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CONDENSED TRANSCRIPT AND WORD INDEX
OF THE DEPOSITION OF

STEPHEN J. DEVOE, M.D.

TAKEN JUNE **18, 1999**

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COMMON PLEAS COURT
FRANKLIN COUNTY
STATE OF OHIO

Denise Dooley, Administrator :
of the Estate of :
Jeremy Dooley,
Plaintiffs, :
-vs- : No. 98CVA08-5982
John S. Russ, M.D., :
Defendant. :

JUNE 18,1999
DEPOSITION OF
STEPHEN J. DeVOE, M.D.

A witness herein, called by the Plaintiff for cross-examination under the applicable Rules of Ohio Civil Court Procedure, taken before me, Michael A. Caswell, Professional Reporter and Notary Public in and for the State of Ohio, pursuant to Notice and Agreement, at the offices of Plymale & Associates, 350 South High Street, Suite 200, Columbus, Ohio 43215-4510, on Friday, June 18, 1999, commencing at 2:00 p.m.

APPEARANCES:

TERRI LEN JOHNSON, Attorney at Law
Plymale & Associates
350 South High Street, Suite 200
Columbus, Ohio 43215
(614) 221-1166,
On behalf of the Plaintiffs.

WARREN M. ENDERS, Esquire
Reminger & Reminger
505 South High Street
Columbus, Ohio 43215
(614) 461-1311,
On behalf of the Defendant.

Friday Afternoon Session
June 18, 1999
2:00 p.m.

STIPULATIONS

It is hereby stipulated by and between counsel for the respective parties herein that this deposition of STEPHEN J. DeVOE, M.D. may be taken at this time by the Notary; that said deposition is being taken pursuant to Notice and Agreement; 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 qualifications of the Notary, the time and place of the taking of said deposition are hereby waived.

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EXHIBITS

PROCEEDINGS

STEPHEN J. DeVOE, M.D.,
being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MS. JOHNSON:

Q. Okay. Dr. DeVoe, my name is Terri Johnson. I'm here representing Denise Dooley and the estate of their son, Jeremy Dooley. If for any reason you don't understand my question or don't hear my question, will you let me know?

A. Yes.

Q. And you've done other depositions so you know that your answers have to be verbal, correct?

A. Yes.

Q. Have you ever testified as an expert in any other fetal demise malpractice cases?

A. One that I remember.

Q. And when was that approximately?

A. About a year ago or maybe 14 months ago.

Q. What were the circumstances in that case that led up to the fetal demise?

A. It was late pregnancy. I think the patient had borderline high blood pressure, made a similar claim about decreased fetal movement that she told the doctor, the record didn't support that and it was a defense verdict.

Q. Do you know who the plaintiffs attorney was in that case?

A. No. I don't remember.

Q. Was that here in Franklin County?

A. Yes.

Q. Did you testify at trial in that matter?

A. I had to do that by video. They changed it. At the last minute, they changed my court appearance from a day I was able to go to a day I could not go. So we did a video here one night in the middle of trial.

Q. And was that in 1998?

A. Yes.

Q. Do you recall who the defendant was in that case?

A. Somebody's name was Strausbaugh. I think that was the plaintiff. I'm drawing a blank on the defendant doctor's name. It's a family physician in Dublin, but Strausbaugh could've been the physician

also.

Q. Do you recall who the defense counsel was?

A. Jeff Beausay.

Q. Do you recall testifying in any other malpractice cases involving fetal demise?

A. No, I don't.

Q. In that Strausbaugh case, did you give a discovery deposition also?

A. I don't remember. I would imagine. I don't remember that though. I've done a couple videos or trial things where there was no discovery. So I don't remember.

Q. Have you testified in any other cases involving the standards for antepartum fetal surveillance?

A. None that come to mind. As you know, I've testified a number of times over the years. I would think that I probably have, but none of them come to mind specifically.

Q. Prior to testifying today, did you review any records?

A. I did.

Q. What records did you review?

A. I reviewed Dr. Russ's office records, records

from Grant Hospital on February 22nd of '98, office records included a postpartum visit and also autopsy records. I don't know which thing they're a part of. Autopsy records from the infant, several depositions of Mr. and Mrs. Dooley, Dr. Russ and Dr. Goldstein, I believe were the depositions. And I reviewed Hockenberry's -- I don't know if it was Hockenberry's notes or what, stuff related to his visit that appeared in Russ's chart. He was the general surgeon that saw her for the abdominal pain in the right upper quadrant. I believe that's everything.

