

1 THE STATE OF OHIO)
 COUNTY OF SUMMIT) ³³
 2 IN THE COURT OF COMMON PLEAS

3 VICTORIA EINARSEN, a minor, *
 4 by and through her next *
 5 friend and natural mother, *
 6 Angela Einarsen, *
 7 Plaintiffs *

8 *
 9 vs. *

10 * Case No.
 11 DR. DAVID JACKSON, et al., * CV 98051884
 12 Defendants *

13 * * * * *

14 Deposition of **STUART CHARLES EDELBERG,**
 15 **M.D.,** taken on Friday, July 16, 1999, at
 16 2:00 p.m., at the BWI Marriott Hotel, Linthicum,
 17 Maryland, before Triminie M. Shelton, Notary
 18 Public.

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20 Reported by:

21 Triminie M. Shelton, RPR-RMR

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A P P E A R A N C E S

On behalf of Plaintiffs Victoria Einarsen and
Angela Einarsen:

HOWARD D. MISHKIND, ESQUIRE

Becker & Mishkind Co., L.P.A.

Skylight Office Tower

1660 West 2nd Street, Suite 660

Cleveland, Ohio 44113

216-241-2600 (Voice)

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On behalf of Defendant David Biats, M.D.:

DAVID HANNA, ESQUIRE

Buckingham, Doolittle & Burroughs

50 South Main Street

P.O. Box 1500

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330-376-5300 (Voice)

330-252-5544 (Fax)

1 A P P E A R A N C E S (Cont'd.)

2

3 On behalf of Defendant David Jackson, M.D.:

4 **THOMAS P. MANNION, ESQUIRE**

5 (via telephone)

6 Reminger & Reminger

7 113 St. Clair Building

8 Cleveland, Ohio 44114

9 216-687-1311 (Voice)

10 216-687-1841 (Fax)

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1 P R O C E E D I N G S

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3 Whereupon --

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5 **STUART CHARLES EDELBERG, M.D.,**
6 being first duly sworn to tell the truth, the whole
7 truth, and nothing but the truth, testified as
8 follows:

9 EXAMINATION BY MR. HANNA:

10 Q. Would you state your full name for the
11 record again.

12 A. Stuart Charles Edelberg.

13 Q. Doctor, we met a few minutes ago. I am
14 Dave Hanna, I represent Dr. Biats and the Cuyahoga
15 Falls General Hospital. We are going to take your
16 deposition today, I am sure you know how this goes,
17 and if you have any questions along the way, please
18 stop me.

19 What is your current business address?

20 A. I am at Maryland General Hospital, 827
21 Linden Avenue --

1 MR. MANNION: Can you please speak up,
2 Doctor. I don't know if the phone is not over
3 there, but I couldn't hear that answer.

4 A. I am at Maryland General Hospital, 827
5 Linden Avenue, Baltimore, Maryland 21201.

6 Q. Did you bring a CV with you today that we
7 can reference?

8 A. Yes, I did.

9 Q. We had originally arranged to take this
10 deposition at that office address. Why did that
11 change, anyway?

12 A. Well, I never do depositions in my office
13 at the hospital. Secondly, I am usually not in my
14 clinic area where my office is, on Fridays.

15 Q. Okay. So it was a matter of realizing we
16 needed to find a place for this, huh?

17 A. That is correct.

18 Q. Is it common for you to do these at the
19 airport like this?

20 A. I will do them wherever you want to do
21 them. If we had done this on a Monday afternoon, I

1 would ask to do it downtown in the reporter's
2 office because I work at an inner city hospital.

3 Q. What hospital is that?

4 A. Maryland General Hospital.

5 Q. Where do you have privileges to practice
6 now?

7 A. Just at Maryland General Hospital,
8 although I still believe my privileges at Sinai
9 Hospital of Baltimore are intact because I still
10 get mail from them.

11 Q. What is your current affiliation with
12 Johns Hopkins?

13 A. I am an assistant professor.

14 Q. And how long have you held that position?

15 A. Since 1990.

16 Q. Do you actually teach courses at Johns
17 Hopkins?

18 A. Rarely. I am asked to teach physical
19 diagnosis every few years, but other than that, I
20 am based off-campus.

21 Q. When was the last time you ever actually

1 taught a course at the School of Medicine?

2 A. It is not a course. It is just going
3 down there occasionally to teach a class in
4 physical diagnosis.

5 Q. Well, you are not actually on the faculty
6 at Hopkins, then, are you?

7 A. Yes, I am.

8 Q. Well, when did you last teach at Johns
9 Hopkins?

10 A. I have never officially taught there
11 except for occasionally being asked to teach
12 physical diagnosis.

13 Q. When did you last teach physical
14 diagnosis?

15 A. About three years ago I did one class in
16 physical diagnosis. I have not been asked since.

17 Q. When you say one class, does that mean go
18 to a one-hour or two-hour session, or teach a
19 quarter or semester?

20 A. No, it was just a one-day session.

21 Q. And that was in what department?

1 A. The Department of Obstetrics and
2 Gynecology. It was basically the same thing when I
3 was at Case Western. I was an assistant professor
4 at Case Western but I never taught any classes
5 there except for maybe occasional physical
6 diagnosis. I was based strictly at Cleveland
7 Metropolitan General Hospital.

8 Q. Okay. When were you first contacted to
9 consult in this case?

10 A. It was probably just before the letter I
11 have written on February 26, 1999. I don't have
12 the correspondence from that, when material was
13 initially sent.

14 Q. Who were you contacted by?

15 A. I was probably contacted by
16 Mr. Mishkind concerning the case. He ran it by me
17 and I would have said, okay, send it down to me and
18 I will take a look at it.

19 Q. You don't believe you consulted with him
20 before the beginning of this year, then?

21 A. I don't know exactly what date that was,

1 because I don't have that letter of correspondence
2 in my file.

3 Q. Well, could it have been as long as a
4 year before that report?

5 A. It is possible.

6 Q. How would you determine when you were
7 first contacted?

8 A. If I have that letter of communication I
9 could tell you exactly.

10 Q. Did you bring your entire file with you
11 today?

12 A. Yes, sir, I did.

13 Q. So why wouldn't that letter of
14 correspondence be with you?

15 A. Well, what often happens is when I
16 dictate a letter to my outside secretary, in the
17 envelope I put tape and a correspondence so she can
18 get addresses off there, and for inexplicable
19 reasons, the letter never made it back into the
20 file.

21 Q. So you have no record in the file you

1 brought with you as to when you were first
2 contacted?

3 A. No, sir, I do not.

4 Q. Have you ever met the Einarsens?

5 A. No, I have not.

6 Q. Never examined the child?

7 A. No, I have not.

8 Q. Have you ever talked to Mr. Einarsen
9 himself?

10 A. No, I have not.

11 Q. Or to Dr. Biats or Dr. Jackson?

12 A. No, I have not.

13 Q. Can you tell me what information you
14 received and what you have reviewed in connection
15 with this case.

16 A. I have reviewed the medical records and
17 the neonatal records. I have reviewed the office
18 records of the obstetrician, and I have reviewed
19 Dr. Biats' deposition. I have reviewed
20 Dr. Jackson's deposition, and I have reviewed
21 Mr. And Mrs. Einarsen's deposition.

Q. Have you reviewed any of the depositions
2 of the nurses?

A. We discussed them today. They are going
4 to be given to me to read. I have not reviewed
5 them to date.

Q. When you say you have reviewed the
7 medical records, what records are you talking
8 about?

A. I have the office records of
10 Dr. Jackson, I have Cuyahoga Falls, the obstetrical
11 records.

Q. From what time period?

A. From 12/10 to 12/13, and I believe I have
14 the neonatal records. And then I have some
15 follow-up records on the baby.

Q. You have a notebook with you there that
17 has the records separated by a blue page
18 divider. Did you do that or was that the way it
19 was provided to you?

A. That was the way it was provided to
21 me.

1 Q. Who put the pink stickers on it?

2 A. I did, sir.

3 Q. Is there any handwriting on any of those
4 records that you have added?

5 A. No, sir.

6 Q. Have you prepared anything in writing?

7 A. Well, sir, these are the notes I took
8 when I originally reviewed the records.

9 Q. So we have a one-page yellow sheet with
10 about eight or ten pieces of information on it.

11 A. And then, of course, the letter that I
12 think you have.

13 Q. Right.

14 A. And here, someplace in here is a
15 follow-up on the baby, its current status, from Dr.
16 Buckley.

17 Q. That is the report dated June 25 of '99?

18 A. Correct.

19 Q. Okay. I have not read this report. Is
20 there anything -- have you read it?

21 A. Other than the baby still has a

1 disability, that is basically what it says. It
2 confirms that it is an ongoing problem.

