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IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO

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Ann N. Nardi, et al.,

Plaintiffs, :

vs. :Case No. 94CVA-05-3151

Saeeda Mobin-Uddin, M.D.,

Defendant.

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DEPOSITION

of Stephen DeVoe, M.D., a witness herein, called by the Plaintiffs under the applicable Rules of Civil Procedure, taken before me, Xendra E. Johnston, a Notary Public in and for the State of Ohio, at the offices of Porter, Wright, Morris & Arthur, 41 South High Street, Columbus, Ohio, on Thursday, March 28, 1996, at 2:00 o'clock, P.M.

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ORIGINAL

APPEARANCES:

Mr. George Sarap,
Attorney at Law,
P.O. Box 779,
Worthington, Ohio 43085-0779,

On behalf of the Plaintiffs.

Porter, Wright, Morris & Arthur,
By Ms. Lisa L. Eschleman,
41 South High Street,
Columbus, Ohio 43215,

On behalf of the Defendant.

- - -

Thursday Afternoon Session,

March 28, 1996.

- - -

STIPULATIONS

It is stipulated by and between counsel for the respective parties that the deposition of Stephen DeVoe, M.D., a witness herein, called by the Plaintiffs under the applicable Rules of Civil Procedure, may be taken at this time and reduced to writing in stenotypy by the Notary, whose notes thereafter may be transcribed out of the presence of the witness; that proof of the official character and qualification of the Notary is waived; and that the examination, reading and signature of the said Stephen DeVoe, M.D., to the transcript of his deposition are waived by counsel and the witness; said deposition to have the same force and effect as though signed by the said Stephen DeVoe, M.D.

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STEPHEN DEVOE, M.D.,

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

EXAMINATION

By Mr. Sarap:

Q. Doctor, my name is George Sarap, and apparently you have been retained to be an expert and to give some opinions in this case, in the Ann Nardi case; is that correct?

A. That's correct.

Q. Okay. And I'm going to ask you some questions about those opinions, Doctor, and if there's something you don't understand, let me know and I'll rephrase it. Okay?

A. Okay.

Q. And I know you've probably given a number of depositions before; is that correct?

A. Yes.

Q. Okay. Now, Doctor, in regard to this case, first of all, could you tell me something about your background and training just briefly? In other words, you're board certified, I take it?

A. I am board certified in OB-GYN. I went to medical school at Ohio State. I graduated in 1969. I spent five years at the University of Pennsylvania in

Philadelphia for internship and residency. I'm on the faculty at Ohio State. I'm involved in medical education by teaching residents and medical students at Riverside, and I'm in private practice.

Q. Okay. And how often on a yearly basis, Doctor, let's say, do you review medical negligence cases, approximately?

A. I really would be guessing only, and I would guess probably 8 to 12 new cases a year, one a month.

Q. And approximately how many times a year do you end up having to, let's say, testify either by deposition, for use at court, or in court, approximately?

A. These are really crude guesses, and I really don't know. I would guess I probably testify six to ten times a year.

Q. Okay. And what was your charge in this case for reviewing and rendering an opinion, Doctor, to date?

A. I don't know what I've -- Lisa said she wasn't even sure I sent her a bill. I charge $300 an hour. I don't know whether I've sent her a bill or not.

Q. Okay. Now, in this case, Doctor, could you tell us -- I want you to list for me the items or the documents you reviewed in regard to giving an opinion.

A. I reviewed the medical record. I reviewed -- that included the hospitalization where the baby was delivered. I reviewed some of Dr. O'Leary's office records, some of Dr. Uddin's office records, some records related to physical therapy for the child, an evaluation at Nisonger Center. I think that was a one-time only thing at Ohio State. I reviewed interrogatories that the plaintiff provided or answers to interrogatories. I reviewed the complaint and three depositions.

Q. And those would be the depositions of Dr. Uddin, Dr. Krane, and the plaintiff?

A. That's right, those three.

Q. Okay. First of all, Doctor, have you formed any opinions in regard to the damage aspect of the case? In other words, Ann Nardi obviously has a withered arm; is that correct?

