85029

IN THE COURT OF COMMON PLEAS

OF SCIOTO COUNTY, OHIO

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Rhonda Bland, Administratrix of the Estate of Jacob Lawson,

Plaintiff,

vs

George P. Pettit, M.D., et al.,

Defendants

Case No 95CIA00015

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Deposition of STEPHEN J DeVOE, M D , a Witness, herein, called by the Plaintiff for cross-examination under the statute, taken before me, Kathryn E Stischok, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without notice or other legal formality, at the offices of Riverside Obstetrics & Gynecology, 3555 Olentangy River Road, Suite 3070, Columbus, Ohio, on Thursday, December 18, 1997, at 11:02 o'clock a.m.

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APPEARANCES:

Butler, Cincione, DiCuccio,
Dritz & Barnhart
50 West Broad Street
Suite 700
Columbus, Ohio 43215
By Mr. N. Gerald DiCuccio,

On behalf of the Plaintiff.

Porter, Wright, Morris & Arthur
41 South High Street
Columbus, Ohio 43215
By Mr. Greg Foliano,

On behalf of the Defendants
George P. Pettit, M.D. and
Ronald Lopez, M.D.

Bannon, Howland & Dever
325 Masonic Building
Portsmouth, Ohio 45662
By Mr. Robert R. Dever,

On behalf of the Defendant
Southern Ohio Medical Center.

ALSO PRESENT:

Cheryl Patzer, R.N.

Thursday Morning Session
December 18, 1997
11:02 **o'clock** a.m.

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It **is** stipulated by and between **counsel** for the respective parties that the deposition of **STEPHEN** J. DeVOE, **M.D.**, **a** Witness herein, called by the Plaintiff for cross-examination under the statute, may **be** taken at this time by the Notary, by agreement of counsel without notice or other legal formality; that said deposition may be reduced *to* writing in **stenotypy** by the Notary, whose notes may thereafter be transcribed out of **the** presence of the witness; that proof of the official character and qualification of the Notary is **waived.**

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STEPHEN J. DeVOE, M.D.

by me first duly sworn, as hereinafter certified, deposes and says as follows:

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CROSS-EXAMINATION

BY MR. DiCUCCIO:

Q. Doctor, my name is Jerry DiCuccio. I am here this morning on behalf of my client, Rhonda Bland.

You and I have never personally met before.

A. We have.

Q. We have?

A. Yes.

Q. Well, you see, my hair is not only thinning and getting gray, but my memory is going very rapidly.

If you could refresh my recollection when we met.

A. You sued me about 15 years ago.

Q. I did?

A. Um-hmm.

Q. Why did I do that?

A. You alleged that a lady got a

wound infection with a tubal and it was mismanaged and she got breast abscesses as a result. It was dismissed.

Q. I don't remember the case, but --

I understand why.

Q. You have been identified as an expert witness on behalf of the medical center involved in this case retained by Mr. Dever; is that correct?

A. That's correct.

Q. You are a medical doctor?

A. That's correct.

And you specialize in obstetrics and gynecology?

A. Correct.

And your office is located in Columbus, Ohio?

A. Correct.

Q. And we are in your offices at the present time?

A. That's correct.

Q. When were you first contacted regarding this case?

A. Earlier this year. I don't know

when. February or March would be my guess. I could be wrong on that.

Q. Did you know Mr. Dever before his ccntact?

A. No. We just met this morning.

Q. You had received correspondence from him?

A. That's correct.

Q. And materials from him?

A. Correct.

Q. Do you have those with you?

A. Yes. Some of them.

Q. Where are all of them?

A. Well, some of them are at home. This is a voluminous case and some of them are here at my feet.

Q. What is at home and what: is at your feet?

A. My feet are the records of the medical care and a number of the depositions, I think the most important depositions or the ones I read most recently. Because of the volume of the material, I didn't bring them all with me.

Q. Can you tell me from your recollection what you have reviewed in this case?

A. I reviewed the records of the hospital care from 8-28 through 31-95 for Mrs. Bland; two nonstress tests from August 13th ana August 22nd, same case obviously; I reviewed depositions of Lopez and Pettit, Ballenger, a number of nurses. I will do the best I can. It was Ruby, Rawlins, Triplett, Montavon, LaNier, Hines, Cooper I think there are eight or nine nurses' depositions. I have left out severa

Q. [illegible]

A. Yes.

Q. Did you read Dr. Ballenger's deposition?

A. Yes.

Q. Do you know Dr. Ballenger?

A. Yes.

Q. Do you find him to be a competent and qualified obstetrician and gynecologist?

A. I have never practiced with him. He has been across town for his whole

career. He has a gosd reputation.
Q. Any reason to believe he is not competent and qualified in obstetrics and gynecology?
A. No.
Q. You are a medical doctor?
A. Yes.
Q. Are you a nurse also?
A. No.
Q. Have any nursing degrees of any type?
A. No.
Q. Ever go to nursing school?
A. No.
Q. Receive any type of specialized nurse's training?
A. No.
Q. Do you regularly read any nursing journals?
A. No.
Q. Any nursing texts?
A. No.
Q. Any materials pertaining to nursing?

A. Yes.
Q. Such as?
A. Well, nurse's notes in the hospitalized patients; as a quality assurance -- head of the quality assurance committee here for several years, I have reviewed a lot of hospital care which involves evaluating nursing as well as physician care.

I think in my role as a practicing physician I am inevitably evaluating nursing care as I take care of my patients.

Q. From the standpoint of what nurses are taught, is that separate and apart from what you do?

I don't teach nurses, at least not

A. That's correct.
Q. Never sat for a nursing Licensure examination?
A. Correct.
Q. You are, in fact, an expert in obstetrics and gynecology?
A. I hope so.
Q. Well, are you or aren't you?
A. I think so. I mean I have practiced successfully for 20 odd years.
Q. You can say it like it is. If you think you are, you tell me. I am not going to dispute that if you tell me that.
You are a qualified expert in obstetrics and gynecology,
A. Thank you.
Q. You are not a qualified expert in nursing, are you?
A. In the legal sense, I am not. But I think as a physician practicing, as I said a few minutes ago, you have to be able to evaluate the nursing care because you rely on nurses.
Q. When was the last time you

rendered nursing care to a patient in the hospital?

A. Not officially as such. I think some of the things we do are nursing care, but not officially as such. I don't write nursing notes and those kinds of things.

Q. You don't write on the nursing notes, the entries, do you?

A. I just said that. I just said I don't write on the nurse's notes,

Q. And you don't personally attend the patients as a nurse, do you?

A. Not as a nurse, no.

Q. Have you had an opportunity to review the fetal monitor strips pertaining to Rhonda Bland's admission to Southern Ohio Medical Center --

A. Yes.

Q. -- beginning the 28th of August, 1995?

A. Yes.

Q. Can I give you a copy of them?

A. Sure.

Q. Those are the same ones that you

have reviewed previously?
A. As I look at all of them, I would assume they are. I have no reason to

Q. Have you ever reviewed on behalf of any doctor or hospital any materials in any other cases preparatory to being a witness?
A. Yes.
Q. On how many occasions have you, let's say in the past five years, reviewed materials on behalf of doctors or hospitals in anticipation of being an expert medical witness?
I don't know.
Can you give me an approximate

speculate.
Q. More than five times?