3 Q. Is there anything that you observed in
4 this report that is material to the opinions that
5 you have issued in your report of February 26?

6 A. No, sir, because I will not be talking
7 about the baby's future problems.

8 MR. MANNION: I did not hear the
9 question.

10 MR. HANNA: I asked him whether or not
11 there was anything in Dr. Buckley's report that is
12 material to any of his opinions in this case.

13 MR. MANNION: Thank you.

14 A. No, sir, I will not be testifying about
15 what the baby's ultimate prognosis or disabilities
16 are.

17 Q. What is in the other notebook?

18 A. The other notebook has two depositions
19 from Mr. and Mrs. Einarsen.

20 Q. We have worked our way through the
21 stacks. These are the doctors' depositions here?

1 A. Yes, sir.

2 Q. What do we have left here? You have Dr.
3 O'Shaughnessy's report?

4 A. Correct, which I just saw today, and this
5 is Precis '98 Obstetrics, page 95 and 96, on
6 brachial plexus injuries and causation.

7 Q. Tell me this again. Is this an excerpt
8 from a textbook?

9 A. Yes, sir. ACOG publishes a teaching
10 textbook for obstetrics and gynecology. It used to
11 be one volume. They have now divided it into five
12 volumes, and in Precis '98, in the obstetrical
13 textbook, is a section on brachial plexus injuries.
14 And their basic approach now is that these are
15 traction injuries and they are from excessive
16 traction. They are traction injuries whether you
17 get them at cesarean section, breech delivery or
18 head-first or vertex deliveries. And they have
19 dropped any mention of in utero theoretic causes of
20 brachial plexus injuries.

21 Q. I don't understand, what is the name of

1 the text?

2 A. The textbook is called Precis,
3 P-R-E-C-I-S, and it is published every four years
4 by the ACOG and this is the '98 edition or the
5 latest one.

6 Q. Do we know who authored this section?

7 A. We don't know who authored the
8 section. They are not titled.

9 Q. What is the date of this particular
10 publication, do we know?

11 A. It is 1998. I don't, it might be on the
12 second page. I just believe it says 1998. And
13 those statements are not dissimilar to Williams,
14 20th edition, which states that these are now,
15 these are traction injuries.

16 Q. Well, that is not a revelation, is it?
17 You can't injure the brachial plexus without
18 traction, right?

19 A. That is correct. I was taught that when
20 I was in residency in the '60s, that they are
21 traction injuries, and even then we did not believe

1 in the in utero injury.

2 Q. Well, the question is how is the traction
3 applied?

4 A. The traction is applied by the delivering
5 doctor, or the health care worker, we should say
6 today.

7 Q. Is there any other documentation that you
8 reviewed in connection with this case?

9 A. No, sir.

10 MR. MISHKIND: Just one clarification. I
11 think, in fact, I know that I sent him
12 Dr. DeVoe's report. It is not here. I didn't
13 bring a copy of it with me and I may even be
14 incorrect in terms of having sent it to him, but I
15 have a recollection of doing so. But that is the
16 only other item, I think, that might be hanging out
17 there.

18 Q. Is there any other documentation that
19 comprises your files and records in this case that
20 you have not brought with you?

21 A. No, sir.

1 Q. What about billings?

2 A. I do not have billings.

3 Q. But you have billed for services in case?

4 A. Yes, sir, I have.

5 Q. Do you know how much you have billed to
6 date?

7 A. I can't tell you exactly. My average
8 review of a case is about two and a half to three
9 hours or from two to three hours, and then, of
10 course --

11 MR. MANNION: I missed that question
12 again.

13 MR. HANNA: I asked him what he has
14 billed to date on the case.

15 A. My average review of a case is about two
16 to three hours, and then obviously I had to dictate
17 a letter and I had to read some depositions.

18 Q. And where are your billing records
19 maintained?

20 A. I do my own billing records. I do my own
21 billing and I send the bill to the attorney, and

1 when it is paid, I bucket the bill.

2 Q. So you have no record of your billing at
3 this point?

4 A. No, I do not.

5 Q. Would you outline for me your opinions in
6 this case, the opinions you expect to testify to.

7 MR. MISHKIND: You are talking about your
8 client? Let me object only because there are two
9 defendants and it is such a broad question. I will
10 let him answer it, but to just say tell me what
11 your opinions are without giving him specific
12 questions, I think, is awfully vague and not a
13 proper question.

14 Q. Well, I represent Dr. Biats and Cuyahoga
1.5 Falls General Hospital. Let's start there. Are
16 you prepared to render any opinions critical of the
17 care provided by the hospital or Dr. Biats?

18 A. Yes, sir, I am.

19 Q. Tell me what those are.

20 A. I believe that Dr. Biats failed to meet
21 standards of care in the management of shoulder

1 dystocia by applying excessive traction during the
2 delivery process when he was either diagnosing the
3 shoulder dystocia or freeing, attempting to free
4 the shoulders, and this excess traction fails to
5 meet standards of care and directly caused the
6 brachial plexus injury.

7 I fault the hospital potentially for
8 not having supervision present. However, this is a
9 family practice residency, and they go under
10 different guidelines than does an obstetrical
11 program. Obstetrics and gynecology requires
12 in-house, 24-hour in-house supervision of all
13 residents. Family practice does not require that.
14 I don't know that they have an obstetrical
15 residency program in this program, that is why I
16 have had to take a look at those protocols for
17 supervision of residents on the labor force.
18 Some hospitals have put in ACOG guidelines in terms
19 of supervision; other hospitals' services are so
20 small, and predominantly a private service, that
21 they haven't put it in.

1 My position is if the doctor had
2 supervision, more probably than not excess traction
3 would not have been applied because somebody more
4 experienced in shoulder dystocia would have been in
5 the room. But that is strictly the hospital's
6 policy on that, and as I say, that is family
7 practice. I could be very strong if it were an
8 obstetrical program because it is mandatory that we
9 have 24-hour supervision.

10 Q. Mandatory under what?

11 A. The RRC, Residency Review Committee
12 guidelines. It began in 1991. Before then we
13 operated very similar to this, where all call by
14 attendings was taken at home and when the residents
15 needed you for a service case, the attending of the
16 day came in, and in private cases they came in as
17 they saw it was necessary, as happened in this
18 case.

19 But those would be my basic criticisms
20 of the doctor, and since there was no supervision
21 present, the doctor is totally responsible for his

1 actions in the delivery room.

2 Q. Do you have any other criticisms of
3 either Dr. Biats or the hospital?

4 A. That would basically be it, sir.

5 MR. MANNION: I missed that question as
6 well.

7 MR. HANNA: Does he have any other
8 criticisms of Dr. Biats and the hospital.

9 A. That would basically be it, sir.

10 Q. Do you have any criticisms of
11 Dr. Jackson's care in this case?

12 A. Yes, sir, I do. I have some questions
13 about the care and some criticisms.

14 My primary concern, of course, is the
15 last visit that the patient made that evening. The
16 records appear to be altered in that records that
17 were sent to the hospital after the delivery itself
18 do not contain any mention of a vaginal exam. The
19 records subsequent to that from the office show
20 that a vaginal exam has been recorded. That
21 obviously would fail to meet standard of care, to

1 make a late entry -- one, not mark it, and two, to
2 even make that kind of late entry. An office note
3 should be a contemporaneous note. That would put
4 the records of Dr. Jackson in question because they
5 are by definition altered records.

6 The question is if she were in labor
7 and a vaginal exam was done, it may very well have
8 shown that she was five centimeters or so, she
9 would have been sent to the hospital, and a doctor
10 would have followed behind, knowing that she is
11 already in active labor. We clearly don't know
12 what went on in that visit.