A. She has an Erb's palsy.

Q. She has Erb's palsy; is that correct?

A. Yeah.

Q. Now, do you have an opinion as to whether or not the Erb's palsy was a result of the birth process?

A. Most likely -- yes, I do.

Q. And what's your opinion?

A. Most likely it occurred during the birth

rocess. There is some evidence that suggests that erhaps Erb's palsies happen in the uterus also prior o the onset of delivery or labor, and that always emains a possibility, but we'll never know in this ase, I guess.

Q. In this case, I guess it's your opinion -- I'm lot trying to put words in your mouth -- that in all robability, this Erb's palsy occurred during the birth rocess; is that correct?

A. Most likely.

Q. Okay. Now, Doctor, first of all, you reviewed Dr. O'Leary's chart; is that correct?

A. Yes, I did.

Q. Now, do you have any opinions in regard to the care and treatment rendered by Dr. O'Leary?

A. Yes.

Q. And what is your opinion?

I think his care was adequate, met relevant standards at the time.

Q. And you don't have any opinion that anything that Dr. O'Leary did was inappropriate; is that correct?

A. That's correct.

Q. Okay. And I'll ask the same question about the hospital and the hospital staff, Doctor. Do you

have any opinions as to the care and treatment rendered by the hospital and the hospital staff as to whether snybody in that forum rendered any inappropriate care?

A. I do have an opinion, and it is that the people at St. Ann's met all relevant standards in their care of Ann's mother.

Q. And also, Doctor, do you have an opinion as to whether there -- if it was needed, whether there was appropriate anesthesiology available for Ann Nardi if it was needed?

A. My understanding is that the anesthesia is available at St. Ann's.

Q. And it was available in this situation; is that your understanding?

A. Yes, because an anesthesia representative was present for the resuscitation of the child shortly after the birth, so they're obviously in the building.

Q. So you have no criticisms as to any of the care that may have been rendered or absence of care that may have been rendered by any anesthesiologist in this case; is that correct?

A. That's correct.

Q. Okay. Now, Doctor, in regard to the review of the chart and the office charts, now, isn't it true, Doctor, that this situation presented at least in some

aspects a high risk pregnancy or a high risk delivery; is that correct?

A. Yes.

Q. Okay. And could you list for me those items which you contend led you to form those opinions? What made it high risk?

A. Her weight.

Q. Okay. And what other factors?

A. She had developed some mild hypertension and proteinuria the last couple weeks of pregnancy.

Q. Okay.

A. She was found on the day of induction, that the induction was begun, she was found to have a decreased amount of amniotic fluid, which makes it high risk from a fetal standpoint of a placental insufficiency or umbilical cord compression or both.

Those three support the high risk question.

MS. ESCHLEMAN: Excuse me. Doctor, any time that you feel that you need to look at the medical records, please feel free to do so.

THE WITNESS: Thank you.

MR. SARAP: Yeah, obviously you can look at the records, Doctor.

Q. Now, the decrease in the fluid, Doctor, did you form an opinion as to what caused that problem?

A. I didn't really think about it. It's one of the things we see. It was probably in part tied to the hypertension. She had some marginal hypertension, occasional blood pressures elevated; then you'd check her at rest maybe on the left side and it would be better. But placental deterioration as a result of blood pressure problems can result in decreased amniotic fluid formation, and the net effect is a drop in the amniotic fluid volume.

Q. And that leads or potentially leads to a more difficult delivery process; is that correct?

A. No.

Q. Okay. That puts the baby or the fetus at risk; is that correct?

A. Yes, it puts the fetus at risk for two things. One is mainly compression of umbilical cord because the fluid's no longer there as a buffer to protect the cord; and two, it indicates the placenta may be deteriorating in the quality of its function and, therefore, may not be good enough to sustain the baby. Because of those things, Dr. Uddin knew about the amniotic fluid and did the proper thing, which is the delivery. That's why I didn't spend a lot of time thinking about the amniotic fluid, because her response was immediate and appropriate.

Q. Obviously it's one of your opinions that one of the reasons you want to deliver the child on that day is because of the decrease in fluid; is that correct?

A. Right.

Q. Okay. Now, do you have any criticisms as to the care and treatment rendered by Dr. Uddin, first of all -- let me segment it -- prior to the delivery recess?

A. No.

Q. Okay. And did your review of the records reveal that she did or did not make an adequate review of the prior office chart of Dr. O'Leary?