A. Yes.
Q. More than 15?

A. In five years? Yes.
Q. Can you tell me approximately how many you have done this year?
A. Maybe 10 or 15.
Q. You have a pretty big practice in reviewing medical/legal things, don't you?
A. I don't know. I have no yardstick for comparison.
Q. Well, do you ever talk to any of your colieagues?
A. Not about numbers. I know other people do this stuff from time to time. I don't know whether I do more or less than they.
Q. Do you think 15 to 20 is about what the average reviewer does in these cases, or you just don't know?

reviewer does.
Q. Yours is about 15 to 20 this year that you recollect?
A. I am guessing. I could be wrong. Five or ten either direction. Probably high. I probably gave you a high number

there.

Q. My understanding is that when it was in existence, or still a functioning company, you also sat on the review board for PIE?

A. Not really. That is not true.

Q. Did you review claims for PIE?

A. I have reviewed some claims for the Jacobson office. I went to a couple of their ad hoc one-evening seminars where they would have some sandwiches and look casually

like that.

Q. Do you know my nurse Cheryl Patze

A. No.

Q. Do you ever recall talking to her?

A. I have talked to lots of nurses, as you can imagine. I don't recall talking to her. If she says I did, I expect I did.

Q. She was the person who arranged

those meetings for Jacobson, Maynard over the years.

A. Okay.

Q. So do you recall talking to her meetings?

A. I do not recall talking to her.

Q. But you say you have sat at one or two over a 20-year period?

A. More than one. I would guess two. It could be three. I don't remember.

Q. Could it be four or five?

A. No.

Q. Three tops?

A. I am guessing. There is 20 five?

MR. DEVER: I am going to object.

Let's get on down the road.
A. I don't have any idea. I have made that clear.
Q. In your review of the fetal monitor strips, you may reference them, upon her initial presentation on the 28th of August, would you describe for me what you see on those fetal monitor strips from that period of time from approximately 08:30 a.m. until 11:30 a.m.?
A. I see a fairly fixed fetal heart rate at about 150 I would gather. I see an acceleration here or there. I see some decelerations.
Q. Would you count for me in that first batch how many decelerations you see and mark them, please?
A. Ycu want to go through the whole three-hour batch?
Q. I want to go through that first segment starting at 08:30. Just take the opportunity to circle the late decelerations that you see.
A. (Complies with request.)

There is an acceleration there.
The copies aren't very good.
Those overlap.
Okay.

Q. May I see what you circled?

A. (Complies with request.)

MR. DEVER: Let the record show that he is conferring with Dr. Frank Wright.

(Pause in the proceedings.)

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Thereupon, DeVoe Exhibit No. 1 was marked for purposes of identification.

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BY MR. DiCUCCIO:

Q. Doctor, handing you back what we marked as Exhibit 1 to your deposition, being the fetal monitor strips for the period of time from approximately 08:30 a.m. until 12:00 on the morning of the 28th of August, 1995, as a specialist in obstetrics, how would you describe the characteristics displayed in that fetal monitor strip?

A. Not reassuring.
Q. Something to be concerned about?
A. Yes.
Q. What would you be concerned about on these fetal monitor strips?
A. I think there are repetitive late decelerations there that require further investigation of some kind. Or delivery.
Q. Would you be of the opinion that it would more likely than not have been appropriate to engage in immediate delivery of this fetus given the fact that it was 42 weeks?
MR. DEVER: Objection.
Go ahead and answer, if you are prepared to.
A. I am not sure what you mean by immediate. We might not mean the same thing. I think the baby ought to be gotten out of that environment soon.
Q. A couple hours?
A. Maybe, Not necessarily.
Q. Give me some time parameters. You are called in as a physician. This is your

patient.

A. I would try to rupture the membranes and get a scalp electrode on her.

Q. Was that done in this case?

A. No.

Q. Do you think that should have been done in this case?

MR. DEVER: Objection.

A. Well, it is very easy sitting here in hindsight, knowing the outcome, to say it should have been done differently.

Q. I am asking you on the basis of what you see here now.

A. I know that, but we all know that we know what we know.

How I would have approached this tracing, were this just unfolding today is

I

electrode on her.

The reason for that Is late decelerations are at least half the time falsely threatening. At least half the time they do not represent fetal distress. They

are very poor predictors of bad outcomes.
But in a situation where late
trouble, you are obligated to investigate them further.
Q. What is a contraction stress test?
A. A contraction stress test is where you monitor the baby continuously and induce contractions by one of several means and see what the baby's tolerance for the contractions is.
Q. Did this baby -- did this woman, in fact, have a contraction stress test that was ongoing during the course of this --
A. That's right.
Q. And it was positive, wasn't it?
A. Yes.
Q. And if it is positive, that should alert you to be concerned about something as far as fetal distress is concerned, isn't it?
A. Right. That is the stuff we just went through.

Q. Okay. Now is it -- are you familiar with the use of the drug called Prepidil?
A. I am familiar with it.
Q. Do you ever use it?
A. Very seldom.
Q. Do you know what it is used for?
A. Yes.
Q. What is it used for?
A. It is used for ripening the cervix of someone who is unripe in preparation for inducing labor.
Q. In the management of Rhonda Bland on the morning of the 28th of August, 1995, did you note that the preparation Prepidil was, in fact, used on her?

A. The textbooks, or the PDR, which is not a great reference source to rely on from a scientific standpoint, says you all induction agents.

I think there is leeway for physician judgment in these kinds of things because many nonlabeled indications are -- many medications are used for nonlabeled reasons in medicine, things that aren't in the PDR. The PDR catches up with medicine down the road.

The short answer is that these guys want to get this lady delivered and they are trying to get her ripened to do it vaginally and they thought that was the only way to get her ripe. I would be very Leery about giving her indefinitely Prepidil to do it.

Q. Who was managing this patient at that time?

A. The first day Dr. Pettit was.

Q. Do you have any reference there that Dr. Pettit saw the patient?

A. *Yes.*

Q. At what: time?

A. He saw her about 08:00 that morning, or 08:15 I think, on the 28th.

Q. Was there any fetal monitor

tracing at that time?

A. Little or none. I am not sure about how much exactly when he was up there.

Q. Would you agree with me that there is no real indication that Dr. Pettit ever looked at the fetal monitor tracing on the 28th?

MR. DEVER: Looking at what?

MR. DiCUCCIO: Looking at the

MR. DEVER: Well, let's -- just looking at charts and documents?

MR. DiCUCCIO: Let's see if he understands the question.

A. I understand the question. I have to go back and look at the notes.

He was there at 08:00 or a little after. And he was there again about 10:00-ish. Oliver was there around 11:00 to put in the Prepidil.

All right. Is there any notation on that fetal monitor strip tracing that you looked at that Dr. Pettit reviewed that

strip at 10:00?
A. There is no notations on the tracing, except the Prepidil at 11 something or other.
Q. When you look at a fetal monitor strip, do you customarily put your initials on it?
A. No.
Q. No? You just look at it? You don't make any notation of it anywhere?
A. Yes, in the progress notes.
Q. The progress notes.
A. I don't write on the tracings very often. I write badly enough anyway and it is hard to write on those tracings.
Q. But you do make a notation somewhere that you reviewed the fetal monitor strip?
A. Not always. If it is reassuring,

Q. How about this one?
A. This is not reassuring.
Q. So somewhere we should find some indication that the doctor reviewed this

fetal monitor strip, and taken into consideration those factors that you have told me about this morning; is that correct?