13 The other question I have is if the
14 doctor said he would meet her at the hospital, then
15 it is reasonable to follow through on a promise you
16 make to a patient. I think a patient has a right
17 to be correctly informed when they call the doctor,
18 and if you expect the resident to check them and
19 call you, you must tell a patient that. But if you
20 tell a patient that you are going to meet them at
21 the hospital, then clearly you must follow through

1 on a promise you have made to the patient. Had he,
2 obviously, met them at the hospital, he would have
3 appropriately supervised the delivery, or had he
4 diagnosed labor in his office visit and suspected
5 labor and sent the patient to the hospital, he
6 would have been there for delivery, and more
7 probably than not, the delivery would have been
8 handled in an appropriate manner without excess
9 traction because of much more experience at the
10 attending level.

11 The third criticism I would have is
12 that if the patient reported decreased fetal
13 movement, it was mandatory that she be sent to the
14 hospital that evening for a nonstress test or
15 biophysical profile or some test for fetal
16 well-being. It was totally inappropriate to say
17 wait for the next day. Had she been sent to the
18 hospital for a nonstress test, more probably than
19 not labor would have been diagnosed and, indeed,
20 the patient would have been kept in the hospital,
21 the doctor would have been notified in a timely

1 manner and would have attended the delivery, and
2 more probably than not an appropriate management of
3 shoulder dystocia would have occurred.

4 Q. Do you have any other criticisms of
5 Dr. Jackson?

6 A. No, sir, I do not.

7 Q. Did you have an opportunity to review the
8 records regarding his prenatal care of the patient?

9 A. Yes, sir, I have.

10 Q. Other than at this point in time, the day
11 of her delivery, do you have any criticism of his
12 care?

13 A. No, sir, I do not.

14 Q. Do you have an opinion as to whether or
15 not this patient was a gestational diabetic?

16 A. By definition she was not a gestational
17 diabetic.

18 MR. MANNION: What was the question?

19 MR. HANNA: I asked whether he had an
20 opinion as to whether she was a gestational
21 diabetic.

1 A. And by definition she was not a
2 gestational diabetic.

3 Q. By what definition?

4 A. Where you need two abnormal values out of
5 the four. So she does not meet criteria. And the
6 macrosomic warnings from an article from about ten
7 years ago in the New England Journal of Medicine
8 have not, for one abnormal value, have not been
9 picked up by standard textbooks, nor has another
10 investigator confirmed that one abnormal value
11 portends the danger, same dangers as two abnormal
12 values.

13 Q. In your review of this case did you
14 formulate any opinions that were critical of any
15 activities or involvement --

16 MR. MANNION: Sorry, I didn't hear that
17 question either, Dave.

18 MR. HANNA: You better listen.

19 MR. MANNION: I am listening.

20 MR. HANNA: You know what, I am sorry,
21 Tom, but this phone they gave us, I mean, they got

1 this at Kmart this afternoon.

2 MR. MANNION: Now when you are talking I
3 can hear you perfectly clear.

4 MR. HANNA: All right.

5 Q. My question was whether or not, based
6 upon your review, you were critical of the care or
7 conduct of anyone who was not a party to this
8 lawsuit?

9 A. No, sir, I am not.

10 Q. What experience have you had with the
11 residency programs of a osteopathic hospital?

12 A. I have taught osteopaths who are in
13 family practice at Metro. But I have had no
14 experience of osteopathic residency programs. They
15 are run basically very similar to M.D. programs.

16 Q. Are you a member of the American
17 Osteopathic Association?

18 A. No, sir, I am not.

19 Q. Are you familiar with their guidelines
20 for residency programs?

21 A. I have read some of them for obstetrics

1 but not for family practice.

2 Q. I don't -- Dr. Biats was an obstetrical
3 resident, not a family practice resident, okay?

4 A. Okay, fair enough

5 Q. Have you ever been to Cuyahoga Falls
6 General Hospital?

7 A. No.

8 Q. Do you know how many beds there are in
9 that facility?

10 A. No, sir, I do not.

11 Q. Obviously, depending upon the size of the
12 institution where the residency program is in
13 place, that will affect the number of physicians on
14 staff, for example?

15 A. That is correct.

16 Q. It will affect the number of supervising
17 physicians in the program?

18 A. That is correct

19 Q. And when you are talking about the
20 supervision of residents, let's talk about that for
21 a minute.

1 First of all, would you agree that
2 under the standards for a residency program, the
3 degree of supervision is in part dependent upon the
4 extent of the training and education of the
5 resident?

6 A. On what you do with them in the hospital.
7 It has nothing to do with the guidelines for
8 in-house supervision.

9 Q. What I meant, maybe that is not very
10 well-articulated, but a first-year resident, for
11 example, requires more supervision than does a
12 second or third-year resident, typically?

13 A. That is correct.

14 Q. And guidelines defining residency
15 programs specifically discuss the fact that whether
16 you are a first, second, third or fourth-year
17 resident, the extent of supervision depends upon
18 your experience and skill?

19 A. Well, the RRC for M.D.s does discuss
20 that. They do it in terms of guidelines for how
21 you run your program, but in terms of in-house

1 supervision for operative procedures, no, they feel
2 that all residents must be supervised.

3 Q. Under what -- well, I am not saying they
4 are not supervised. I am talking about the extent
5 of supervision, hands-on, presence, that sort of
6 thing.

7 A. I think each doctor who takes calls does
8 it a little different.

9 Q. Okay, and that is basically my point.

10 Now, typically, do each of the
11 attending physicians on staff serve as supervisory
12 physicians for residents?

13 A. It is different in every hospital

14 Q. But there is nothing inappropriate with
15 that, is there?

16 A. No, there is not.

17 Q. Is there anything inappropriate from your
18 experience with a resident receiving, examining a
19 patient and assisting with that delivery,
20 anticipating the arrival of the attending?

21 A. Well, I have no problem with that. The

1 problem I have is if they are following, if the
2 osteopathic RRC has adopted the M.D. RRC
3 regulations which says you must have an in-house
4 attending, and the hospital did not have an
5 in-house attending there, then the hospital is not
6 following the mandated guidelines of the
7 osteopathic RRC in having an appropriate supervisor
8 aboard.

9 See, what happens normally, for
10 example, when we have a hospital that has a mix of
11 private patients and service patients, although the
12 word "service patient" is becoming a no-no now
13 where they are HMO patients or managed in an HMO
14 that does indigent care; however, if a private
15 attending has a patient there who is about to
16 deliver and they can't find the private attending
17 or the private attending is delayed getting in,
18 then the residents will turn to the in-house
19 attending to come supervise the delivery.

20 Q. Well, and what does that entail? Does
21 that entail notifying the attending that is in the

1 house and explaining the situation with the
2 patient?

3 A. It entails a phone call to the in-house
4 attending saying we have got a patient, we need
5 your help now.

6 Q. Well, did this patient require the help
7 of an in-house attending prior to the dystocia?

8 A. If an in-house attending were available,
9 the in-house attending should have been notified
10 that the private clinician has not arrived yet and
11 the delivery should be supervised by an attending.

12 Q. Well, maybe -- is your testimony that
13 when it comes to standard of care, that in every
14 institution that you are familiar with, if an
15 attending's patient presents and the attending
16 physician is on the way, that it is improper for a
17 senior attending, or senior resident in obstetrics
18 to receive and examine the patient and attend that
19 delivery, which initially does not involve the
20 presentation of a complication, until the arrival
21 of the attending?

1 A. I really don't understand the, the end of
2 the question got me confused.

3 Q. I guess by my layman's knowledge or
4 experience of seeing and hearing what is going on
5 in obstetrical practice in a hospital, if an
6 attending, if a patient is presenting in labor and
7 the hospital knows that the attending is on their
8 way to the institution, that it is certainly
9 appropriate for a senior resident to examine the
10 patient.

11 A. Yes, that is correct. Go ahead.

12 Q. And to attend the situation, absent the
13 identification of an emergency or a problem, to
14 attend to that patient, anticipating the arrival of
15 the attending?

16 A. That is correct.

17 Q. Now, the standard of care also is that
18 there be an attending in the house; is that what
19 you are saying?

20 A. For an M.D. obstetrical program. I would
21 imagine that the D.O. programs adopt it. I am not

1 sure on that.

2 Q. But under that scenario, with the
3 attending on their way and without a complication
4 evident, which in this case, dystocia does not
5 announce itself in advance, does it?

6 A. Correct, but delivery itself should mean
7 that the resident notifies the in-house attending
8 if the private clinician isn't there yet. It think
9 it is a moot point because there is no evidence
10 that Dr. Biats called for help if it was available
11 on the floor, in other words, if they had an
12 in-house attending and he did not call the in-house
13 attending and notify him that, come supervise me, I
14 am going to do a delivery for Dr. Jackson who isn't
15 here yet. But that is a moot point. If you don't
16 call, then you are responsible for the delivery
17 itself.