Q. Did you review any medical textbooks or any other types of medical literature?

A. No.

Q. Did you review any technical bulletins or other ACOG materials?

A. No, I did not. I meant to pull out the technical bulletin Goldstein mentioned. I did not do that.

Q. As a result of your review of the medical records and depositions, did you generate some office notes concerning this matter?

A. I did.

Q. Would it be fair to say that those office

notes contain summaries of the materials that you reviewed?
A. Right. Just abstracts of the records so I don't have to review the original.
Q. Do any of those notes contain any of your opinions or questions concerning the case?
A. No.
MS. JOHNSON: At this time, I'd just request a copy of those be provided at some point. We don't need to go through them at this time.
MR. ENDERS: Sure. We'll do that.
Q. Did you prepare any written reports or other written memoranda to defense counsel concerning this case?
A. No, I did not.
Q. Are there any medical textbooks or other medical literature you consider authoritative on the issues involved in this case?
A. No, I don't think so. There's lots of opinions and some of them are at variance with one another.
Q. In rendering your opinions in this case, are you intending on relying on any specific medical studies, articles or textbooks at trial?

A. Not at the present time.
Q. If at some point you change your mind and decide to rely on any such materials, will you advise Mr. Enders so he can advise us?
A. Sure.
Q. What's the goal of antepartum fetal surveillance?
A. The goal of antepartum fetal surveillance is to verify fetal well-being, identify Cases where there is fetal jeopardy so that appropriate subsequent interventions can be carried out.
Q. And to what end?
A. Deliver a healthy baby.
Q. In your day-to-day practice of obstetrics and gynecology, do you perform any antepartum fetal surveillance testing?
A. Yes.
Q. Do you have the facilities to do some of that testing here in your office?
A. Yes.
Q. What kind of surveillance testing can you do here in your office?
A. The only testing we do in the office is *nonstress* testing and contraction monitoring if

somebody is contracting spontaneously.
Q. And on occasion, do you do any other types of fetal surveillance testing?
A. I don't personally. I do order ultrasounds from time to time as a means of fetal surveillance and occasionally I have patients count fetal movements.
Q. And the ultrasounds that you would order, are they done here at the hospital some place?
A. I have them done at the perinatal center in the hospital. There's a full-time staff over there who's better at it than I am. And I don't have the time.
Q. When you order -- I think you mentioned that sometimes you order fetal movement counting for some of your patients?
A. Right.
Q. And is that something that's done while the patient is here or in the hospital or at home or some place else?
A. The usual situation is somebody who's not here and they're doing it between visits on a daily basis like at home.
Q. When you ask your patients to do that, are they given any written instructions on how to do that?

A. We give them a chart with the directions on the back of it.
Q. And the chart, does that have places in there for filling in their observations or their counting results?
A. Yes.
Q. Do you have a copy of a blank one of those?
A. Sure.
Q. Perhaps at the end of the deposition, we can take a break and you could get a copy of that for me?
A. Sure.
Q. Under what circumstances do you have patients of yours fill out one of those forms?
A. People who are recognized as high-risk patients, chronic hypertensives, diabetics. The most common usage is people who've past their due date.
Q. And for the other patients that aren't postterm, approximately when in the pregnancy do you start having them do those charting?
A. I don't have them do it routinely. For the ones I mentioned, clinical high-risk patients, I'll have them start doing it 32, 34, 36 weeks.
Q. And is that based on their medical condition at the time or some other factors?

A. Medical condition at the time, but I don't use it very often because it's strictly for the people I've described.
Q. And those particular high-risk patients would be just the ones you've listed or do they encompass other types of medical conditions?
A. There might be some other medical conditions. The occasional patient with lupus and people who have renal insufficiency and other causes and those kinds of things, but generally chronic medical problems, diabetes, hypertensive being the most common.
Q. Prior to having the patients initiate the home charting, do you order any other types of antepartum fetal surveillance testing first?
A. No. It depends on the reasoning. It's possible, but not routinely.
Q. And on those patients where you do request that they perform this home charting, are any of those patients ones that have come in during one of their office visits with complaints of decreased fetal movement?
A. Some of them may be. I don't customarily order that for those people. The most common decrease fetal movement complaint is someone who says, I

