the tracings starting at about 3:17, which you pointed out before, which I think was 741, starting at the end of 74154 and forward, would you agree with me that this nurse's failure to notify you of what, of what was appearing on these tracings constituted a deviation of her obligations to you?
MR. BARRON: Objection.
A. I think I should have been notified.
Q. And isn't it true, doctor, that

120

based on your many years of experience, that you know that the standard of care requires an obstetrical nurse that under the circumstances they notify you?
MR. BARRON: Objection.
MR. BONEZZI: Objection to the term standard of care.
A. Usually I will be notified.
Q. Okay. You mentioned that it was Julie's preference to go to Providence rather than Firelands.
A. Yes.
Q. Is it fair to say, doctor, that you would not have sat down with her and Dwight and gone through a laundry list of features that are available at Firelands that aren't at Providence and have, for instance, have told them that if there's an emergency C-section, there's people at Firelands that aren't at Providence, are you? That's not the kind of thing you do, is it?
A. Yes, we do, but I don't recall going through that with Julie.
MR. SCHNEIDER: Okay. That's all I have. Thank you.

121

EXAMINATION OF WILLIAM D. BRUNER, D.O.
BY MR. BARRON:
Q. Doctor, do you know precisely where you were between 3:17 p.m. and 3:30 p.m. on March 15, 97?
A. I believe I was at Providence Hospital.
Q. Do you know where?
A. I would have either been down in the emergency or in labor and delivery area. I just, I don't recall that. I don't recall.
Q. Do you recall how it was you came to be in the room at 3:30 p.m.?
A. Well, I had given them a time frame that I would check them and then came back in an hour and checked her.
Q. So you told them at 2:30 that you would be back in an hour?
A. That she had another hour to go.
Q. Okay. You told the nurse that, in your view, this was a situation where the patient had another hour to go and that you would be back at 3:30 p.m., correct?
A. I don't recall saying that specifically to the nurse.

122

Q. Well, when I ask you the question, how was it that you came to be back in the room at 3:30 p.m., I believe your answer was that I had given them that I would be back in an hour, am I right about that?
A. Yes.
Q. So by some mechanism, you had communicated to the nurse or nurses at 2:30 that you would be returning around 3:30?
A. Yes.
Q. Mr. Schneider just asked you a question whether or not you would have gone through a listing of various factors that may be different or the same or comparisons or whatever between having a baby born, delivered at Firelands versus at Providence Hospital, and I believe you indicated that that's the sort of thing that you generally do with your patients, is that correct?
A. Yes.
Q. Okay.
A. Well, not generally, but there was a period of time initially when this program started up, people wanted to know, well, which one would you go to, and we would give them the

123

particulars about each place, but I don't recall saying it to the Gregorys.
Q. Is that because of the -- was there something specific about the Gregorys that -- well, wait a minute. Let me back up.
Is it you're saying that you don't have a recollection specifically of that conversation with the Gregorys or is it your testimony that you believe you did not have that conversation?
A. I believe that I did not have that conversation.
Q. Okay. And is there, was that because of the time frame of this delivery as opposed to the other pregnancies and deliveries where you did have that conversation or was there something specific about the Gregorys that led you not to have that conversation?
A. No, not at all, not at all. It was the former.
Q. It had to do with the time frame, in other words, after a period of time passed?
A. Six months, 12 months, yes.
Q. Okay. But I take it that --
MR. BARRON: I believe that's all

124

the questions that I have.
MR. SCHNEIDER: Okay. Thank you, doctor.
MR. BONEZZI: For the record, a request was made prior to the commencement of the deposition for a full and complete copy of Dr. Bruner's office chart. I will be taking the chart. I will provide copies to both counsel and then I will return the chart. We will read and I will take a copy of the transcript.
MR. SCHNEIDER: Copy.
MR. BARRON: Copy.

(Deposition concluded 6:26 p.m.)
- - - - -

125

CERTIFICATE

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

I, Donnalee Cotone, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, WILLIAM D. BRUNER, D.O., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.
I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

126

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this day of _____, 2000.

_____
Donnalee Cotone, Notary Public
within and for the State of Ohio

My commission expires February 7, 2002.

127

INDEX

128

SIGNATURE OF WITNESS

The deposition of WILLIAM D. BRUNER, D.O., taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

It was agreed by and between counsel and the parties that the Deponent will read and sign the transcript of said deposition.

129

AFFIDAVIT

The State of Ohio,)
) SS:
County of Cuyahoga)

Before me, a Notary Public in and for said County and State, personally appeared WILLIAM D. BRUNER, D.O., who acknowledged that he/she did read his/her transcript in the above-captioned matter, listed any necessary corrections on the accompanying errata sheet, and did sign the foregoing sworn statement and that the same is his/her free act and deed.

In the TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at this day of A.D 2000.

Notary Public

My Commission Expires:

DEPOSITION ERRATA SHEET

RE: JULIE GREGORY, ETC., ET AL. VS. SANDUSKY OBSTETRICS & GYNECOLOGY, INC., ET AL.
RRS File No.: 1930
Deponent: WILLIAM D. BRUNER, D.O.
Deposition Date: MARCH 17,2000

To the Reporter:
I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.