18 Q. Well, my question to you is if there was
19 an attending in the house, what would have been,
20 are you saying that it would be a deviation from
21 standard of care for the senior resident to attend

1 to this patient until Dr. Jackson's arrival?

2 A. No. He should attend the patient; he
3 just should notify the in-house attending that
4 there is a private patient delivering, and usually
5 they want us in the room so that the patient is
6 covered by an attending also, since that is what
7 they were paying for. But as I say, it is a moot
8 point. I was faulting the hospital if they didn't
9 have in-house attendings and it was required that
10 they have in-house attendings and --

11 Q. That is the only criticism of the
12 hospital?

13 A. That is correct.

14 Q. So if they had an in-house attending
15 pursuant to requirements, you are not criticizing
16 the hospital's function in this case?

17 A. That is correct. In other words, it is a
18 resident's responsibility to call the doctor and
19 say, "help."

20 Q. Was this baby macrosomic?

21 A. Depends on whose definition you use.

1 Q. Well, yours.

2 A. It is by definition macrosomic, because
3 greater than 4,000 grams defines macrosomia.
4 However, some people will define it as 4500 grams
5 for a nondiabetic and 4,000 grams for a diabetic.
6 It is a large-for-dates baby and one must be
7 cautious in the management of such a baby, and the
8 primary thing is to avoid mid-pelvic delivery by
9 vacuum or forceps, but that is not germane to this
10 case. And it was appropriate to do a vaginal
11 delivery for this baby.

12 Q. All right, now, this child experienced
13 shoulder dystocia --

14 A. Correct.

15 Q. -- during the delivery, and I am
16 assuming, am I correct that Dr. Biats did not cause
17 the shoulder dystocia?

18 A. That is correct.

19 Q. That was a function of the birth process?

20 A. Correct.

21 MR. MANNION: I missed the question.

1 MR. HANNA: That is not a function of the
2 birth process -- that is a function of the birth
3 process?

4 A. That is correct.

5 Q. Am I correct that a shoulder dystocia is
6 viewed as an obstetrical emergency?

7 A. That is also correct.

8 Q. And that shoulder dystocia is one of the
9 most dangerous complications you will experience in
10 a vaginal delivery?

11 A. Not one of the most, but it has its
12 dangers.

13 Q. Well, it has some very serious dangers,
14 does it not?

15 A. Correct.

16 Q. If that dystocia is not reduced, the
17 child may, and in all probability would, die,
18 wouldn't it?

19 A. You have about five minutes to do your
20 reduction. Indeed, after five minutes, the baby is
21 at risk for brain damage or death. So you look for

1 a five-minute-head-to-body time.

2 Q. And where is the definition of five
3 minutes or where would this standard of five
4 minutes be defined?

5 A. That really comes from the monkey
6 data. That is dating back to the '60s. In the
7 '60s, with the monkey data, they occluded monkey
8 feti's cords and they found that if you deligated
9 the cord within ten minutes, none of the monkeys
10 were brain-damaged as far as we could tell, and
11 after ten minutes, there was progressive damage.

12 Basically, what the five-minute rule
13 does is sort of halve the data for safety. What
14 one assumes is that when you have encountered
15 shoulder dystocia, head out, that there is
16 impingement of the cord, and traditionally,
17 for example, in utero, if we get a profound
18 bradycardia, which is essentially like a cord
19 impingement, you have five minutes to attempt to
20 resolve it by mechanical means, by external means,
21 and if you can't resolve it, then you have to move

1 towards prompt delivery.

2 Q. Is there a written standard somewhere
3 that guides obstetricians and gynecologists, that
4 sets this five-minute time limit?

5 A. I would have to look to see where that
6 five minutes comes from, and we have been using it
7 for 35 years now.

8 Q. If I follow what is happening, what is
9 actually happening is that the baby is being
10 compressed in the vaginal canal during shoulder
11 dystocia?

12 A. Correct, the cord is being compressed.

13 Q. And the point is if you do not reduce it,
14 that will progress to asphyxia?

15 A. Correct.

16 Q. That can result in brain damage?

17 A. Correct.

18 Q. And can result in death?

19 A. Correct.

20 Q. That is the reason for the description of
21 this emergency as being life-threatening?

1 A. Correct.

2 Q. The measures that obstetricians take to
3 attempt to reduce a shoulder dystocia include what?

4 A. Include suprapubic pressure, include the
5 McRoberts maneuver, include the Woods maneuver or
6 Woods screw maneuver, and the posterior arm
7 maneuver. In this particular case three maneuvers
8 were required, the third maneuver was successful,
9 which was the posterior arm maneuver.

10 Q. The shoulder dystocia must be reduced to
11 save the child's life?

12 A. That is correct.

13 Q. If McRoberts maneuver and suprapubic
14 pressure do not work, you say you try the Woods
15 screw maneuver?

16 A. Or the posterior arm maneuver.

17 Q. On occasion, to reduce a dystocia, is it
18 necessary to fracture the clavicle of the child?

19 A. You can attempt to do that. I have never
20 been successful in fracturing a clavicle that I
21 wanted to fracture, and I have fractured numerous

1 clavicles that I never wanted to fracture.

2 Q. All of which meets standard of care in an
3 effort to save the baby's life?

4 A. Oh, yes.

5 Q. How about fracturing the humerus?

6 A. That is part of the posterior arm
7 maneuver and often occurs inadvertently as an
8 acceptable injury and a known complication from a
9 posterior arm maneuver, and it didn't happen in
10 this case.

11 Q. Based upon your review of records, do you
12 have an opinion as to how long it took
13 Dr. Biats to reduce this shoulder dystocia?

14 A. We have a two-minute head-to-body time.

15 Q. And you base that on what?

16 A. Times on the chart, plus, I believe,
17 deposition.

18 Q. And what do you mean by the chart, times,
19 on what chart?

20 A. We have a time when the head is out and a
21 time of delivery, I think 36 and 38, if I remember

1 correctly.

2 MR. MISHKIND: That is correct.

3 A. 2338 was the delivery, and someplace I
4 have 2336, head out. On the nurse's notes. So it
5 was a very short head-to-body time.

6 Q. So you are referring to the handwritten
7 notes reconstructing time by one of the attending
8 nurses?

9 A. Correct.

10 Q. Is that where that came from?

11 A. Correct.

12 Q. And is a two-minute time period, from a
13 standard of care perspective, an acceptable time
14 period within which to resolve the dystocia?

15 A. Very acceptable, very short, very good
16 maneuvering.

17 Q. This child had a nuchal cord?

18 A. Correct.

19 Q. Wrapped tight around the neck?

20 A. Well, it was wrapped around the neck.
21 They often get tighter as the baby comes down.

1 It is a given.

2 Q. What was the condition of the child at
3 delivery?

4 A. Excellent.

5 Q. What was the child's Apgar?

6 A. I am talking about the cord pH. That is
7 the real measure. The Apgars show that the baby
8 had a 2-minute Apgar of 1, 6 at 5 minutes, 9 at 3
9 minutes. It was probably low from the baby being
10 somewhat beaten up from the delivery process, but
11 the cord pH is absolutely at a high-normal level
12 for a delivery, which tells you how long the
13 head-to-body time really was. It was minimal.

14 Q. The baby was not breathing spontaneously?

15 A. That is correct.

16 Q. Required resuscitation?

17 A. That is correct.

18 Q. Had no spontaneous movement?

19 A. Correct.

20 Q. Can you tell from any information you
21 have how much longer the child could have remained

1 in that position before suffering an asphyxic-type
2 injury?

3 A. Probably another ten minutes or so, at
4 least.

5 Q. And you base that on what?

6 A. The cord pH.

7 Q. Would there be any way for Dr. Biats or
8 an attending to know that?

9 A. No, that is why we use the five-minute
10 rule.

11 Q. What relationship did the nuchal cord
12 have to the condition of the baby at delivery?

13 A. Probably none at all.

14 Q. Am I correct in my understanding of the
15 records in this that this baby, other than the
16 brachial plexus injury, suffered no other injury
17 that can occur from a shoulder dystocia? No
18 asphyxic-type injury, it obviously survived, no
19 brain injury?