haven't felt the baby move for 24 hours or something. We'll bring them in, we'll do a nonstress test, it's reactive and it's fine. And they say, oh, yeah, I feel all that. I just wasn't aware that it was moving. I was busy and missed a lot of movement. I don't routinely put them on charts.
Q. Are those generally first-time pregnancy mothers?
A. I don't know. I've never made an observation or drawn a conclusion about that.
Q. And the nonstress test that you would do on those patients, that's a test you would do here in the office?
A. Yes.
Q. Aside from your patients that say, I haven't felt any fetal movement in 24 hours, do you have other patients that make complaints of decreased fetal movement?
A, We get that from time to time, yes.
Q. And what, if anything, do you do for those patients?
A. Depends on what they say, how the situation is presented.
Q. Why don't you give me some of those variables

that would play into what you would do?
A. It depends on how abrupt the decrease fetal movement is. I had a patient this week say, I haven't felt the baby move for an hour. It was 9:00 o'clock in the morning. I'm not worried about that. Call me back tomorrow or the next day if it -- if you feel it's really decreased all day. So that's a situation where I would just send her home.
Other situation is they may call up and says. The movement is precipitously dropped off, or words to that effect, over a several-day's period or even all day to day and it's 3:00, 4:00. I felt nothing. You might say those people are getting a nonstress test done on them.
Q. Do you also perform antepartum fetal surveillance testing on your patients where you've noticed severe growth restrictions from the fetus?
A. Yes.
Q. And how do you determine severe growth restrictions in those patients?
A. I think the diagnosis is made by -- the severe extent is made by ultrasound usually. In the office you notice growth restriction, you may notice it by a discrepancy between the number of weeks of

pregnancy and the size of the baby. I would tell you that the majority, two-thirds, of growth restriction is not recognized clinically at all until delivery or late pregnancy or until demise. So it's uncommon to recognize growth restriction.
Q. If you did notice -- Strike that.
In the past when you have detected growth restriction in some of your patients, what did you do in those cases?
A. Many times I think I'll have identified a discrepancy in the office setting and get an ultrasound and see if -- to see if it's real. And usually it's not real. The baby is 58th percentile or 40th percentile or something and they just go back in the normal pool with the rest of the patients. For the occasional patient that does have growth restriction, she goes on the -- gets plugged into a home management protocol that depends on a variety of details.
Q. And again, that would be testing that would be done over in the ultrasound?
A. The ultrasound would be done over there.
Q. Do you routinely perform fundal height measurements on your obstetrical patients?

A. Yes.
Q. Which visit does that start at?
A. Around 20 weeks. Before that, they're not very reliable. From 20 weeks to about 38 weeks, 36 weeks, they're pretty reliable.
Q. Is that the time frame in which you continue to do the fundal height measurements?
A. I measure them from then until delivery, but I think they're a little less meaningful close to term.
Q. Now, the patients that you instruct in home charting, do you make notations of that in your charts when you give them the charts to fill out at home?
A. Yes, I do.
Q. Is there any office follow up concerning the results of that home charting?
A. I ask them to bring the charts with them the next visit and I ask them to call if they haven't got the prescribed number of movements by the evening meal.
Q. And what prescribed number of movements do you use in your practice?
A. Ten in a day. It's a count-to-ten chart.
Q. In your practice, have you ever had an

occasion where you've asked a patient to, who was here for an examination, to stay and count movements for a certain period of time before they left?
A. No.
Q. Would that be rather impractical in an office setting practice?
A. It would be. I guess you could do it. I never even thought about it, but if a patient has the time and willingness, et cetera, there's nothing wrong with that.
Q. Now, as a result of being retained as the expert for Dr. Russ in this ease and having reviewed the medical records and any other deposition transcripts, have you made some conclusions or opinions concerning the care that was rendered to Denise Dooley in this case?
A. Yes, I have.
Q. And what's the sum and substance of those opinions?
A. The sum and the substance of his care is that Dr. Russ met Rollins standards of care in his management of Mrs. Dooley in her pregnancy, that the fetal demise was unexpected, obviously tragic outcome, not preventable in this situation even though the care