A. That is the way I would have done it, as I have outlined.

Q. And you feel that's standard of care as far as you are concerned, isn't it?

A. I think the doctor needs to respond to the tracing information he has ordered to be obtained.

Q. What was done to evaluate this patient in the morning hours of August the 28th, 1995 to come to some conclusion as to why this woman was having late decelerations?

A persistent pattern of late decelerations, wasn't she?

A. More or less. I don't see

baseline, start the Prepidil and see what the response was, I gather.

Q. And what was the response?

A. She had contractions.
Q. Was she dilating?
A. Not very -- very *little* over the next day and a half.
Q. Would that be worrisome to you?
A. No. By itself, no.
In conjunction with the tracing and the goal of accomplishing delivery, yes. But by itself, not a big deal.
Q. But as I understand it, this lady was postdate.
A. Right at. And whenever you evaluate postdates now, we call her postdates. But for many years, 14 days was within the normal limits. She was at 14 days I think. Fourteen and one maybe.
Q. Well, we are not -- I am not asking you *to* use your retroscope and look *back.* I an asking you to be fcrward looking on the basis of the materials that you have had to review and to analyze these materials and to come to some conclusions which I am sure you have.
This patient was transferred from

a monitoring floor to a nonmonitoring -- a monitored location to an unmonitored location; is that correct?
A. That's correct.
Q. And that took place sometime around noon or little thereafter on the 28th.
A. Yes.
Q. Do you feel that that was appropriate for this lady to be taken off of a monitor and placed on an unmonitored location given the nature of the monitor tracings that you see here?
A. No, I don't.
Q. That clearly would have been inappropriate to do in this case, wouldn't it?
A. I think so.
Q. No real definition had been made as yet as to what this lady's problem was; is that correct?
A. Correct.
Q. And there was no physician attempting to find out at this time either,

was there?

MR. DEVER: Objection.

If you know.

A. Based on the information we have, I don't see any efforts to evaluate that.

Q. All right. Now as we move down the line here, the next set of tracings you have I believe start sometime at 06:00 in the evening. That is the next pack I think.

A. Yes. There are a few that Frank marked here that I was borderline with. He taught me how to Look at these things. I want to see if he did a good job.

Q. Dr. Wright taught you how?

A. He is much older than I am and he was a resident when I was a student.

Q. I understand you went to Jefferson Medical School?

A. No, I didn't. Ohio State Medical School.

Q. You went and did your residency at Jefferson?

A. No. I did my residency at Penn.

Q. At Penn?

A. Yes.
Q. You didn't have anything to do with Jefferson, did you?
A. I used to go to dinner there once a month. We had the OB society down there.
Q. All right. I mention that because I have two cousins who went there and would have been in the same --
A. Really?
Q. -- age group as you and I thought that --
A. I didn't know any Jeff students. At least I don't remember any right now. I knew some residents because we used to cross-cover at City Hospital with Jeff people. A lot of good people down there. Good place.
Q. Okay. I an going to ask you to do the same thing with this next segment of fetal monitor strips that you have. And

A. Begins at 06:07?
Q. Yes. And tell me if you see anything on there that we ougnt to discuss

from the standpoint of any abnormalities.

MR. CEVER: What do you want him to do?

MR. DiCUCCIO: Do the same thing as he did on the other set.

MR. DEVER: Okay.

MR. DiCUCCIO: Mark any abnormalities that he sees in the fetal monitor strip.

A. (Complies with request.)

Is it things that matter or just abnormalities?

Q. First of all, let's look at late decelerations.

A. Okay.

(Complies with request.)

There are some late decelerations here, but this tracing looked better than the one earlier in the day.

Okay.

MR. DEVER: Let the record show he is consulting with Dr. Wright.

(Pause in the proceedings.)

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Thereupon, DeVoe Exhibit No. 2 was marked for purposes of identification.

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MR. DiCUCCIO: Those are marked as Exhibit 2. That is the period of time from 06:07 p.m. on the 28th until --

THE WITNESS: It is 04:07, 16:00. I got hooked by the same thing.

MR. DiCUCCIO: I'm sorry.

THE WITNESS: The 1 didn't print very well. It was 04:00.

MR. DiCUCCIO: Is it 04:00?

MS. PATZER: Yes.

THE WITNESS: It is 16:07.

BY MR. DiCUCCIO:

Q. In reviewing those, Doctor, you have made notations of iate decelerations again appearing on that fetal monitor strip; am I correct?

A. Yes.

Q. Is there any indication to you in the record that any physician was called in to review that fetal monitor strip at 04:00

-- the tracing from 04:00 to 06:00 on the 28th?

A. I am not sure about that. I would have to look at my notes about that.

Q. Okay.

A. Yes, I think McKee in labor and delivery called Oliver at 04:00 that afternoon.

Q. Did Dr. Oliver come in and look at them?

A. I am not sure he did. McKee did call him is my recollection.

Q You don't see anywhere that he came in to look at them?

A. No, not to my knowledge.

Q. There is nothing in the chart that I recall seeing. Is there anything you recall seeing in the char', itself that Dr. Oliver was in there to see those strips?

A. No.

Q Should a physician have looked at those strips between 04:00 and 06:00 in the evening?

A. I would have preferred so.

particularly if they were called and advised about them,

Q. Is there something wrong with those strips?

A. Well, we have identified several late decelerations in that two-hour period.

Q. And these late decelerations are -- had also been occurring in the morning; is that correct?

A. Correct.

Q. So now we have late decelerations going from 08:00 in the morning at least until 06:00 in the evening, presumably, correct?

A. I don't know that she was having those all the time because after the Prepidil wore off, she probably stopped contracting. I think the Prepidil was replaced in the afternoon and as a result she started contracting again.

Q. That would be pure speculation on

A. We don't have any records she was

contracting either.
Q. But we know that whenever she was contracting virtually she had late decelerations, didn't she?
A. Not all of them. But she had a lot of late decelerations.
Q. And what would that imply to you between 04:00 and 06:00 as far as this particular woman was concerned and the status of her fetus as a specialist in obstetrics?
A. She is at risk for uteroplacental insufficiency. This is suggesting uteroplacental insufficiency.
Q. Which means what?
A. Just that, the placenta is not doing a good job oxygenating the baby. It is not getting oxygenated well enough to

occurs during a contraction.
Q. This is harmful to the fetus?
Has the potential to be. Not

As I said before, late

decelerations frequently are false alarms at least half the time.

Q. Let's assume this was your patient at this time now and you were called in to take a look at these strips and you had seen the strips that you saw at 08:00 and or 08:30 in the morning, now you see this persistent pattern at 04:00 in the afternoon, have you got an answer as to why this is occurring?

MR. DEVER: Go ahead and answer.

A. Have I got an answer as to why these decelerations are occurring?

Q. Yes.

A. I think as I said earlier, the speculation has to be uteroplacental insufficiency.

Q. What do you do in that situation?

MR. DEVER: Objection.

A. I would try to either get the membranes ruptured and get a scalp electrode on her or deliver her.

Q. Do you think that at some point in time on the 28th of August, 1995, standard of care in obstetrical practice would have militated that this woman be delivered?

MR. FOLIANO: Objection.

MR. DEVER: Objection.

A. Or have the membranes ruptured and get a scalp electrode on and see what the tracing looks like, a scalp electrode tracing.

Q. One or the other?

A. One or the other.

Q. Either one -- neither one was done; is that correct?

A. That's correct.

Q. So do I take it that you are familiar with the standards of care of good obstetrical practice?

A. I hope so.

Q. Do you feel that the appropriate standards of care would have been to have either delivered this baby or ruptured the membranes to get a scalp electrode in place?