20 A. That is correct.

21 Q. Would it be fair to characterize the

1 techniques used to deliver and reduce a shoulder
2 dystocia as life-saving?

3 A. Yes, sir, they can be described as
4 life-saving.

5 Q. What was the position of this baby in the
6 vaginal canal at the time of the shoulder dystocia?

7 A. Well, prior to delivery the baby was left
8 occiput anterior, so when the shoulder dystocia was
9 encountered the baby was probably facing the
10 mother's right side with the occiput to the
11 mother's left, with the right arm, I believe, under
12 the pubic symphysis and the left -- I mean the
13 right shoulder above the pubic symphysis and the
14 left shoulder above the sacral promontory.

15 Q. And in layman's terms that means if mom
16 is laying on her back, the right shoulder was hung
17 up on her pubic bone?

18 A. Correct.

19 Q. And the baby then would effectively be on
20 its side, so to speak?

21 A. Correct.

1 Q. With its head facing to her right?

2 A. Correct.

3 Q. After the posterior shoulder is reduced
4 such that the body is now delivered, what position
5 is the baby going to be in?

6 A. The baby is out at that point.

7 Q. Well, not completely out.

8 A. The baby remains in relatively the same
9 position as it comes squirting out. Sometimes
10 there is a slight rotation more towards the stomach
11 down and backside up. Depends on the design of the
12 mother's pelvis.

13 Q. Is there a point in this delivery where
14 the baby's head is going to be, the body is going
15 to be turned such that the baby's head is looking
16 straight up at the ceiling?

17 A. Should not be, but it could happen.

18 Q. How would that happen?

19 A. If you are twisting the baby as the baby
20 is delivering, you can turn it so that it would be
21 facing up. Statistically, they usually stay facing

1 the right side, as the baby was, and they come
2 squirting out. They actually, you have to be very
3 careful not to drop a baby once you free up that
4 posterior shoulder. They usually come out very
5 rapidly at that point.

6 Q. There is not going to be a position of
7 this baby's head facing straight up to the ceiling
8 that is part of the reduction of the shoulder
9 dystocia, is there?

10 A. Well, it could be, if you do Woods and
11 you run a 360 degrees, yes.

12 Q. But by the time you get to that point,
13 you have actually reduced the shoulder dystocia?

14 A. That is correct, but the baby may be
15 facing up as you do that.

16 Q. In Mr. Einarsen's deposition, he
17 describes events during this delivery, specifically
18 he describes some of the conduct, some of Dr.
19 Biats' delivery techniques as he viewed them. Is
20 your opinion in this case based upon Mr. Einarsen's
21 description of events?

1 A. No, it is not.

2 Q. Why not?

3 A. Well, first of all, I never regard lay
4 opinions as part of my review. That is up to a
5 jury to decide, in terms of the validity of those
6 observations. They are not trained observers in
7 the delivery room. But more probably than not,
8 excess traction was used because the baby has the
9 injury.

10 Q. Would you agree with me that it is common
11 for patients or lay people to be confused about
12 things that they are observing in the delivery
13 room?

14 A. That is correct.

15 MR. MANNION: I didn't hear the question
16 or answer.

17 MR. HANNA: Would you read it back.

18 (The record was read by the reporter.)

19 MR. MANNION: Thank you.

20 Q. Would you agree with me that what he
21 described in his deposition, anyway, is not the

1 lateral traction that you are talking about that
2 causes brachial plexus injuries?

3 A. Well, all he did, all I remember is him
4 talking about traction or pulling on the head, but
5 it wouldn't matter because I am not regarding
6 that -- whether I read it or not wouldn't affect my
7 interpretation of the facts of this case.

8 Q. But you remember what he said
9 sufficiently to have an opinion as to whether he is
10 describing lateral traction that could result in a
11 brachial plexus injury?

12 A. I don't remember, sir.

13 Q. What is the, we have talked about it, I
14 want to make sure we are talking about the same
15 thing. What is the McRoberts maneuver?

16 A. McRoberts is where you flex the baby --
17 not the baby -- the mother's legs back against her
18 chest wall. It is a painful position. It usually
19 requires two health care workers, but in some
20 delivery rooms the father's help is enlisted, and
21 whether I believe that is good or bad, it is done.

1 Q. As I understand that maneuver, it is a
2 matter of picking the legs, putting the legs out
3 and up, which is intended to alter the position of
4 the pelvis relative to the vaginal canal?

5 A. That is what it is supposed to do.

6 Q. And to facilitate the release of the
7 shoulder and the delivery of the baby?

8 A. Correct.

9 Q. Now, the McRoberts position is going to
10 be different, a little bit different for every
11 patient; isn't that right? Because of their
12 anatomical differences?

13 A. That is correct.

14 Q. Would it be fair to say that in larger
15 women, that you typically cannot move their knees
16 back as far as thinner women?

17 A. That is also correct.

18 Q. Do you have any reason to believe that
19 this patient was not placed in the McRoberts
20 maneuver?

21 A. I am not critical of their employment or

1 methodology for the McRoberts maneuver.

2 Q. Dr. Biats did not do an episiotomy in
3 this case; are you critical of that?

4 A. No, I am not.

5 Q. He described and explained that when he
6 observed the shoulder dystocia, that he examined
7 her and felt that there was sufficient posterior
8 space to reduce this?

9 A. If he were able to get it into a
10 posterior arm maneuver, he obviously had enough
11 space to get through. The reason for an episiotomy
12 is to get your hand into the lower uterine segment
13 to either do the Woods or the posterior arm, so
14 obviously there was enough perineal relaxation so
15 that the maneuver could be adequately done.

16 Q. Tell me the basis of your opinion that
17 Dr. Biats applied excessive lateral traction.

18 A. The fact that the baby has a brachial
19 plexus injury.

20 Q. Is there any other basis for that
21 opinion?

1 A. No, sir.

2 Q. There is nothing in any record or
3 anything that Dr. Biats said that leads you to
4 believe he applied excessive lateral traction?

5 A. No, sir. I only reviewed one record that
6 said, "I did employ excessive lateral traction,"
7 and I defended that document.

8 Q. Is it possible for a brachial plexus
9 injury to occur in a vaginal delivery with shoulder
10 dystocia without a physician applying excessive
11 lateral traction?

12 A. In all probability, no.

13 Q. Does it occur in vaginal deliveries
14 without a shoulder dystocia being encountered?

15 A. Yes, it can.

16 Q. Does it occur in a certain percentage of
17 cases of cesarean deliveries?

18 A. Yes, it does.

19 Q. How does it happen in a cesarean
20 delivery?

21 A. Same way. It is traction. Often, there

1 is a prolonged second stage with the head wedged
2 deep in the pelvis, and during the abdominal
3 delivery process, the doctor attempts to bring the
4 head out of the pelvis by pulling on the shoulder
5 area of the baby. And what you are supposed to do
6 is elevate the head vaginally from below or you
7 will get a brachial plexus injury, and that is why
8 clearly ACOG now says if you get them in cesarean
9 section, these are traction injuries.

10 Q. Well, I just read quickly what you showed
11 me, and that is that it is a traction injury. Tell
12 me what traction is, that injures the brachial
13 plexus on the right side.

14 A. Well, the traction is putting the
15 brachial plexus on stretch, and in shoulder
16 dystocia the shoulder itself is wedged in position,
17 and by putting lateral traction on the head and
18 putting the brachial plexus on stretch, it is
19 injured or torn or evulsed. Now, in cesarean
20 section it is an opposite mechanism.
21 The head itself is fixed in position and the

1 shoulders may be tugged upon, putting the brachial
2 plexus on stretch.

3 Q. Now, show me what lateral traction is
4 relative to your right shoulder. Is it pulling
5 your head to one side?

6 A. It is pulling your head to the opposite
7 side.

8 Q. And whatever the force is, it is a force
9 somewhere that separates and moves the head in the
10 opposite direction of the shoulder?

11 A. That is correct.

12 Q. And if it is lined up right, it will
13 stretch the brachial plexus?

14 A. Correct

15 Q. Now --

16 A. For example, a forceps pull may be in the
17 70-pound range yet does not cause a brachial plexus
18 injury because it is axis traction. You may
19 disrupt the spine but you don't put the brachial
20 plexus on stretch, whereas this is a nonaxial
21 stretch.

1 Q. Are there instances in which it is within
2 the standard of care for the obstetrician to apply
3 first lateral traction?