was up to Rollins standards and that, you know, it shows our tools aren't perfect and it's just one of those things that just happen, unfortunately.
Q. Going to the second of the things you just mentioned, that the results were unexpected for this patient?
A. Right.
Q. What exactly are you referring to that was unexpected?
A. The fetal demise.
Q. Were there any symptoms or warnings concerning this fetus prior to the demise?
A. In retrospect, it's tempting to say, well, there was a warning because the baby was not as active, in quotation marks. And I'd probably -- If it was real, that probably was a warning, but in the prospective sense, we all have patients who report fluctuating periods of fetal activity where babies aren't as active at one time as they are at a different time in the pregnancy.
MS. JOHNSOS: Would you read back his response, please?
(Record was read back as requested.)
Q. Do you have any reason to believe that the

complaints Denise Dooley had of decreased fetal movement were not real complaints?
A. No. I think they were real whether they -- but as I said, patients all experience fluctuations of fetal activity, and if she had some decreased fetal movement prior to the hospitalization, it may have been related to the subsequent demise or it may not have been. It may have been the normal fluctuations we see.
Q. Do you know when a patient makes a complaint to you of decreased fetal movement whether that's a normal fluctuation or if it's a warning sign of fetal distress?
A. You can't always tell. It depends on the magnitude of every complaint. Almost always when they make that complaint things are fine and everything is okay.
Q. And that's determined by doing the objective testing and seeing that the baby is okay and --
A. That's determined by --
Q. --the nonstress test?
A. It's determined by the outcome. Say you evaluate the report and decide not to do anything, most of those babies turn out fine, deliver

uneventfully at term.
Q. And when you make reference to "those babies turn out fine", which particular babies are we talking about?
A. In most cases where you take a history of that complaint and, for whatever reasons, you decide the investigation or evaluation is not required, the majority of those babies turn out fine.
Q. And is that as a result of additional information you elicit from the mother after she makes that initial complaint of decreased fetal movement?
A. I talk a little more about over what period of time. Like we talked a little bit ago what period of time? How long is this observation? What period of time does it relate to? How long a time? How big -- How real -- Not real. How profound is the change? Is it just a little less active or has it stopped? You know, trying io get some more details. In taking those questions, you in inevitably arrive -- not you, I inevitably arrive at the conclusion that this a patient that doesn't need to be evaluated, this one does, based on some assessment of what they're experiencing.
Q. At her deposition, Denise described that the

change in fetal movement had gone from feeling movement hourly to feeling it once every four or five hours and that this had been going on for a couple of days. Is that what you would consider within the realm of normal fluctuations in fetal movement?
A. Yeah, it probably is. My thing at this point, we all have ways in dealing with -- We all get the same questions. Probably 15 or 20 questions. account for 90 percent of the things I'm asked. My next thing would be to say, Do you feel ten movements a day? Oh, yeah, I do. That's the usual answer. Do you feel ten movements by dinnertime, I might say. That's the usual answer. And I'll say, Well, keep track of it and let me know if you don't; or If it gets worse or changes, call me back.
Q. And that would be the circumstance where you give them one of the charting forms to use at home?
A. I would give them a charting form to use at home or I'd just say, Keep track of it for a while and let me know. If I'm not particularly concerned, I'll tell them, I'm not particularly worried about this. You could miss a lot. Most people miss a lot of fetal movement when they're busy and they're concentrating on something else. Call me back if this persists or

if your impression of this persists. Sometimes I'll give them a chart and sometimes I won't depending on how worrisome the complaint is.
Q. To your knowledge, are there any studies which definitively define how many fetal movements a mother should feel in a given time period?
A. I don't know of any. I haven't read -- Fetal movements were a hot topic in the early to mid '80s and there was a lot published on it and you should feel four in two hours, or ten in a day. There's lots of schemes. I'm not inclined to read those because they're repetitive. I don't know if there's a definitive answer or not. I would say not.
Q. Would you agree that rather than a definitive quantitative measurement it's more important to assess the mother's perception of a change in the pattern of movement?
A. Well, both are important. If somebody says no fetal movement, obviously that's quantitative and that's important. Change in quality doesn't bother me. If the baby is due --
I'll say, Are you still feeling the baby move? How's the fetal movement?
And they'll say, It's fine. It's not as

strong as it was. And then they'll say, you know, No, I'm getting closer to my due date. The baby doesn't have much room.
And I think that's right. It's hard for them to quantitate strength of movement. So I've never placed much reliance in that the baby has a strong kick or a weak kick I mean it's present or absent.
Q. Let me phrase that a little differently. Do you think rather than having a definitive number of movements per hour or two hours or in a day it's more important that the frequency of movements for a particular mother whether that changes over a period of time?
A. I don't have an opinion on that. I think --
Yeah, but you're still applyingquantitative standards to it. I guess I do have an opinion.
The frequency for a particular mother has a lot to do with what she does for a living, how much movement she notices, how much attention she pays to it. So I guess in a sense that applies to a particular mother, but I think the same ground rules apply. If somebody says, I got no fetal movement or I felt one in two days, regardless of what she previously reported, that merits some evaluation.