MR. FOLIANO: Objection.
A. Yes.
Q. Do you feel that in failing to do so, any physician who failed to do so would have fallen below appropriate standards of care?
MR. FOLIANO: Objection.
A. Yes.
Q. You are an expert in, as we discussed, in obstetrics, but as far as nurses are concerned, do you have any

the care and management of patients, obstetrical patients who are in a state such as Mrs. Bland presented on the 28th of August, 1995?
A. I know what I expect of nurses who

Q. What do you expect of them?
A. I expect them to keep me advised of developments in the patient's care,

for Mrs. Bland, weren't they?

A. Yes.
Q. Should the attending physicians have been made aware of the condition of this patient?
A. I think they were.
Q. What evidence do you have that they were?
A. They are at the bedside with the tracings in front of them at 08:00 in the morning, and then again at 10:00 in the morning, and again at 11:00 in the morning, and then at 04:00 the nurse on the postpartum calls Oliver to come -- about this tracing.
Q. And there is no indication that

A. No.
Q.
She has called the resident. If the resident doesn't show up, what should the nurse do?
A. In this case, she did what I think was reasonable, sent her to labor and delivery where the monitoring was continued,

and after collecting some more information, had the attending advised.

Q. You would want to be advised, wouldn't you, as the attending --

A. Yes.

Q. -- if this were your patient?

A. Yes.

Q. So if the resident didn't respond, you would have expected her to call you?

A. Right.

Q. You would have expected her to call you on the 28th, wouldn't you?

A. Right.

Q. Did she?

A. I think she called him at 06:00 that evening,

Q. Who called?

There were a lot of calls between the nursing staff and the physician staff.

I guess not.

Q. There is no indication, is there, that she ever called the attending physician when the resident didn't respond, is there?

A. I can't find any.
Q. And that should have been done, shouldn't it?
A. I think they already talked to him four times in the preceding eight or ten hours.
Q. But labor, would you agree with me, is a dynamic process?
A. She is not in labor, but yes, the whole process is dynamic.
Q. It is continually changing, isn't it?
A. But she wasn't in labor. It is splitting hairs, but the process here we are talking about is dynamic.
Q. It is evolving and changing?
A. Can be.
Q. And the resident doesn't respond. Now appropriate standards of care for a nurse would be to then call the attending, wouldn't it, in a situation such as this?
MR. DEVER: Object. You are assuming that Oliver didn't call Pettit.
MR. DiCUCCIO: He can testify. We

don't need you to eestify.

MR. DEVER: I can object.

MR. DiCUCCIO: You can make your objection, that is fine.

MR. DEVER: I know it.

MR. DiCUCCIO: Make your

MR. DEVER: I know it.

MR. DEVER: I know it.

Q. It would have been appropriate to call the attending if the resident doesn't respond, would it?

A. It wouldn't have been inappropriate. E don't think it was required. They have already advised the attending four times -- or the medical staff

anything the nurses were telling them?

A

The attendings were advised by the

nursing staff of what was going on.
Q. I would like to know what anyone was doing to assure Mrs. Bland that her baby was going to be delivered and delivered alive.
What was being done by anybody, nurses or doctors?
A. Nursing staff did all the appropriate things they should have done, which is monitor the patient, make the information available to the docs.
Q. What docs?
A. Well, Pettit, Lopez -- Pettit and Lopez. Pettit the morning of the 28th and Oliver, and then Oliver again in the afternoon. They executed their responsibility.
Q. But you agree with me that other than notifying the resident who apparently did not appear following the 04:00 to 06:00 tracings, we find no indication that the attending was ever notified after that on the 28th, do we?
MR. DEVER: Objection.

Go ahead and answer.
A. I think that is right.
Q. Okay. And that should have been done, shouldn't it, because there is nobody taking care of this woman at this point but the nurse; is that correct?
MR. DEVER: Objection.
A. I think the nurses executed their responsibility.
Q. How?
A. Because they notified them already. Bokoo times.
Q. In other words, these doctors should have done something far sooner than to put these nurses in the position where they had to continually keep telling them there was a problem; is that what you are telling me?
MR. FOLIANO: Objection.
A. You are misconstruing what I am saying.
Q Well, I'm trying to understand what you are telling me.
A. I think it is very straight

Eorward. The nurses advised the doctors and nade sure they were aware of the tracings several times during the day. They accomplished their mission. That was their responsibility and they had done it.

Q. After 06:00 when that final tracing was taken and no one, no physician had responded, are you telling the jury that the nurses had fulfilled their responsibility to this patient?

A. You mean from 06:00 on, did they fulfill their responsibility?

Q. When no physician appeared after 06:00 p.m. --

A. They had no other resources. There were no other physicians in town. It is a small hospital. It is not like they have o-> dccs wandering around and they can snag somebody who walks by. They've done what they can.

Q. Are you familiar with the progression of authority in your hospital here at Riverside if a physician doesn't respond to a call?

A. Yes, I helped draw it up.
Q. What happens?
A. I don't have it memorized, but if a physician doesn't respond to a call, they call the in-house physician.
Q. Was there an in-house physician here?
A. No.
Q. No in-house physician?
A. It is a different hospital. That is the whole point.
Q. That is what I am trying to find cut
No in-house physician, okay, What is the next step?
A. At Riverside?
Q. Urn-hmm.
A. See, you can't compare Riverside to Southern Ohio Medical Center.
MR. DEVER: I am going to object to any questions about Riverside.
You can go ahead and answer.
A. I think this is irrelevant because we have so many more staff.

Q. Let me and the judge decide that. I will ask the questions.
A. I am trying to answer.
Q. Let's just talk about the progression here.
A. Why don't you ask your question again.
Q. I will do it again.

At 06:00 you have told me that between 04:00 and 06:00 the resident was called and there is no indication in that record the resident ever responded to that call, is there?
A. Correct.
Q. There is no indication either that the nurses then called an attending physician, is there?
A. That's correct.
Q. Why did they call the resident?
A. I think for the Prepidil and for the sracing, advised them of the tracing, that they didn't have long-tern availability.
Q. And late decelerations too?

A. They didn't say that. They said long-term variability.
Q. They were concerned about it?
A. Yes, they were concerned about the tracings.
Q. They were concerned about it enough to want to have a doctor there; is that correct?
A. Correct.
Q. So they made a call to the resident and he doesn't appear?
A. Correct.
Q. And there is no indication that the attending physician appeared or that any call was made to him, is there?
A. Correct.
Q. Okay. Is it your impression that

.. since the nurse has made a call to the resident, at this point in time, I am not

the morning, noontime, I am saying at 06:00, do you feel that the nurse now can simply wash her hands of this patient and walk away

from this patient since she has fulfilled the responsibility and notified the resident who hasn't appeared?

A. I think she has done all she can.

Q. All she can?

A. Wait a second. Oliver is there at 05:30.

Q. Okay. So Oliver comes at 05:30?

A. Right.

Q. And when is the tracing completed?

A. Six something. Let's see, 06:30.

Q. Now if the nurse is not reassured by what the resident has told her, what should the nurse do?

A. Depends on the details and circumstances.

Q. Well, let's take in Rhonda Bland's case.

A. Okay.

Q. The nurses weren't reassured. They have already testified to that.

MR. DEVER: Objection.

A. They have the option of either resting with Oliver's evaluation or calling

the attending.

Q. Do they have an independent responsibility from the physician in the care of this patient?

A. An independent responsibility?

Q. Yes. Is their care of this patient independent of whatever the physician does?

Do they have independent responsibilities towards patients in the hospital?