A. My review of the records suggested she reviewed the records. I don't think it really addresses one way or the other that she's studied the whole record. She picked up the care. The problem of this lady presents itself when you weigh her, you take her blood pressure and check her urine and protein, and review of the records is really not as important as the problem she presents on June 30th.

Q. And when you have a situation where the mother is overweight, as obviously is the case here, approximately what? Three hundred pounds, give or take?

A. 303 at delivery.

Q. Could you tell me, Doctor, what problems that leads to in the birth process or the delivery process?

A. It makes her a high risk patient from a variety of facets. One is she's a terrible risk for a C-section because of chances of wound infection, blood clot in her legs, blood clot in her lungs, pulmonary emboli, which is much more common to heavy people. Infection in the lining is more common. She'd be technically a hard C-section to do in terms of getting access to the uterus, controlling bleeding, all this sort of thing. She is at higher risk for requiring a C-section because of her weight, and the weight takes up space inside, so there's less room available for the baby to come through. She has high blood pressure, which is more common in heavy people, so the weight contributes to that. She presents a formidable challenge to the obstetrician.

Q. Now, a lot of those risks you just mentioned are risks to the mother; is that correct?

A. Right.

Q. Now, specifically, how about risks to the child in the delivery process as far as being overweight?

A. Mother's weight increasing the child's risk;

s that the question?

Q. Yes.

A. Well, I think any time you have a situation Jhere there's a greater possibility of the baby being stuck increases the likelihood of fetal injury at the time of delivery, requiring a forceps delivery, for example, or some other delivery that's going to be potentially hazardous. Also, heavy mothers tend to ave slightly bigger babies. If the baby's big enough, t can run out of space.

Q. Okay. That was my next question, Doctor. Iow, did you review records in this case that would indicate or basically indicate to you what size the baby was?

A. Yes.

Q. Okay. And what were those records?

A. Well, the birth records, the records from the hospital. The baby's birth weight was 9-11, nine pounds 11 and a half ounces.

Q. I mean prior to that time, by sonogram, anything like that?

A. They're not useful. There was one done a 32 weeks. I'd have to verify the date. Somewhere in O'Leary's record, he put down the baby weighed, somewhere he estimated, 3,000 grams. I don't know

whether that was his estimate putting his hands on her
sonogram. I'm not sure. But it's not really
seful. Estimates of fetal weight aren't very useful
ate in pregnancy.

Q. In other words, the sonogram would not have
een useful; is that correct?

A. That's correct.

Q. Okay.

A. Because --

Q. What other ways would you determine the size
or the weight of the baby? Could you list those for
me? I guess sonogram is one indicator; is that
correct?

A. Sonogram is one, is the best one, but a well
done sonogram still can be off 10 percent in an
estimate of fetal weight. So in this baby's weight of
nine pounds 11 ounces, it could be estimated to be
eight pounds six ounces and still be a well done
sonogram. So they really aren't useful enough or
accurate enough even when they're done well to make
much difference clinically.

Q. Okay. And I'll show you this sonogram,
Doctor, from St. Ann's Hospital. Did you review that?

A. Yes.

Q. And on what day was that sonogram done?

A. The day of induction, the 14th of July.

Q. Okay. And is there any indication on there as to the size of the baby?

A. No.

Q. Okay. Now, besides the interpretation of the sonogram, Doctor, there are also, I guess I call it, a film or a printout of the sonogram; is that correct?

A. There usually are some pictures taken. The reason there's no estimated fetal weight is because it talks about her weight again compromising the accuracy. The only thing they could see was length of the femur. They couldn't really measure head, abdominal circumference, some of the other things that go to constructing a fetal weight.

Q. In other words, that sonogram was really not able to detect the exact size or close to the size of the baby? Nobody could be exact?

A. That's right.

A. That's right.

case, that the safe thing to do would be to presume that the baby's going to be rather large if you have a large mother?

MS. ESCHLEMAN: Objection.

A. No, it's not. It doesn't logically follow.

Q. Okay. And let me ask you this, Doctor, before

we get into some other things. Do you have an opinion s to whether it was inappropriate in this case that r. Uddin did not perform a C-section in this delivery rocess?