Q. In the questioning of some of the witnesses, there was questions concerning Denise's complaints of upper quadrant pain in January and the gall bladder and those issues. In your opinion, does any of that have any bearing on what ultimately happened to the infant in this *case?*

A. The question isn't very clear.

I don't think that hemangioma in the liver had anything to do with what happened in the *case.* Her feeling the day she saw Hockenberry and he elicited fetal movement, I find that as reassuring that the baby was okay then. I think that was February 18th.

Q. And is that an indication that the baby was okay or that the baby was alive still?

A. I think that probably we frequently use fetal stimulation on nonstress tests. And that's very much like you do when you stimulate a baby to wake up and give you a reactive NST. When she felt movement in response to that stimulus, I think she probably had a reactive NST at that point, had she been on a fetal monitor.

Q. When you're giving that kind of stimulus to the baby in a testing situation there, you're

monitoring the fetal heart rate though, aren't you?

A. Right.

Q. There wasn't any monitoring of the fetal heart rate in connection with that stimulus in that situation though, right?

A. That's correct, but I think it's noteworthy that the patient -- that the fetus responded to the stimulus by moving.

Q. In his deposition, Dr. Goldstein had given the opinion that when the mother complained of decreased fetal movement, the appropriate standards of care required to perform antepartum testing to objectively rule in or rule out an abnormal condition. Do you recall reading that?

A. Right.

Q. Do you agree or disagree with that opinion?

A. I think in general, I would agree with it, but I think you have the obligation to kind of get some feel of some details with the patient. What's the decrease? You know, is it just some really nervous mom who has felt eight movements and not ten by noon, or is it somebody who's felt little or nothing for 24 or 48 hours? I think it's reasonable *to try* and quantitate this.

Q. Is there any quantitation that's in Dr. Russ's office records?

A. He just put -- Not in the records themselves. He put down what he discussed with her. And as I said before -- He put down what he discussed with her in the deposition.

Q. But not in his records?

A. As I said before, we tend to get asked the same bunch of questions all the time and we have stock answers. And I'm sure what he says he said in the deposition is just what he said to her at the bedside because you do. You work out the best answer over the years and that's the way you deal with that recurring same questions you get from everyone.

Q. Well, do you disbelieve Denise's testimony where she said that Dr. Russ informed her that it was just stress and nothing to worry about?

A. I don't disbelieve that. I think that's reasonable. As I said several times, some patients miss their fetal movements -- much of the fetal movement that occurs because they're occupied with their job or whatever else is going on around them.

Q. If Dr. Russ had not advised her to make some quantitative assessment on fetal movement, would you

think that that's a departure from accepted medical practice?

A. No. That just happens to be something I do.

Q. So on February 16th, when she came in with complaints of decreased fetal movement, accepted medical practice didn't require him to take any actions towards evaluating that complaint?

A. I think he testified that he took actions. He evaluated the magnitude of this change and decided it didn't warrant anything more than what he did, which was take a history.

Q. How was it that he evaluated?

A. He talked to her about it. And he said -- Basically, he said, Pay a little more attention if you're able and to try to quantitate what you feel, what's real for you in terms of how much change there really is and let me know if you really feel like it's decreased. That's a reasonable approach.

Q. What was it that he said --Because I must have missed it. What did he say that he elicited during that conversation from her concerning the quality of the complaint?