4 A. Well, you may always apply gentle lateral
5 traction and particularly that is when you may
6 diagnose the shoulder dystocia. Either you see the
7 turtle sign, which was seen in this case, or you
8 attempt to apply gentle downward lateral traction,
9 and if the shoulders don't move, you immediately
10 make the diagnosis of shoulder dystocia and then
11 switch to your maneuvers.

12 Q. And are there instances in which, to save
13 the life of the child or to avoid asphyxic-type
14 injuries, that lateral traction is applied
15 intentionally?

16 A. Yes, and that is exactly the case that I
17 told you that I defended. The doctor had written
18 that she had gone through all her maneuvers twice.
19 They all failed, all four standard maneuvers, and
20 then as a life-saving mechanism, she employed
21 excessive downward traction, I believe also

1 McRoberts and suprapubic at the same time, and
2 delivered the baby with a brachial plexus injury.
3 And to me that was well-documented and an
4 acceptable complication, given the circumstances.

5 Q. And at what point in time after diagnosis
6 was that done?

7 A. It was around six minutes or so of head
8 out, body in.

9 Q. Am I correct from our previous
10 discussion, though, that you do not know the extent
11 of asphyxia to the child during the process of the
12 delivery?

13 A. Well, you assume that you have cord
14 occlusion, it is always an assumption, and I have
15 not documented this but you assume if you did
16 listen, there is a bradycardia. Not all babies
17 will show that, but you make that assumption.

18 Q. What, if any, significance is it to this
19 case that this mother presented within about ten
20 minutes of her delivery?

21 A. That is just a precipitous delivery.

1 Precipitous deliveries often are not associated
2 with shoulder dystocia.

3 Q. The fact that she presents and is in
4 active labor and precipitous delivery, therefore
5 not having an anesthetic or anything else, you do
6 not think that is material to the case?

7 A. No, I do not. I have some suspicion that
8 an epidural may actually contribute to shoulder
9 dystocia by relaxing the pelvic sling, but it would
10 be very hard to get really clean data to show that
11 that truly exists.

12 Q. What is fundal pressure?

13 A. Fundal pressure is pressure on the uterus
14 at the top of the uterus, often just above the
15 umbilicus or belly button; as opposed to suprapubic
16 pressure, which is at the hairy area just above the
17 pubic bone called the mons pubis.

18 Q. And this suprapubic pressure is intended
19 perhaps to push the shoulder down and release it
20 underneath the pubic bone?

21 A. Either that or to cause some rotation.

1 There are two theories behind it. I am in the
2 school that says you are trying to compress the
3 shoulders and push it through.

4 Q. If fundal pressure is applied in the
5 presence of a shoulder dystocia, that would be
6 contraindicated?

7 A. That is correct. That is supposed to
8 increase the impaction, and now they are starting
9 to talk about maybe the mother shouldn't push,
10 because that is akin to fundal pressure.

11 Q. And the fundal pressure will stress that
12 stretch between the head and the shoulder by
13 pushing from the opposite side?

14 A. No, it does not increase the stress.
15 It increases the impaction. The stress is from the
16 traction on the head. In other words, as long as
17 you are just pushing from above, nothing happens.
18 You will not cause a brachial plexus injury with
19 fundal pressure or suprapubic pressure or any of
20 your maneuvers.

21 Q. Well, fundal pressure is going to

1 continue to push all parts of the body down, other
2 than the shoulder?

3 A. Correct. But it doesn't push the head.
4 For example, if I took your body and I am going to
5 take you to that door over there and we are going
6 to open the door about 10 inches and we are going
7 to let your head out of the door but your one
8 shoulder is going to be on the doorjamb and the
9 other shoulder is on the door, and now I am going
10 to apply fundal pressure where I am going to grab
11 your lower abdomen or below that, and I am going to
12 wedge you against the door as hard as I can. Your
13 head doesn't protrude any further. Your head stays
14 right where it was. Your shoulders have jammed up
15 a little harder but your head doesn't move.

16 Q. All right. You haven't read the
17 depositions of the nurses so you don't have any
18 criticism of the nursing care in this case?

19 A. And I probably will not have criticism of
20 the nursing care unless they have really done
21 something they shouldn't do, and it is unlikely.

1 Q. Following standard of care, I would
2 assume that the first order of business is to
3 diagnose that you have a shoulder dystocia?

4 A. That is correct.

5 Q. And according to records, depositions and
6 everything else, this condition was diagnosed by
7 the turtle sign?

8 A. Correct.

9 Q. An appropriate diagnosis?

10 A. Correct.

11 Q. Responded to appropriately with McRoberts
12 and suprapubic pressure?

13 A. Correct.

14 Q. Your only criticism, then, if I am
15 following this, is that you assume from the injury
16 that the baby experienced that Dr. Biats somewhere
17 in that process must have applied excessive lateral
18 traction?

19 A. Absolutely.

20 Q. Now, in terms of your analysis of these
21 types of injuries, I am assuming you haven't

1 actually studied shoulder dystocia, its causes, as
2 a scientist?

3 A, No, I have not. There are potential
4 projects in the works, but no, I have not done
5 that.

6 Q. Your CV references six publications.
7 Do any of these relate to this case?

8 A. No, they do not.

9 Q. How many deliveries occur at the hospital
10 where you practice now, a year?

11 A. I think we are up to now, back up to
12 about a thousand. We were at 1200. We took a hit
13 and dropped to 600. We are now back up to a
14 thousand and growing.

15 Q. How many brachial plexus injuries from
16 shoulder dystocias have you seen at that
17 institution in the last ten years, say?

18 A. Well, I have only been in the institution
19 for about two and a half now, two and a half years,
20 and we have had one since I have been there.

21 Q. Brachial plexus injury?

1 A. Correct.

2 Q. Were you attending that delivery?

3 A. No, sir, I was not.

4 Q. Was a resident handling that delivery?

5 A. I don't know the particulars of that, and
6 I can't discuss it, because I was in a quality
7 assurance meeting on that.

8 Q. When you have trained residents and are
9 dealing with shoulder dystocia, if I am following
10 this discussion, would I be correct that one of the
11 very first things you teach them is to avoid
12 applying excessive lateral traction?

13 A. That is correct.

14 Q. They are taught how to handle the
15 maneuvers that you are talking about?

16 A. Correct.

17 Q. Do you know what the percentage of -- let
18 me rephrase that.

19 Do you know how many shoulder dystocias
20 are encountered nationally at vaginal delivery on
21 an annual basis?

1 A. Well, it is about one in 150 deliveries,
2 so you could calculate it from there.

3 Q. Do you know how many there are, total?

4 A. I don't know the numbers, sir.

5 Q. Do you know what percentage of those
6 brachial plexus injuries -- do you know what
7 percentage of those shoulder dystocias have a
8 residual brachial plexus injury?

9 A. It is very low. I have always quoted
10 5 percent brachial plexus injury secondary to
11 shoulder dystocia, and about 10 percent of those
12 are permanent. The most recent ACOG material
13 suggests that 10 percent of shoulder dystocias are
14 associated with a brachial plexus injury and 10
15 percent are permanent.

16 Q. And if I am following your testimony,
17 then, unless the physician has tried the maneuvers
18 we have discussed several times and passed the
19 five-minute time period, all of those brachial
20 plexus injuries are the result of malpractice?

21 A. I believe he or she only has to go

1 through the maneuvers once and when you are up
2 around five minutes or thereabouts, however you
3 deliver that baby, so be it, whether you do the
4 Zavanelli, whether you use excess traction.

5 Q. Have you experienced brachial plexus
6 injury when you have encountered shoulder dystocia?

7 A. I have had one, sir.

8 Q. 1972?

9 A. You have done your homework.

10 Q. That is the only time you have ever
11 experienced it, transient or otherwise?

12 A. Correct.

13 Q. You have never seen it in a case
14 involving other physicians that you were assisting
15 or training?

16 A. Not that I was assisting. I thought I
17 was going to see one about three years ago.
18 Fortunately, the baby was fine.

19 Q. How many shoulder dystocias have you
20 encountered in deliveries in the last five years?

21 A. Well, I overcall them so it is really

1 hard to say, but I was probably seeing about two a
2 year. Now I will see maybe one a year, with the
3 number of deliveries I am doing.

4 Q. How many deliveries a year are you doing
5 now?

6 A. I am down to one or two a month, but I am
selectively called in for those that they
8 anticipate possibly a problem.