A. I am not familiar with that concept particularly in a legal setting.

Q. What is their function?

A. medical staff in taking care of the patients, and their function is delivering nursing care.

Q. Are they also to be an advocate on behalf of the patient with the physician?

A. That is when you get into nursing philosophy and that is certainly the current philosophy among nurses, expand their role and become patient advocates, call them

clients.

Q. Do you have a problem with that?

A. No.

MR. DEVER: Objection.

Q. So in this particular situation, if the nurse was dissatisfied with the answers she was receiving from the resident, do you feel that she had a responsibility to do something else on behalf of the patient?

MR. DEVER: Objection.

A. I think she had the responsibility. I think she had the opportunity. It would not have been inappropriate for her to call the attendings.

Do we know contemporaneously with the nurses' investigation as opposed to now,

They have testified, but that is two years later.

Q. Fine. Was there a nursing supervisor there?

A. I am sure there was.

concern who can't get a response from physicians she is satisfied with to go to the supervisor?

A. Your question is in general. Yes, in general that is true.

Q. And if the supervisor is not satisfied that the physician is responding on behalf of the patient, is there anywhere that a supervisor can go?

A. In general, like Riverside or anywhere?

Q. Yes.

A. Sure. There is usually -- we started earlier this line of progression of whom to call that exists. She can call the head of the department or the section, she can call the chief of staff, whatever. There is usually a pecking order drawn.

Q. Are you proposing that at this particular hospital there was no safety net to protect this patient from failure of physicians to respond and adequately evaluate a patient according to the concerns

of the nurse?

MR. DEVER: Objection.

A. I am sure that is not true.

Q. You are sure that is not true?

A. I am sure there are bylaws or policies and procedures drawn up to protect patients,

Q. And to guide the nurses on how they should accommodate the patient's needs if they see something that is not right?

MR. DEVER: Objection.

a. Wouldn't you agree?

A. Yes.

Q. That should be in place, shouldn't it?

A. Yes.

And the nurses should follow those guidelines, shouldn't they?

A Yes.

Q They are there for a purpose?

A Yes.

Q. This patient was returned to another portion of the ward following 06:00 p.m. I believe, wasn't she?

A. 06:30, yes.
Q. And again, she was unmonitored; is that correct?
A. That's correct.
(Discussion off the record.)
BY MR. DiCUCCIO:
Q. Next in progression would be fetal monitor tracings that started on the 29th of August at 08:13 a.m. I think *you* have that packet *of* materials in front of you.
a. Right.
Q. I am going to ask you, Doctor, to *go* through those materials again, just as you did the other two packets that I gave decelerations.
A. Okay.
(Complies with request.)

point that out to me.
A. I tried to, but I may have missed some duplicates there.
Q. In reviewing those, are you able to make any assessment regarding the long-term variability?
A. Actually it looks a little better there than it did earlier, the day before. There is some long-term variability from time to time. Other areas it is reduced.
Q. Is there anything reassuring by any of these tracings that this baby is not still in distress?
A. Well, again, we don't know that the baby is in distress because of the low predictive value of late decelerations. We also have the mother saying this baby is still moving. So that is reassuring. We have a nonreassuring tracing is all you can say.

you what I would do with this lady.

Q. And that wasn't done, was it?
A. Right.
MR. DEVER: Let the record show that Mr [illegible] and [illegible] Wright are reviewing what is probably going to be Exhibit 3 and they are marking on it, like they did the first two exhibits.
(Pause in the proceedings.)
MR [illegible]: We will mark this as Exhibit 3 in order.

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Thereupon, DeVoe Exhibit [illegible] was marked for [illegible] of identification

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BY M[illegible]:
Q. Was this fetus alive on the 28th of August, 1995?
A. Yes.
Q. Was it viable?
A. Yes.
Q. If it had been delivered by Cesarean section, do you feel it would have been born alive?

MR. FOLIANO: Objection.
A. Born alive, yes.
Q. On the 29th of August, at approximately, give or take a bit, 03:00 in the afternoon, Mrs. Bland reported that she could not detect any fetal movement.
Do you recall that from your review of the records?
A. It was 03:30, that's correct.
Q. She reported that to a nurse?
A. Right.
Q. What did the nurse do in response to that?
A. Asked her to lay on her left side and continue to evaluate for an hour.
Q. We have already discussed the dynamism of this process that Mrs. Bland was going through. We have already discussed the fact that there are fetal monitor strips that one would be concerned about; is that correct?
MR. FOLIANO: Objection.
A. Correct.
Q. Now at 03:30 in the afternoon on

the 29th, she has been in there approximately 24 and eight, about 32 hours?

A. Something Pike that, yes.

Q. Give or take an hour. She has been in these about 32 hours, She is now saying she doesn't -- she no longer has fetal movement.

MR. DEVER: Objection. That is not what the records say.

Q. Reduced fetal movement.

Is this something for the nurses to be concerned about?

A. Yes.

Q. How should they have responded to that?

A. Lay her on her left side and see what: she feels in the next hour. I think that is a totally appropriate response.

Q. They did that, didn't they?

A. Yes.

Q. Did you read the deposition of the nurse who came on duty following the 03:30 shift?

A. Right. Rawlins.

Q. Did you read her deposition that she didn't know that there hadn't been any fetal movement reported before?
A. I don't remember that.
Q. Let's find that testimony.
MR. DEVER: Objection. That is not what the testimony was.
A. It actually says on page ten, Rawlins says, I recall the nurse before telling me that she had put the patient on her left side at 03:30 for complaints of decreased fetal movement. So she --
Q. Let's go to page 14.
A. Okay.
Q. But when you undertook her care at 16:30, which was an hour after she first, according to the records, voiced complaints about reduced fetal movement, she told you she hadn't felt any movement of the baby for an hour?
Answer, correct.
Did she say she hadn't felt any movement?
She said I haven't felt any

movement: from the baby in the past hour.

And did that mean to you that she felt no movement?

That is what she said, that was her quote.

And what did no fetal movement for an hour mean to you?

That meant that that was a reportable symptom, something that needed to be investigated further. So that is why E called the labor room nurse where they could put her onto a monitor to evaluate if she was contracting to see if the baby was moving.

Shouldn't the physician have been called at this point?

A. No. That is a standard nursing procedure and it is perfectly okay.

Q. Now let's look at Nurse Ruby's testimony.

A. Okay.

Q. Because she was the nurse who was in labor and delivery.

A. I don't think so. She was the

postpartum nurse on days.
Q. Postpartum.
Let's go back. Let me ask you and not confuse you. Let's go back to Nurse Rawlins.
A. Okay.
MR. DEVER: That is always a sign that you are confused when you say let's not confuse you.
(Pause in the proceedings.)
BY MR. DiCUCCIO:
Q. Sheryl Hines, She was the nurse that came on duty at 03:30.
A. On labor and delivery. I don't have her deposition, I don't think.
Okay. I don't have that one.
Q. You don't have her deposition?
A. I have notes from it. I don't have the deposition.
Q. Well, I asked her a question an page 31 of her deposition.
I said, were you by this time aware of the fact that Mrs. Bland still was not having any fetal movement?

Answer, no.

MR. DEVER: Objection.

Q. That is when she came on her shift:

A. She wouldn't have come on at 06:30.

Q. No, 03:30.

MR. DEVER: Objection.