A. The question -- The conclusion I reached from reading the record was that the baby was active. She

felt it was not as active. And that's on the record.
You know, also there was a great deal of discussion apparently at that visit about the demands of her job, how tired she was and the stretching overhead and getting some relief from work and that sort of thing. And he summarized the situation -- or analyzed the situation to be in which -- to be one in which where she was having a great deal of stress and fetal movement was frequently missed or probably was missed or she was not getting an opportunity to quantify it. And he suggested to do that and let me know.
Q. Did Denise say in her deposition that he told her to do that?
A. I don't know. I'd have to -- I don't recall that specifically.
Q. If she says he did not tell her to do that, would that affect your opinion concerning that appointment?
A. I'd have to read the whole context of that answer of how that goes.
Q. If she saw another doctor that week and reported that there were no new instructions concerning her obstetrical care, would that affect

your opinion?
A. She saw a general surgeon.
Q. I said if she saw another physician that week.
A. You're talking hypothetical?
Q. Well, no. Actually, it's in the records. She did see another physician that week and reported that she had no new obstetrical instructions.
A. The general surgeon.
Q. No.
A. She saw another doctor that week?
Q. Yes.
A. I'm unaware of who else she saw that week besides she saw Russ on the 16th and Hockenberry on the 18th.
Q. She saw her family physician, Dr. Olmo (ph.), that week.
A. I forgotten that. If it was in there, I don't remember when she saw him or what for. I didn't make a note of that.
Q. Would you expect a patient that had been told to keep track of fetal movements to report to her family doctor a couple days ago that she had not received any new obstetrical instructions?

MR. ENDERS: Objection. That calls for pure speculation. You can answer that, Doctor.
A. Repeat the question. I guess 1was listening to what he said and I got lost on that.
Q. Would you expect a patient who had been instructed to do home quantitative measurements of fetal movement to report to her family doctor a couple days later that she had not received any new obstetrical instructions on her last visit?
MR. ENDERS: I'll object to that.
A. I don't -- Not necessarily. I mean it depends on what he asks her for. How's your pregnancy going? She says, Fine, That's not the same thing as saying, Did you specifically get any new instructions at your last visit? If the latter question is what's asked, then I would expect her to say, Yeah, I'm supposed to be counting the movements. If the guy -- If she's seeing him for some other reason and offhandedly he asks, How's the pregnancy going, and she says, Fine, I wouldn't expect that that's the same question; therefore, I wouldn't necessarily infer that that means she got other instructions or didn't get them.
Q. Okay.

A. Maybe she saw him for ERI or something. I missed that. Didn't know that.
Q. When Dr. Russ saw her on February 16th, did he perform a fundal height examination?
A. Yes. He said he did, yes.
Q. And is it recorded in his office notes?
A. It's not.
Q. When he said that he did, you're referring to his deposition testimony rather than some other reference in his chart?
A. That's right. It's also very automatic I'm sure he did it. You just do it automatically.
Q. Now, you said in the February 16th visit you felt one of the reasons why she might not have been perceiving as much fetal movement was because of the stresses at work?
A. She was complaining about being extremely fatigued, how hard her work was and that sort of thing. And I think that was the visit where she was seeking some disability. I know that that had been discussed earlier also. I think there was -- The impression I got from the deposition was that it was Dr. Russ's feeling that she had enough going on at work that she didn't really have a fair opportunity to

assess fetal movement and he asked her to pay as much more attention as you can and let me know.
Q. That was something that had been discussed in the past on prior office visits though also, correct?
A. The disability thing.
Q. Yes. About the stress at work and physical demands.
A. Yes.
Q. And that was discussed on other occasions when her husband was present for the exam?
A. Right.
Q. On those other exams when that was discussed, did she have any complaints of decreased fetal movement at that time?
A. She didn't say that she did and there's nothing in the record about that.
Q. Do you have an opinion as to what her fundal height would've been at the February 16th visit given the size of the infant at delivery?
A. I'd be really speculating. I don't know. No. I don't have an opinion, not to reasonable medical probability.
As I said earlier, two-thirds of growth restrictions are not recognized clinically.

Q. And would that hold true also for severe growth restriction?
A. I don't know what "severe" is. I mean Goldstein threw that in as a diagnosis. I'm not sure he defined what was severe or what he required to be severe. I don't know if it was truly severe or not. It was below the tenth percentile, but that's the definition of growth restriction, not severe.
Q. I believe he said this one was less than --considerably less than the three percentile --
A. I think he said that.
Q. --for gestational age.
A. I didn't go look up that. I think he cited Hadlocks's data. I didn't look it up. Now, there are other data. The ones most used in the midwest are not Hadlock's. They're used in -- What's used mostly is the stuff from North Carolina which is Brenner & Hendricks. And they're a little lower -- or not at sealevel.
Q. Do you have an opinion as to whether or not, with the size of this infant delivering six days later, whether or not the fundal height would've been in the range of 32 centimeters on that visit?
A. In the range, yeah. I think it would've been