A. Your question has two negatives in it. Was it nappropriate not to do a C-section?

Q. Right.

A. At what point? I think her care was totally appropriate in all aspects.

Q. Okay. Then I want to break it down into different aspects, Doctor.

A. Okay.

Q. As far as, obviously, when you have a difficult delivery process in some situations -- and this is a general question -- a C-section is appropriate; is that correct?

A. That's correct.

Q. Okay. And generally, Doctor, under what guidelines would that follow? In other words, what type of difficulties would lead you to do a C-section and in what cases would they be appropriate? I know the answer might be long, but generally speaking, in other words.

A. The shorter answer is you spend four years in training learning the answer to that question, so the

answer I give you will be kind of rough and approximate.

A number of things don't apply here, such as active herpes, placenta praevia, placental abruption. None of those things apply here. There is no evidence of fetal distress, so there's no indication from that that she should have a C-section. It's tempting for people who don't understand shoulder dystocia very well to say "Aha, big mother, big baby, big risk of shoulder dystocia. Let's do a C-section." That's very fallacious reasoning in that the instance of shoulder dystocia is .15 to one percent out of all deliveries. Even when the baby weighs more than 4,000 grams, only about two or three percent of them will have shoulder dystocias, so in that case, you would be sectioning 100 women because two or three of the babies might get a shoulder dystocia. If you're going to say, "Well, she's at risk for shoulder dystocia, therefore, section her," that's a totally wrong approach because you're going to do a lot of sections due to the numbers I gave you.

So indications for a section, the most common one is that baby gets stuck in labor. You have good labor, poor progress, eventually a lack of progress, and you have no choice but to deliver by section. That

id not happen. This lady had very effective labor. She went from four centimeters at 12:30 to completely ilated at 3:00 a.m., 3:05. That's a very effective abor. She didn't have a prolonged second stage, which ight be a problem for her and might indicate a -section. Second stage was 3:05 to delivery, an hour nd 15 minutes or something pretty reasonable. Breach resentation is another indication for C-section. Doesn't apply here.

Q. I forget my conversions. Four thousand grams is about how many pounds?

A. I don't know. I think in grams, I think that's nine pounds. I think it's right at nine pounds.

Q. Okay. I don't know if I forgot that or just never knew that.

A. I never remember.

Q. All right. Doctor, now, you have also -- well, let me ask you this first. Now, let's talk about -- I know you've already commented on this, but I have to ask you for the record again.

The delivery process, we've talked about Dr. Uddin's care and treatment rendered up and to the delivery process, and you've indicated you had no criticisms or opinions of anything that was inappropriate; is that correct?

A. That's correct.

Q. And it's also your opinion today that the fact that a C-section was not done, that that is not inappropriate care in this situation; is that correct?

A. That's correct.

Q. Now, how about the birth process, Doctor? In other words, when the delivery process started and Dr. Addin entered the birthing room or the delivery room, so the end, do you have any opinions or do you have any criticisms as to any care and treatment rendered by Dr. Addin during that process?

A. No.

Q. Do you have any opinions as to whether anything she did was inappropriate during that process?

A. No.

Q. I mean you have an opinion.

Q. Okay. I think the baby started to crown, and hat was -- things were looking good then; is that :orrect?

A. That's correct.

Q. Okay. And then some problems happened after :hat in the baby being delivered; is that correct?

A. That's correct.

MS. ESCHLEMAN: Objection.

Q. And based upon your review of the records, Doctor, from the time the crowning started until the time the delivery took place, do you remember how much time elapsed?

A. I'd have to look at the record, but the two lon't logically follow, you know, especially with what {our understanding of what crowning is and my understanding may be two different things. I think she vas described as crowning like a half-hour, 40 minutes before the baby was born. That doesn't really have anything to do with the difficulty of the delivery.

Q. Okay. Well, here is what I'm trying to get at, Doctor. Now, when Dr. Uddin started to get involved with the process and started to try to deliver the baby, okay?

A. Okay.

Q. Now, there were a number of things that she

lid to perform this delivery.