Q. Do you have the chart?

A. I have the chart, yes.

Q. Let's look at the chart.

A. You said you asked her at 06:00 i thought you said. it was -- at 06:00 the would not have been aware at 03:00.

MR. DEVER: What part of the chart do you want to look at?

MR. DiCUCCIO: We will direct you to ehe chart. We will find it in a second.

(Pause in the proceedings.)

3Y MR. DiCUCCIO:

Q. This particular nurse began to interface with the patient: -- Sheryl Hines began to interface with the patient at 14 --

16:30. Actually 16:36.
A. Right.
Q. And she has testified in her deposition --
A. Right.
Q. -- that she was not aware of the fact that Mrs. Bland was not having fetal movement.
A. Right.
Q. Should she not have been aware of that as her nurse?
A. I don't think it influences anything. Probably would have been ideal. I don't think it matters because she puts her on a monitor anyway.
Q. Well, you have got a monitor, but you have got someone who is saying there is no fetal movements here.
As a matter of fact, didn't Mrs. Bland report that there was no fetal movement for over four hours?
A. Right. But the patient is not mute. You are right.
Q. She expressed that.

It was ideal that the nurse from labor -- from postpartum tell Hines that she hadn't had any fetal movement, but the patient is also part of the equation.

I am sure Hines became aware readily that there was no fetal movement.

Q. She didn't know.

A. She said she wasn't told that. That is not the same thing.

Q. You are assuming that she did know.

A. The patient is not -- she is not mute here.

Q. So you are assuming that the patient told Nurse Hines that she didn't have any more fetal movement?

And secondly, she is doing the same thing she would do anyways, put her on a monitor and watch her.

Q. Is there a difference between having fetal movement and not having fetal movement now?

A. Yes. One has fetal movement and one doesn't.

What is the significance of that?
A. There may be no significance. It requires evaluation. That is why she was sent to labor and delivery.
Q. I see. The fact that the baby is not moving is really not a concern to you as an obstetrician?
A. Not at any one moment in time. You have to evaluate the details.
Q. How about a four-hour period of time?
A. It is not four hours. It is 16:00, that is only an hour and a half at 16:00. Because 02:15 on the record the patient said the fetus is active, so it is only two hours later here.
Q. From 03:30 on, is there any indication there was ever any fetal movement reported?
A. The four hours begins at 03:30 and that is true.
Q. None?
A. Right. But you were asking me about 04:00.

Okay. Let me ask you about the rest.

From 03:30 on, is there any indication in here that the patient ever reported or any nurse ever charted that there was any fetal movement?

MR. DEVER: Objection. The record shows at 03:30 there was decreased fetal movement.

Q. From -- after 03:30.

A. I think that's right.

Q. After 03:30 there is no indication there was ever any fetal movement; is chat fetal movement at 03:3

Q. And at 04:30 no fetal movement?

A. Right.

Q. After 04:30, is there ever any indication that there was ever any fetal movement?

A. No.

Q. None. What was being done to evaluate that?

A. She was on a monitor and Lopez was informed. The nurses executed their responsibility.

Q. As far as you are concerned, that is all the nurses had to do?

A. Right. That is all they have access to. That is the only tools they have in this situation.

Q. If you had been notified, and you are an expert in obstetrics, that there had been no fetal movement for four hours, would you be concerned?

A. Yes.

Q. Why?

A. Because it may mean something after four hours. It may not. We frequently get that all the time. Not frequently. We get that quite frequently.

Q. Do ycu wait four hours with somebody with no fetal movement before you exanine them?

A. No. Patients call and say I haven't felt the baby move all day, you bring them in the hospital and everything is

fine.
Q. This isn't a lady who is at home saying she hasn't felt the baby move all day, is it, Doctor?
A. You are changing the subject. My subject is that if a patient goes four hours without fetal movement --
Q. You are changing the subject.
A. No -- yes, but you asked about four hours. We frequently get complaints that they haven't felt the baby move for X hours. It may or may not mean anything, you Just do the next step, which is evaluate it.
Q. Let's take it in the setting of Rhonda Bland on August the 28th and August the 29th with a worrisome fetal monitor strip, with late decelerations, with lack of

A. Yes.
Q. Who was postdated?
A. Right at the edge, yes.
Q. Okay?
A. Agree with you.
Q. And she now reports reduced fetal

movement and then she reports no fetal movement.

A. Right.

Q. Somebody should be very concerned at this point, shouldn't they?

A. Right.

Q. Somebody should be doing something, shouldn't they?

A. The nurses did what they are supposed to and did what they could.

Q. How about the doctors, did they do what they are supposed to?

MR. FOLIANO: Objection.

A. It was my opinion earlier they didn't.

Q. And they still weren't, were they?

MR. FOLIANO: Objection.

A. Right.

Q. They were still not adhering to appropriate standards of care, were they?

MR. FOLIANO: Objection.

A. My feeling is they didn't.

Q. Nurses did, but the doctors

didn't?

A. That is what; it comes down to.

Q. Okay. So in your opinion it was the physicians who should have been more responsive to the concerns of the nursing staff and addressed this problem?

MR. FOLIANO: Objection,

A. You can characterize it that way, that is fine. The nurses -- the physicians should have addressed the problem.

Q. And they didn't?

A. Right.

Q. And the baby died because of that, didn't it?

MR, FOLIANO: Objection.

A. Well, you know, I guess there is equivocation of how the baby died. We know the baby died and I don't think the docs acted appropriately, The two are probably related in a causal manner. We don't know chat for sure because there is --

Q. Probably they are?

A. -- the cardiomegaly business and meconium aspiration. And I guess there is

some uncertainty about all that.

Q. Probably was related to the fetal distress, wasn't it?

MR. FOLIANO: Objection.

A. The meconium aspiration mast likely was related to fetal distress. The cardiomegaly, which independent of itself could have killed the baby, we don't know that, I don't know if that was related to fetal distress or not.

Q. Probably the baby died because of what was going on during the period of time. And you already told me that on the 28th your opinion was the baby would have been deiivered alive?

MR. FOLIANO: Objection.

A. Right. I still agree with that.

MR. DiCUCCIO: I have no further questions.

MR. FOLIANO: I think I will have to ask some.

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CROSS-EXAMINATION

BY MR. FOLIANO:

Q. Let's just clarify a couple things and then we will move on.

Doctor, you would agree with me that the fact that a patient is showing some late decelerations does not mean that there is fetal distress, correct?'

A. Does not mean necessarily that there is, yes.

Q. Okay. Now when you look at these and you look at fetal monitor strips, the physician who is Looking at them interprets them, correct?

A. Correct.

Q. Meaning that there is judgment involved, correct?

A. Yes.

Q. And so that physician must use his

that the strips warrant furthar intervention or not, correct?

A. Correct.

Q. And I just want to make sure that we are clear on this.

What you said was, and I think

that this is true, is that the patient, when sent back off of labor and delivery tu postpartum, was probably not having contractions, correct?

A. I looked at the notes after that and there is no indication she was having contractions. She mentioned some irregularity and some vague stuff.

So I think she probably was not there on the 28th in the afternoon.

Q. When we talk about uteroplacental insufficiency causing late decels to show up, a late decel can only be monitored with a contraction, correct;?