in the range. Concurrent range between fundal height and the gestational age is plus or minus two. I think it would've probably been 30 to 34, yes.
Q. And on all the prior visits before that, had a fundal height been right at the weekgestation?
A. It had.
Q. When Dr. Goldstein gave his opinion that Dr. Russ failed to perceive the severe intrauterine growth restriction, is that an opinion then that you disagree with?
A. Well, again, I might be taking issue with the "severe." I think Dr. Russ did not perceive the growth restriction and that is, as I've said a couple times now, is quite commonly the case, particularly at 32 weeks. The difference between what a baby feels like who's AGA at 32 weeks and one that is below the tenth percentile is pretty small at that point. It's only later on that the discrepancy becomes more obvious clinically. So it's not unusual to under appreciate growth restriction at 32 weeks. In fact, it's more common than not.
Q. If a nonstress test had been performed on February 16th, do you have an opinion as to what it would've shown?

A. I think it would've been probably reactive because she had fetal movement in response to the stimulus that Hockenberry put on her on February 18th.
Q. And can you define for me what a reactive strip consists of?
A. Reactive strip is the most common usage. The one we use is acceleration of 15 beats per minute in the fetal heart rate over baseline twice in ten minutes.
Q. And the reaction from the examination in Dr. Hockenberry's office, that did not in any way assess fetal heart rate though, correct?
A. Right. But fetal movements generally associate with an acceleration of fetal heart rate.
Q. And one of the reasons why you do the nonstress test is to verify whether there's an acceleration of fetal heart rate in connection with movement, correct?
A. Right.
Q. Is there anything else about the facts that you know at this point to lend support the fact you feel it would've been a reactive strip if one had been performed on February 16th?
A. No, not with certainty. We do -- We start

out doing nonstress tests weekly. And we found that --That's kind of --

Never mind. That doesn't have anything to do with this.

MS. JOHNSON: Okay. Can you read back the last question?

(Record was read back as requested.)

Q. Do you have an answer for me on that?

A. No. I was going off on a direction that's unrelated, I think So I stopped.

Q. Okay. So the answer is no then?

A. Do I have anything else, idea or basis that it was reactive? No.

Q. Do you have any opinion as to the cause of death for this infant?

A. The most likely explanation is it's related to the umbilical cord being around the child's neck four times with an obstruction of flow and ultimately cardiac arrest.

Q. And do you have an opinion as to when it's most likely that the infant died?

A. Well, based solely on what Mrs. Dooley told the nurses when she got there, that's about as contemporaneous as we get, she, I think, said she had

not felt the baby move since Friday night. So I would assume the baby died sometime shortly after she felt the last fetal movement.

Q. That would've been Friday night or Saturday?

A. Yes. Friday night or Saturday morning probably.

Q. If the fetal surveillance testing had beeo done on February 16th and had shown a nonreactive strip, what would the standard of care have required to have been done at that point?

A. Since most nonreactive strips do not mean fetaljeopardy, then what we usually do is a biophysical profile or an oxytocin challenge test or a nipple stimulation test which is to elicit some intrauterine contractions either through nipple stimulation or oxytocin and see how the fetal heart rate of the fetus tolerate the contractions.

Q. So the decisions that would've been made after that point would've been based on further testing and evaluation, correct?

A. Yes. And the same results could've happened because of the cord around the neck.

Q. Well, if the nonstress test had been performed in his office and had been nonreactive, how

long would it have taken to get her to have a biophysical profile or one of the other challenge tests?

A. I would assume that he could do a biophysical profile in the office. They have an ultrasound machine there. A biophysical profile is five points, one of which is NST and four are ultrasound criteria. So that could be done then. People usually don't do an oxytocin challenge test or a nipple stimulation test in their offices. Although, they could do a nipple stim in the office. They have to send them to the hospital for OCT. That could've been done that afternoon, that evening.

Q. And at that point, the infant still would've been alive, correct?

A. If we're assuming we had a heart rate when we did our NST and was nonreactive, but yes, sure.

Q. If nothing happened in the interim to change the course of the infant's decline, there was approximately four days in which to attempt other treatments or make a decision about delivery before fetal demise, correct?

A. Which -- You're assuming nothing was done and we had no NST, or where are we?

Q. If we're back on the 16th and he had done a nonstress test in the office and then he had done a biophysical profile.

A, What are the results of our biophysical profile?