9 Q. Do you have any criticism of Dr. Biats'
10 resuscitation of this child?

11 A. No, sir, I do not.

12 Q. Let's just get some statistical stuff
13 here.

14 What do you charge for your time now?

15 A. I charge 300 an hour to review a case. I
16 charge 350 an hour for deposition,

17 Q. When was your deposition last taken?

18 A. I believe I did one a week or two ago.

19 Q. How many depositions have you given in
20 the last 60 to 90 days?

21 A. I have probably done three or four during

1 that time.

2 Q. How many cases have you reviewed during
3 that time period?

4 A. I see about two new cases a month.

5 Q. In the last six months, do you know how
6 many cases you have reviewed?

7 A. I probably have seen ten to 15 cases
8 during that time. It has been about, I have been
9 away for part of that time so it is hard to say.

10 Q. Have your privileges ever been suspended
11 or revoked from any hospital?

12 A. No, sir.

13 Q. I assume you don't have any criminal
14 record?

15 A. No, sir.

16 Q. What is, do you know what your income was
17 last year from case reviews and services as an
18 expert witness?

19 A. It was around 70,000.

20 Q. Before tax or after?

21 A. That is before taxes. But not including

1 expenses.

2 Q. Do you advertise your services as an
3 expert at all?

4 A. No, sir, I do not.

5 Q. Have you ever done that?

6 A. I guess technically I have. I was listed
7 with an agency over, I believe, a weekend, and then
8 dropped out.

9 Q. Are you affiliated with any organizations
10 like TASA or other technical services that put
11 attorneys in contact with physicians?

12 A. No, I never even heard of that one.
13 No, I am not affiliated with any agencies.

14 Q. Do you know how you came in contact with
15 Mr. Mishkind?

16 A. Well, I believe when he was with Wiseman
17 & Wiseman we did some cases together. I believe.
18 I think we had one or two then and, of course, he
19 joined Mr. Becker and I have done cases with Mr.
20 Becker over the years.

21 Q. How many cases have you done for

1 Mr. Becker's office?

2 A. I am not really sure. I mean, it has
3 been a relationship that has gone on maybe for 15
4 years now, so I would be guessing if -- I would say
5 five cases. I have seen five or six cases from
6 their firm. I don't know how many I accepted over
7 the years, because I reject a fair number right
8 over the phone. They will present to me the case
9 and I will say no, I am going to tell you it is no
10 go.

11 Q. And how do you define that over a
12 telephone call?

13 A. It is very simple. For example, if an
14 attorney called me representing a plaintiff that
15 had a ureteral injury, I am going to tell him that
16 more likely than not I am going to find that that
17 is an operative complication and not malpractice.

18 Q. What percentage of your review at this
19 time is for plaintiffs versus defense?

20 A. I have about 10 to 15 percent defense and
21 about 85 percent, obviously, plaintiff.

1 Q. And in how many cases have you given
2 trial testimony this year, not necessarily in court
3 but testimony actually taken for use as a
4 transcript?

5 MR. MISHKIND: You are talking about
6 including a discovery deposition?

7 MR. HANNA: No, trial testimony.

8 MR. MISHKIND: Okay.

9 A. It has been a very busy year. Maybe five
10 times in court.

11 Q. Have you actually appeared?

12 A. Over an entire year, yes, sir.

13 Q. In the last year?

14 A. Yes, sir.

15 MR. MISHKIND: I am not sure we are
16 talking about -- you are talking about just from
17 January to now, or, I think he was talking about an
18 entire year.

19 Q. What period of time are you talking
20 about?

21 A. I am giving you an entire year.

1 Q. The last 12 months?

2 A. Correct.

3 Q. You have actually gone to court and
4 testified five times?

5 A. It is around five times.

6 Q. In how many different states?

7 A. Two states, I believe.

8 Q. What states were these five in?

9 A. New Jersey, there was a number in New
10 Jersey, and one, the other one was Illinois.

11 Q. Do you remember the name of the case in
12 Illinois?

13 A. The firm was Power, Rogers. I don't
14 remember the name of the case.

15 Q. During that time period, have there also
16 been occasions where your testimony for use in
17 trial has been taken by a court reporter, in other
18 words, a deposition or videotape?

19 A. I don't think, I don't remember one video
20 I have done for trial in a long time. It is
21 possible. I don't know anybody who has read -- I

1 try to only accept cases where I will be able to
2 appear if I am needed.

3 MR. HANNA: All right, let me look
4 through my notes. Tom, go ahead and ask him what
5 you need while I am doing that.

6 MR. MANNION: Can we take a five-minute
7 break?

8 MR. HANNA: You can take a break.

9 MR. MANNION: Do you guys want a break
10 before I start questioning?

11 MR. HANNA: I don't need one, do you?
12 I would like to catch a plane today.

13 EXAMINATION BY MR. MANNION:

14 Q. Doctor, I represent Dr. Jackson and first
15 I would like to talk to you about the prenatal flow
16 sheet

17 The prenatal flow sheet that was in the
18 records of the hospital did not contain
19 Dr. Jackson's notations from the last office visit,
20 correct?

21 A. Correct.

1 Q. The prenatal flow sheet in Dr. Jackson's
2 records contains those notations, correct?

3 A. Correct.

4 Q. But that is the only difference in those
5 two records, correct?

6 A. Well, no, there is also a group B strep
7 notation and treatment in labor of ampicillin.
8 Those -- I am sorry, that is there, but not the
9 group B strep.

10 Q. Okay. But that was a notation that he
11 made after that last office visit, correct?

12 A. Correct.

13 Q. Okay. Dr. Jackson did not go back and
14 change any of the information that the nurses
15 entered, correct?

16 A. Correct.

17 Q. He did not go back and change any of
18 information that he previously entered, correct?

19 A. Correct.

20 Q. The only criticism is that he did not
21 make those notes contemporaneously with the visit,

1 correct?

2 A. Correct.

3 Q. And you cannot tell me to a reasonable
4 degree of medical certainty that his failure to
5 make those notes contemporaneously had any effect
6 on the delivery of this baby, correct?

7 A. That is correct. Well, other than he
8 might have been at the delivery itself.

9 Q. I am sorry?

10 A. He might have been at the delivery itself
11 if he had diagnosed labor by doing a vaginal exam
12 in the office.

13 Q. That was not the question, though. The
14 question is, the fact that these notes were not
15 made contemporaneously did not cause this brachial
16 plexus injury?

17 A. That is correct.

18 Q. Okay, and in fact, the fact that these
19 notes were not made contemporaneously had no
20 proximate cause to the injury, correct?

21 A. Well, assuming that he wouldn't have done

1 a better delivery; I can't agree with that.

2 Q. I am sorry. How would the fact that he
3 wrote the notes late somehow affect that?

4 A. Well, I am questioning whether a vaginal
5 exam was done.

6 Q. But that is a different story, Doctor. I
7 am talking about the mere fact that the notes were
8 made late did not affect this delivery, correct?

9 A. That is correct.

10 Q. Okay. Now, you are saying that you
11 question whether or not a vaginal exam was ever
12 done?

13 A. Correct.

14 Q. And on what basis do you question that?

15 A. The fact is it doesn't appear
16 contemporaneously written in the notes, and number
17 two, the patient and her husband stated that a
18 vaginal exam was not done.

19 Q. Okay. You cannot tell me to a reasonable
20 degree of medical certainty what a vaginal exam
21 would have shown, correct?

1 A. That is correct.

2 Q. So likewise, you cannot tell me to a
3 reasonable degree of medical certainty whether or
4 not Mrs. Einarsen was in active labor at the time
5 of that office visit, correct?

6 A. That is correct. Statistically it should
7 have shown, though, if she were in labor.

8 Q. Again, though, like you said, to a
9 reasonable degree of medical certainty you cannot
10 tell me whether she was in active labor, correct?

11 A. That is correct.

12 Q. Now, if in fact Dr. Jackson, after his
13 examination and evaluation, made a determination
14 that there was not decreased fetal movement, then
15 he had no reason to send her to the hospital,
16 correct?

17 A. Sir, he could not determine that by
18 asking questions.

19 Q. How is he supposed to determine that?

20 A. You have to do nonstress testing. The
21 note clearly says "decreased fetal movement."

1 Q. What would a nonstress test have shown?

2 A. In all probability it would have been
3 reactive and shown fetal movement.

4 Q. It would have shown fetal movement,
5 correct?

6 A. Correct.

7 Q. Is that correct?

8 A. Correct.

9 Q. Okay. It would have been normal,
10 correct?

11 A. Correct.

12 Q. Okay, and in fact, you cannot tell me to
13 a reasonable degree of medical certainty what would
14 have happened if a nonstress test had been done,
15 correct?