A. Why don't you tell me what time of day you're thinking about so we both know exactly we're agreeing with one another.

Q. Well, I think we're talking about -- let's start at 4:50.

A. Okay.

Q. Okay. Now, I believe there were some maneuvers or procedures that were performed; is that correct?

A. Yes.

Q. Okay. And ther'e was a McRobert's maneuver performed; is that correct?

A. That's correct.

Q. [illegible] what a McRobert's maneuver is?

A. McRobert's maneuver is removal of the patient's feet from her stirrups and flexion of the upper leg against the abdomen. In other words, she's basically lying on her back, putting her knees up toward her abdomen, out and open to the side.

Q. And is it your opinion that was done in this case?

A. Yes.

Q. Okay. And what other procedures did Dr. Uddin

perform to deliver the baby?

A She rotated the shoulders to the oblique diameter; I believe then she also put pressure behind the pubic bone of the mother to help slip the shoulder underneath the pubic bone, and she tried to rotate the baby, and it popped out

Q When she tried to rotate the baby, I think she indicated she thought maybe the clavicle had broken, is that correct?

A. Yes.

Q. And hypothetically, assuming that the injury occurred during the birth process, the Erb's palsy, was that probably the time that it occurred?

MS. ESCHLEMAN: Objection.

A. I don't know. I don't know when it occurred.

Q. Okay. Now, Doctor, in regard to having an anesthesiologist on board, is it your opinion that when these problems arose, that it would not have been appropriate to administer any other anesthetic or general anesthesia in this case?

A. That's correct, it would not have been appropriate.

Q. Okay. Now, also, Doctor, the method in which Dr. Uddin turned the baby, she reached in and turned the baby I believe with her fingers to try to get the

shoulders in the proper position; is that correct?

A. Yes.

Q. Okay. NOW, is there anything about that procedure in your opinion that she did that was inappropriate?

A. No. All we have is what she says, and she tried to turn it to an oblique diameter in the pelvis where there's more room.

Q. NOW, when you turn a baby in this fashion, Doctor, I guess based on experience, you apply a certain amount of pressure; is that correct?

A. Right.

Q. Okay. And then that's something that's hard to describe; is that correct?

A. It's hard to measure. It's hard to describe to someone else, yes.

Q. And that's just something that comes with experience and years of doing this; is that correct?

A. Right.

Q. And there is such a thing as excessive or too much pressure; is that not correct, Doctor?

A. You're talking about now where she's putting pressure on the baby's shoulders to rotate it to an oblique diameter?

Q. Yes.

A. I don't know if you -- I don't know what too much is in this situation. I don't know how that would hurt it.

Q. Okay. Now, how about the pressure? Was there any pressure applied to the head in this delivery process?

A. To the head. Well, I think she probably was holding the baby's head as it delivered, as you do -- as the baby's head crowns, you grab what you're able to grab, and that would be pressure on a baby's head. She's holding it and trying to maneuver the baby.

Q. Okay. And at the time the baby was -- after the baby was turned, okay? Now, do you have an opinion based on a review of the records as to, if you could describe it to me, the position of the baby's head and the position of the baby's shoulders as the baby came out?

A. As the baby came out, I would imagine the shoulders were oblique, and that is kind of, if you're looking at the pelvis as the face of a clock, on a 1:00 to 7:00 diameter would be the shoulders, maybe 2:00 to 8:00. Initially the shoulders had probably been directly up and down, 12:00 to 6:00, and she was able to rotate it to the oblique diameter, where there's more room, and the baby came out.

Q. How about the position of the arms? Can you determine what those were from the records, Doctor, from your review?

A. No. You assume they're folded up along the body.

Q. Now, Doctor, you've read Dr. Krane's deposition, is that correct, his discovery deposition?

A. Yes.

Q. And Dr. Krane had some criticisms of the care and treatment rendered in this case; is that correct?

A. Yes.

Q. Could you comment on those criticisms, Doctor, and address that and what your opinions are as to those?

A. Why don't you ask me about the ones you have in mind or about them one by one.

Q. All right. We'll go about them one by one. I have them marked. Just give me a second.

I believe he had a criticism about the lack of anesthesia, Doctor?

A. Yes.

Q. And I think you've already commented on that; is that correct?

A. Yeah. I'm not sure what he had in mind for anesthesia. We don't want to put this lady to sleep.

she got some local. This is a time when we need her enthusiastic participation and cooperation, so you don't want her narcotized, or general anesthesia is obsolete in obstetrics except under unusual circumstances. I don't know exactly what he had in mind there. He doesn't offer any evidence or details either.