Q. I'm just saying you still would've had a four-day window before there was fetal demise on Friday or Saturday for other interventions to have been tried before the baby died, correct?

A. Yes.

Q. And those would've included admitting her to a tertiary care hospital?

A. You're trying to list the options that could've been done had we had a nonreactive NST?

Q. Correct.

A. The options could've been if the biophysical profile was eight out of ten, they probably would've sent her home and said, Come back in a couple of days and we'll do this again, NST. Ranging to a delivery that day or somewhere in between.

Q. Okay. Do you know Dr. Russ personally?

A. We're acquainted. We're not good friends or anything. He was a resident at the university when I used to go down to the high-risk clinic. I don't see

him socially except once in a while, once or twice a year.
Q. Are you on staff of any of the same hospitals together?
A. No.
Q. I believe Dr. Goldstein in his deposition also indicated that the mother's complaints of decreased fetal movement is the number one listed reason for ordering antepartum fetal surveillance. Would you agree with that opinion?
A. I don't think that's right. I think it's postdatism (ph.).
Q. Have we covered all of the opinions that you have formulated in this case based on your review of documents and testimony so far?
A. Yes.
MS. JOHNSON I don't have any other questions right now. I would like to just take a break and get a copy of the charting form and make it an exhibit to the deposition and then that's it.
MR. ENDERS: The Doctor will take the option to read his transcript.
THE WITNESS: Whatever you want to do. I'll read it.

(Signature not waived.)

Thereupon, a document was marked for purposes of identification as Deposition Exhibit 1 by the reporter.

Thereupon, the deposition concluded at approximately 2:48 p.m.

AFFIDAVIT

THE STATE OF OHIO:
SS:
COUNTY OF FRANKLIN:

I, STEPHEN J. DeVOE, M.D., do hereby certify that I have read the foregoing transcript of my deposition given on June 18,1999; that together with the correction page attached hereto noting changes to form or substance, if any, it is true and correct.

STEPHEN J. DeVOE, M.D.

I do hereby certify that the foregoing transcript of the deposition of STEPHEN J. DeVOE, M.D. was submitted to the witness for reading and signing; that after he had stated to the undersigned Notary Public that he had read and examined his deposition, he signed the same in my presence on this 14th day of July, 1999.

NOTARY PUBLIC, STATE OF OHIO
My Commission expires:

JANICE A. GREVE
NOTARY PUBLIC, STATE OF OHIO
My Commission Expires Aug. 17, 2000

CERTIFICATE

THE STATE OF OHIO:
SS:
COUNTY OF FRANKLIN:

I, Michael A. Caswell, a Professional Reporter and Notary Public in and for the State of Ohio, do hereby certify that before the taking of this said deposition, the said STEPHEN J. DeVOE, M.D was first duly sworn by me to tell the truth, the whole truth and nothing but the truth;
That said deposition was taken in all respects pursuant to the stipulations of counsel heretofore set forth; that the foregoing is the deposition given at the said time and place by the said STEPHEN J. DeVOE, M.D.;
That I am not an attorney for or relative of either party and have no interest whatsoever in the event of this litigation.
IN WITNESS WHEREOF, I have hereunto set my hand and official seal of office at Columbus, Ohio, this 1st day of July, 1999.

My Commission expires
June 28, 2004

MICHAEL A. CASWELL
Notary Public
In and for the State of Ohio

ERRATA SHEET

PLEASE DO NOT WRITE ON THE TRANSCRIPT.
Any changes in form or substance you desire to make should be entered upon this sheet.

TO THE REPORTER:
I have read the entire transcript of my taken on the 6 day of JULY 19 , or the same has been read to me.

I have signed my name to the transcript **AFFIDAVIT** page and authorize you to attach the same and a copy of this Errata Sheet to the original and all copies of the transcript.

PAGE	LINE	CHANGE	REASON
15	9	ANOMER NOT ONCE	
17	13	SHOULD BE A PERIOD AFTER SAT & NOT AFTER NOR	
18	21	RELEVANT IN PLACE OF Rolling WRONG WORD	
19	1	" " " " "	
25	16	OMIT PRIORITY	DOESN'T BELONG
32	1	ERI SHOULD BE URI	
36	3	INSERT " FOR 15 SECONDS " AFTER MINUTE	OMIT
38	15	OMIT " INMA-	WRONG WORD

DATE 7/14/99 SIGNATURE