A. By definition it requires a a.

And so more likely than not, at the time she was back to the floor, even if we assume the fetal distress was secondary to uteroplacental insufficiency, when she not having contractions, she was probably not having uteroplacental insufficiency,

correct?
A. Probably wasn't having fetal distress at that point. The placenta probably was adequate for the low stress time of no contractions.
Q. Now when we -- you mentioned that cardiomegaly can, in and of itself, kill an infant, correct?
A. Possibly. It depends on what the cause of cardiomegaly is.
MR. DiCUCCIO: Objection. Move to strike.
Q. And you know from your review of the records that this patient did have cardiomegaiy -- the fetus did have cardiomegaly which was found by autopsy, correct?
A. Correct.
Q. And cardiomegaly can lead to congestive heart failure in a fetus, correct?
A. Correct. I am kind of out of my field here as a fetal neonatal cardiac expert.

Q. Okay. Cardiomegaly can lead to fetal distress, correct?
A. I guess it can, if I think about it. Cardiomegaly can reflect an ongoing problem that is causing fetal distress, maybe the body's -- the baby's adaptation to a bad situation, the heart can enlarge or dilate because of the disease process. And eventually may function poorly enough to call it fetal distress.
Q. Do you have any idea in this case as to at what point in time the meconium was passed?
A. No.
Q. Does the fact that the placenta was meconium stained give you an indication that the meconium was passed many hours prior to the delivery?
A. There seems to be differences of opinion how long it takes for meconium to stain membranes. But it is probably six hours, four to six hours. I have heard people say 12, 18.
Q. So in some people's opinion, it

would take at least six hours and in som people's opinion it would take at least 1 hours?

A. Right.

Q. It could be even longer than that, correct?

A. It could have been longer than

stain it or it could be present longer than that.

Q. It could be present longer than that, couldn't it?

MR. DiCUCCIO: Objection. Move to strike.

A. Yes, it could be present a long time,

MR. DiCUCCIO: No probability.

Q. Now you looked at Exhibit 1, which

starting on the 28th in the afternoon, and then Exhibit 3 were apparently the strips on the morning of the 29th, okay.

Now I heard you say that Exhibit

3, the strips look better than they did on tne previous day. Is that true?

A. That is true.

Q. So you are seeing a better long-term variability, correct?

A. There is some improvement in variability from time to time on the tracing,

Q. You see some accelerations on that?

A. I saw a couple areas I thought might be accelerations. They also could be artifact. I also had the impression, I didn't count them, but the impression there were fewer late decelerations on the morning of the 29th.

Q. So looking at these strips as a

doing even better on the morning of the 29th, correct?

MR. DiCUCCIO: He doesn't say that. Objection.

MR. FOLIANO: I am asking him.

A. All we have is the tracing. The

tracing is marginally improved. I am not going to tell you it is a fabulous tracing.

Q. That is okay. Accelerations are a sign that the baby is doing well, correct?

A. Yes.

Q. Long-term variability is a sign that: the baby is doing well, correct?

A. Yes.

Q. And when ycu talk about late decelerations in and of themselves, what you are looking for in order to determine if there is a problem is repetitive decelerations, correct?

A. Correct.

Q. Because many times a baby can have a late deceleration and it doesn't mean anything other than the mother is laying the wrong way?

A. Correct.

Q. So if we -- and you talked about a couple things that you would have done, but there are other physicians who use different methods to reassure themselves of fetal well-being, correct?

A. Correct.

And those different methods to a reasonable degree of medical probability are within the standard of care, correct?

A. Correct.

Q. And one of those different methods is taking an ultrasound and performing an ultrasound an a patient to assess amniotic fluid, to assess fetal breathing and to assess fetal heart rate, correct?

A. Fetal heart -- tone, yes, heart rate. The biophysical profile.

Q. Right. So if on the morning of the 29th Dr. Lopez came in and performed a limited ultrasound on this patient to reassure nimself, that would have been within the standard of care, correct?

A. Yes.

Q. And if in his judgment he felt reassure6 by performing this ultrasound, then he has met the standard of care to a probability, correct?

A. Yes.

Q. And he wouldn't at that point in

time need to go forward with an emergency C-section, true?
A. In his judgment, yes.
Q. And he wouldn't need to place a scalp electrode at that time, true?
A. That was his judgment, yes.
Q. And if he received a call in the afternoon when the baby went back and the nurse told him that there was really no change from the previous morning strips, then he would not have to come in and see the patient, correct?
A. You know, that was his judgment. I would -- it would have bothered me if there was no change. I think I -- I already said I would have acted sooner, So I guess I would have at least come in and looked things over.
Q. So that is within his judgment to make that determination based upon his earlier view of the strips, his earlier ultrasound and what the nurse is telling him, correct?
MR. DiCUCCIO: He didn't say that.

He said it would have bothered him.

MR. FOLIANO: Jerry, would you mind?

MR. DiCUCCIO: Objection.

MR. FOLIANO: That is the appropriate word to say, is objection.

A. It: is -- his thought processes are logical. If he got reassurance from the ultrasound assessment in the morning, eight hours later, it is logical to assume things are okay then, it is not much different.

I would not necessarily agree with that posture. Maybe I am not as laid back and casual, you know, comfortable with that.

Q. You would not necessarily agree with that posture, but: you do not believe that that posture is a deviation from the accepted standards of care of a raasonably

A. I think you have to react to the

of information that comes out of the

reassuring.

It is not awful and it is marginally better than the day before, but it is not reassuring. Of the five tools there, the amniotic fluid volume, that was okay. So that is where he is choosing to hang out. I wouldn't have been as comfortable with that.

Q. And breathing movements are --

A. Breathing movements have predictive value.

Q. And you know that he did see fetal breathing movements on his ultrasound?

A. Yes.

Q. And so even though on day one you gave the opinion that Dr. Pettit did not do anything to reassure himself of fetal well-being after the two earlier strips, correct?

A. Correct.

Q. Even though that happened on day one, on day two, Dr. Lopez did something to reassure himself of fetal well-being, and that would be the limited ultrasound, true?

A. True.

MR. FOLIANO: Thanks. Appreciate it.

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FURTHER CROSS-EXAMINATION

BY MR. DiCUCCIO:

Q. Doctor, would you look at the report of Dr. Lopez of the obstetric ultrasound done on the 29th? Actually -- yes, on the 29th, yes, of August.

MR. DEVER: I got it.

A. Okay.

Q. Are you familiar with the scoring system for a biophysical profile?

A. Yes.

Q. Okay. Can we score it on the basis of what we know here, this ultrasound?

Q.

test was positive, correct?

A. Nonreactive.

Q. Nonreactive. So out of two points it gets no points, correct?

A. Correct.

MR. DEVER: Wait a minute. Are we going to go ahead and do the biophysical profile anyway?

MR. DiCUCCIO: I am asking him questions. He can answer them, He understands them.

MR. DEVER: I just want to know what we are doing. We are going to go ahead and do the biophysical profile?

MR. DiCUCCIO: We are going to do that.

MR. DEVER: Even though we can't do it.

MR. DiCUCCIO: He didn't say he couldn't do it.

MR. DEVER: He said not completely.

BY MR. DiCUCCIO:

Q. index, is it measured here on the ultrasound?

A. You have gotten some bad information that you have to do an index. You don't. You have to make a judgment of

amniotic fluid volume. And the judgment is okay that the amniotic fluid volume is okay.

Q. It is not listed here, is --

A. Yes, it is. Amniotic fluid volume okay.

Q. It just says okay, but you don't know what it is.

A. You don't need to. That is my point. You don't have to do a full AFI to make a judgment. Amniotic fluid is evaluated subjectively and that is okay.