Q. And I believe he also has some criticisms as to the pressure in the delivery applied to the shoulders; is that correct?

A. I don't think so.

Q. Okay. Or pressure applied to the head; is that correct?

A. No.

Q. Just give me a second and 1/11 find the exact one here.

Okay. I think he indicates, Doctor -- and 1/11 certainly let you read this if you want, but the second deviation -- I think the first one he refers to is the anesthesiology, which we've already talked about. Second deviation was that there was fundal pressure used to deliver the head. Okay? "The mother had no anesthesia, and if she couldn't push his head out, something must have been keeping it up." Remember reading about that, Doctor?

A. Yeah, and I think he retracted that in the next statement or so.

Q. Okay. And I believe -- I know he retracted part of that. Okay? But I believe he had an opinion, and I can't put my hands on it right now; if necessary, I'll take a minute and find it -- about excessive pressure being used when the procedure was taking place. Do you remember that?

A. Yes.

Q. Okay. That's what I'm trying to find out. What is your opinion of that, Doctor, and your response to that?

A. Fundsal pressure is what you're talking about. It's pressure on the top of the uterus during the time of delivery, one part or other, of the baby, and he was critical of the use of fundal pressure while the shoulders were being delivered. Fundal pressure is a very controversial tool in obstetrics, and there are -- you probably can find a textbook that will say it's wrong to do it either sometimes or always wrong, yet fundal pressure has saved a lot of babies' lives, and there's not an obstetrician around who hasn't used it or relied on it at one time or another to save the day, and I think fundal pressure is very appropriate in certain circumstances. In fact, if you read deeply

enough on this topic, some of the maneuvers described for dealing with shoulder dystocia include fundal pressure as part of the maneuver.

Q. okay. And --

A. Let me finish my thought. I'm sorry.

Q. I'm sorry. Go ahead.

A. So the use of fundal pressure in certain situations is appropriate, I think, and in this situation, it was appropriate.

Q. Okay. And then my next question along those lines is, again, the application of fundal pressure is also one of those things that are based on experience; is that correct?

A. That's correct.

Q. In other words, how much is too much or not enough is something that you base on your experience and years of doing this; is that correct?

A. Right.

Q. Okay. And then there is a level at which the fundal pressure is too much and it would be inappropriate; is that correct?

MS. ESCHLEMAN: Objection.

A. Again, depends on who you talk to. The thing you have to understand is the obstetrician is not applying the fundal pressure. She's trying to deliver

.he baby between the legs, and a nurse is applying the 'undal pressure. I suppose if you've got someone in :here with my strength and size, you could put too much in. If you've got a 110 pound nurse, you probably :an't put enough on to do any harm. It's hard to measure.

Q. Okay. But would you agree or admit at least that there is a level at which when too much fundal pressure is applied -- and I'm not talking about this situation; I'm talking about in general -- that it would amount to inappropriate medical care?

MS. ESCHLEMAN: Objection.

A. Yes, either too much or at the wrong time;

Q. Okay. Now, Dr. Krane also commented on the time that elapsed when these procedures were taking place, the McRobert's maneuver and the other procedures; is that correct?

A. Yes.

Q. And I think there were only what, two minutes marked in the chart from start to finish?

A. Right.

Q. Do you have an opinion as to whether that's kind of a short amount of time for all these procedures to be used?

A. No. Basically I think he insinuated that Dr.

Uddin was lying in that he said he didn't believe the record, he didn't believe you could do a McRobert's maneuver and position the shoulders and do episiotomy and apply fundal pressure in a minute or two. I think you can. Dr. Uddin most likely had a checklist or plan like most of us do for shoulder dystocia. You can do your maneuvers quickly. If you realize the first thing you're doing isn't working, you quickly abandon that. It doesn't take too long to figure out this baby isn't just going to fall out. And two minutes in this situation is a long time. Even the plaintiff recognized that when it was a minute or two and she said it felt like five or six. I don't think it is true that it's impossible to go through that in two minutes.

Q. I don't think he said Dr. Uddin was lying.

A. He inferred he didn't believe the record.

Q. All right. Now, also, Doctor -- and I know you've listed some risk factors in this case. Is there -- strike that. Let me ask you this first.

By reviewing the records, do you have any opinions as to what else the mother could have done to assist in this birth process to make it go better or to be more cooperative?

MS. ESCHLEMAN: At what time, George?

MR. SARAP: During -- right after the crowning until the delivery.

A. I don't think there's any evidence that she was uncooperative. Where she should have been more cooperative is when they wanted to put her in the hospital on July 3rd, and she refused, and I guess a couple days later --

Q. That was my next question. Before this process started, tell me what else you have opinions of as far as the mother's conduct.

A. I think she was cooperative, as near as we can tell from the record, for the most part. She wouldn't let them start the IV till her husband got there, and that's unrelated. She was cooperative during labor and delivery. I don't know what difference it would have made, I don't know what events would have followed if she'd come in July 3rd. Perhaps she would have been induced and delivered, and then the baby would have been smaller and not gotten stuck. She declined to be admitted on July 3rd. I think she was approached about that five days later and declined again. I don't know what difference those things would have made. As I said, who knows what would have happened if she'd been in the hospital, evaluated, and perhaps induced then. But she was not cooperative at those times. And her

weight, for which she's responsible to some extent, is also a big contributing factor here.

Q. And also, Doctor, the fact that she didn't want the IV started until her husband got there, that probably had nothing to do with the outcome of the case?

A. I said that it's not relevant to the outcome.

Q. Now, as far as the fundal pressure that's applied, Doctor, even though the doctor nay not be applying the fundal pressure, does the doctor still exercise *some* control as to what type of fundal pressure should be applied and how much and when?

A. Yes.

Q. Okay. In other words, based on experience, they get a feel for this? They can observe it and basically know if it's too much; is that correct --

A. Yes.

Q. -- generally speaking?

A. Or not enough.

Q. Or not enough. Okay. And obviously the timing, that's the doctor's call; is that correct?

A. Right.

Q. Okay. We've talked about Dr. Uddin, Doctor, and I know I specifically asked you about the hospital, their staff, anesthesiologists, things of that nature.

Do you have any opinions -- and I'm not talking about Dr. Uddin now -- as to whether any other medical provider in this case that provided care and treatment to Ann Nardi rendered any inappropriate care based on your review of the records?

A. I do have an opinion.

Q. And what's your opinion?

A. I don't think anyone else rendered -- I don't think anyone rendered inappropriate care to this lady anywhere along the way.

Q. And do you have an opinion as to whether there was appropriate help or appropriate staff available in the birthing room and the delivery room when this process took place? In other words, numbers of people, the appropriate people, were they there?

A. Yes, as near as I can tell, they were there.

Q. In other words, they weren't shorthanded, anything like that?

A. That's correct, they weren't, best of my knowledge.

Q. Were there any specific articles, Doctor, that you relied on in this case in rendering your opinions?

A. Not really, no.

Q. Is there any specific treatise that you relied upon?

A. No.

MR. SARAP: Doctor, I don't have any further questions at this time. Thank you very much.

THE WITNESS: Yes, sir.

MS. ESCHLEMAN: Doctor, as you know, you have the right to read this transcript should you so desire if it's transcribed by the court reporter, or you also have the right to waive that reading if you so desire.

THE WITNESS: Do you have a preference? I don't care.

MS. ESCHLEMAN: I don't think there's any reason you need to read it in this case unless you feel so.

THE WITNESS: I'll waive.

(Signature waived.)

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CERTIFICATE

State of Ohio
SS:
County of Franklin :

I, Kendra E. Johnston, Notary Public in and for the State of Ohio, duly commissioned and qualified, certify that the within named Stephen DeVoe, M.D. was by me duly sworn or affirmed to testify to the whole truth in the cause aforesaid; that the testimony was taken down by me in stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony given by said witness taken at the time and place in the foregoing caption specified.

I certify that I am not a relative, employee, or attorney of any of the parties hereto, or of any attorney or counsel employed by the parties, or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this 1st day of April, 1996.

Kendra E. Johnston

Notary Public in and for the State of Ohio and Registered Professional Reporter.

My commission expires July 13, 1997