Q. So he gave it an okay?

A. It is normal. Grossly normal.

Q. How about: any fetal movement, is anything noted on the ultrasound?

A. No.

Q. So he gets no points for that?

A. Right.

Q. That would be fine and gross movement; is that correct?

A. It says fetal movement.

Q. No points on that.

How about breathing, is breathing noted on here?

A. Yes.
Q. Where is that?
A. Fetal breathing movements, there was good fetal breathing movements it says.
Q. So he gets what on that?
A. Two.
Q. So what is the total that we get here?
A. You have only mentioned four things.
Q. What are we missing?
A. I don't know, I can't remember. I have to look at the list to check them off.
We are missing tone I guess, some evaluation of muscle tone.
Q. That would be fine and gross movement, wouldn't it?
A. Movement is movement. Tone is tone, I think. Are the baby's arms flexed or is he laying in there comatose. I don't think tone is mentioned. I think we get four out of six of the things that are here.
Q. You got four of the six things

that are necessary --
A. No, there are five things. You get six possible points. If there are only three criteria here, which I think there are three criteria here, we get four out of the six possible points for those three criteria.
Q. As far as the amniotic fluid index is concerned, you are just saying that is okay because he says it is okay?
A. What else -- *you* can't assume it is bad because he didn't say it was bad. I mean *yes,* amniotic fluid is okay. That is how you evaluate amniotic fluid. You make a subjective evaluation, is it adequate or inadequate.
Q. What was the last recording of amniotic fluid index that you found in Dr. Pettit or Lopez's chart?
A. There aren't any. But don't hang all that much on AFI. It *is* what we do around here. It's also perfectly permissible to evaiuate amniotic fluid as adequate or inadequate. It is Just -- AFI

has kind of come to the fore, but this is not wrong. And this is the last one.

Q. Would you agree with me that on the morning of the 29th there was really nothing here to reassure Dr. Lopez that this fetus was stable and okay, was there?

A. No, I wouldn't agree with that. The amniotic fluid volume, as I said, was probably the second most valuable tool out of the BPP and it is okay.

Q. So he says?

A. You don't know either. You have to accept what is on the record.

Q. Well, I know the baby died.

A. I do too. That is not the question. The question is what is available

Q. So are you telling me that by the 29th you are happy with the status of this fetus and everything you are seeing?

said.

A. I didn't say that the all.

Q. I'm just trying to find out where you are.
A. I didn't say that at all.
Q. You are still not happy with what you are seeing here, are you?
A. That's correct.
Q. And ypu still feel that some form of intervention was necessary at this point, don't you?
MR. FOLIANO: Objection.
A. It would be my preference as I have tried to make clear.
Q. And that to you is the standard of care?
MR. FOLIANO: Objection.
Q. That either the baby should have been delivered or that the membranes ruptured?
MR. FOLIANO: Objection.
A. There is room for judgment in there. That is what I would have done. It is my judgment that that is what I would have done. Frank might have done something else. This guy chose to do something -- to

delay.
Q. Well, your preference -- I assume you practice what you like to think is standard of care medicine, don't you?
A. Right. I do.
Q. If you were teaching here -- do you teach at this institution?
A. Yes.
Q. Do you teach residents here?
A. Yes.
Q. Do *you* teach them the way you think?
A. Yes.
Q. Do you teach them what standard of care is?
A. I think so.
Q. Okay. And so in your opinion, standard of cart would have been either to deliver this baby or rupture the membranes?
MR. FOLIANO: Objection.
A. That would be my interpretation.
Q. Of standard of care?
A. Right.
Q. And the doctors didn't do either

one of those, did they?

MR. FOLIANO: Objection.

A. That's correct.

Q. And that in your opinion fell below the standard of care, correct?

MR. FOLIANO: Objection.

A. Yes, you are right. But I will allow for the fact that there are different people making different judgments.

Q. But there is a standard of care. I am not talking about judgment. I am talking about standard of care, something of care means?

A. I think so.

Q. All right. Let me tell you from a legal standpoint what it means as best I can.

It means that which an ordinarily prudent specialist would do under the same or similar circumstances. Okay?

A. Okay.

Q. An ordinarily prudent specialist would do under the same or similar

circumstances.

Would an ordinarily prudent specialist under the same or similar circumstances have either not delivered this fetus or not ruptured the membranes?

A. A lot of negatives there. I don't think he would have done that. He would not not have.

Q. He would have -- an ordinarily prudent physician under these circumstances would have either ruptured the membranes, put a scalp electrode on or delivered this fetus?

A. That is my opinion.

Q. And that is standard of care?

A. I think so.

MR. DiCUCCIO: Okay. I have no further questions.

- - - -

FURTHER CROSS-EXAMINATION

BY MR. FOLIANO:

Q. And the reason that you would want to put a scalp electrode on a patient is to reassure yourself of the fetal status,

correct?
A. Correct.
Q. And there are other ways to reassure yourself of the fetal status which are within the standard of care, correct?
A. Yes,
MR. FOLIANO: Thanks.
- - - - -
Thereupon, the deposition was
- - - - -

STEPHEN J. DeVOE, M.D.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at _____, Ohio, on this _____ day of _____, 1997.

_____
Notary Public in and for the _____

My commission expires: _____ _____ _____

CERTIFICATE

STATE OF OHIO

COUNTY **OF FRANKLIN** : **SS.**

I, Kathryn E. Stischok, **a** Registered Professional Reporter and **Notary Public** in and for the State **of** Ohio **duly** commissioned **and** qualified, **do** hereby certify that STEPHEN J. DeVOE, M.D. was **by** me first **duly** sworn to testify to the truth, the **whole** truth, **and** nothing but the truth in the cause aforesaid; that the testimony then given **by** him **was by** me reduced to stenotypy in the presence of **said** witness, afterwards transcribed by means of computer; that the foregoing **is** a true **and** correct transcript of the testimony so given **by** him **as** aforesaid; **and** that **this** deposition **was** taken at the time and place in the foregoing caption specified, and was completed without adjournment.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this 9th day of December, 1997.

KATHRYN E. STISCHOR, Notary Public - State of Ohio.

My commission expires December 11, 1999.

RUNFOLA & ASSOCIATES
995 SOUTH HIGH STREET
COLUMBUS, OHIO 43206
(614) 445-8477

December 29, 1997

Bannon, Howland & Dever
325 Masonic Building
Portsmouth, Ohio 45662

Attn: Mr. Robert R. Dever

In Re: Rhonda Bland, Administratrix of the Estate of Jacob Lawson vs. George P. Pettit, M.D., et al.

Dear Mr. Dever:

Your copy of the deposition of STEPHEN J. DeVOE, M.D. taken on December 18, 1997, in the above-captioned case has been submitted to you. You will recall at the time of the deposition that the deponent did not waive the right to read the transcript and therefore must now read and then sign *the* deposition after making any pertinent changes, additions or corrections.

If there are any changes to be made, they should be made in the following fashion: On the page provided at the end of the transcript indicate the paga of the correction, the line, and then the change to be made and the reason for making the change, Please have the deponent sign on page 94 of the transcript and have the signature notarized.

Pursuant to Ohio Rules of Civil Procedure, the deponent now has seven days, after receipt of this letter, in which to complete this.

After having done so, please return the

original signature page and original copy of the correction sheet to this office, and substitute *Xerox* copies of said pages to your transcript.

Thank you very much for your assistance in this matter.

Sincerely,

Kathryn E. Stischok
Registered Professional Reporter

cc: Mr. N. Gerald DiCuccio
Mr. Greg Foliano