15 A. That I am more certain about, because by
17 the time she got tested, it would have been at
18 least an hour or so later and at that point labor
19 would have been picked up and she would have been
20 kept in the hospital.

21 Q. Well, nowhere in your report or in your

1 previous testimony did I hear you say that he had a
2 duty to get a nonstress test.

3 A. No.

4 Q. Are you saying he did?

5 A. Well, you have a duty to do it because of
6 decreased movement.

7 Q. The question is, are you saying that Dr.
8 Jackson at that last office visit had a duty to
9 send her to the hospital to have a nonstress test?

10 A. Yes, sir, I am.

11 Q. And when did you come up with that
12 opinion, Dr. Edelberg?

13 A. It didn't appear in my letter and I
14 apologize for it.

15 Q. I asked when did you come up with the
16 opinion?

17 A. Oh, early on, when I reviewed the chart.

18 Q. But you didn't include it in your record,
19 correct?

20 A. No, because I missed it from my yellow
21 sheet also.

1 Q So are you now altering that record?

2 MR. MISHKIND: Objection.

3 A. I am not altering a record, sir, I am
4 adding to it.

5 Q Doctor, don't you agree that you ought to
6 put the important opinions in the report? You know
7 that people rely on these, correct?

8 A. That is correct.

9 Q. And you didn't put that in here, correct?

10 MR. MISHKIND: Objection, you are taking
11 a discovery deposition. You are asking for his
12 opinions.

13 Q. Isn't that correct, Doctor? You did not
14 put that criticism in here, correct?

15 A. That is correct. It did not appear in my
16 letter.

17 Q. You also didn't put in the criticism
18 about an altered record, correct?

19 A. That is correct, also.

20 Q. When did you come up with that opinion?

21 A. I was told about that early on, so I knew

1 about that early on.

2 Q. But you didn't put that in your letter
3 either?

4 A. Correct.

5 Q. In fact, the only criticism you put in
6 your letter was the fact of whether or not
7 Dr. Jackson should have been at the hospital during
8 delivery?

9 A. Correct. And there were a number of
10 reasons for that so it really doesn't affect my
11 ultimate opinion.

12 Q. Well, my question is why weren't these
13 other opinions put in the letter? Because quite
14 frankly, it made a difference in whether or not I
15 did this by telephone or in person.

16 MR. MISHKIND: Well, now, hold on,
17 Tom. Before he responds, the fact that you chose
18 to be in Cleveland or wherever you are -- wait,
19 hold on, one at a time. The fact that you chose to
20 be in Cleveland rather than here, that is your
21 choice.

1 MR. MANNION: My choice, based upon his
2 report, Howard. You gave me this report as the
3 basis for his opinions and there is one criticism
4 in here that I can address pretty easily, and now
5 we take the deposition and there are four
6 criticisms.

7 MR. MISHKIND: Well, take the deposition.

8 MR. MANNION: You are sandbagging.

9 MR. MISHKIND: No, I am not, Tom.
10 Look, the purpose of me being here and the purpose
11 of you taking the deposition isn't to argue. If
12 you have a problem we will address it later on. If
13 you want to take his discovery deposition, do it,
14 but don't do it in an accusatory --

15 MR. MANNION: I am asking why his
16 opinions weren't in here.

17 MR. MISHKIND: Don't do it in an
18 accusatory manner.

19 MR. MANNION: I am asking my questions.

20 MR. MISHKIND: Go ahead.

21 Q. Doctor, when did you come up with these

1 opinions and why weren't they in this letter?

2 A. It was early on, and the fact is I have
3 stated that he should have been at the delivery. It
4 is his patient. There are multiple reasons why he
5 should have been there.

6 Q. Why weren't the criticisms about the
7 record and the NST put in this letter?

8 A. Because they weren't, and I can't give
9 you a complete answer on that.

10 Q. Doctor, the opinions that you and I have
11 discussed so far, none of those opinions were
12 mentioned in the report, correct?

13 A. That is correct.

14 Q. And you can't give me a reason why,
15 correct?

16 MR. MISHKIND: Objection, asked and
17 answered

18 MR. MANNION: What is that?

19 MR. MISHKIND: I was objecting because
20 you have only asked him that same question three
21 times, so I stated an objection, asked and

1 answered.

2 Go ahead. Answer it again.

3 Q. You can't give me a reason why, correct

4 A. Right. In other words, in my initial
5 review I did not put it on my yellow sheet and
6 obviously, when I dictated the letter, I was
7 referring to the yellow sheet and the chart, and
8 certainly on my rereview, I picked this up and was
9 not asked to do a supplementary letter. Because I
10 did not consider the letter as having to include
11 every fact available, but it just was a broad-based
12 thing on how I feel. I feel the doctor should have
13 been at the delivery and was not.

14 Q. When do you arrive at the hospital for a
15 patient?

16 A, Depends on what I tell a patient.

17 Q. Is that what the standard of care is
18 based upon, what you tell the patient?

19 A. I did not say standard of care is to go
20 into the hospital. I never stated that.

21 Q. Okay, Does the standard of care require

1 that an obstetrician immediately go to the
2 hospital --

3 A. No.

4 Q. -- when he asks his patient to go to the
5 hospital?

6 A. No, sir, and I never stated that. I
7 said, but you don't promise a patient to meet them
8 at the hospital and not meet them.

9 Q. Okay, but that doesn't fall below the
10 standard of care?

11 A. It falls below the standard of care if
12 you tell a patient you are going to do something
13 and don't do it.

14 Q. When do you arrive at the hospital when a
15 patient, when you tell a patient to go to the
16 hospital? When her water breaks?

17 A. I will go to the hospital after I get a
18 resident evaluation.

19 Q. Exactly. The resident or someone at the
20 hospital will call you and then you will arrive at
21 the hospital?

1 A. Correct, but I don't promise the patient
2 that I will be there at the door to meet them. I
3 explain to them that the resident will examine you
4 and he will give, he or she will give me a call to
5 tell me what is going on, and then we will see what
6 we have to do.

7 Q. Well, isn't it possible, Doctor, that the
8 Einarsens misunderstood what Dr. Jackson told them
9 on the phone?

10 MR. MISHKIND: Objection, go ahead.

11 A. It certainly possible.

12 Q. And in fact maybe he said, I will see you
13 later at the hospital, correct?

14 MR. MISHKIND: Objection.

15 A. It is possible.

16 Q. Well, you can't tell me what was said in
17 that telephone conversation, can you?

18 A. No, I cannot.

19 Q. And in fact, if Dr. Jackson did not tell
20 them, did not promise to be at the hospital when
21 they arrived, he did not fall below the standard of

1 care in not being there, correct?

2 A. That is correct.

3 Q. Okay, now, Doctor, let's assume that Dr.
4 Jackson did promise them he would be there. How
5 long after that phone call did the standard of care
6 require him to get there, what time frame

7 A. Well, you simply ask the patient, when
8 will you be at the hospital, and you time your
9 arrival.

10 Q. Okay. Do you know how far away the
11 Einarsens lived?

12 A. No, I do not.

13 Q. Do you know how long it took them to get
14 to the hospital?

15 A. No, that is why you ask that question.

16 Q. I am asking you, do you know how long it
17 took them to get to the hospital in this case?

18 A. No, sir, I do not.

19 Q. Do you know what time the phone call was
20 made?

21 A. No, sir, I do not.

1 Q. Let's assume that Dr. Jackson arrived
2 there and waited around for an hour and they still
3 had not arrived; would the standard of care require
4 that he wait another hour?

5 A. No, normally you will re-call the
6 patient. When you get there and a half hour has
7 passed by and the patient hasn't arrived, you want
8 to know what has happened. More likely than not
9 they have delivered at another hospital.

10 Q. And the fact is that once the woman's
11 water breaks, you can't tell exactly how long is
12 going to pass before delivery, can you?

13 A. No, that is correct.

14 Q. And in fact, you certainly didn't expect
15 Dr. Jackson to arrive at the hospital and wait 12,
16 13 hours, did you?

17 A. That depends on the way that the doctor
18 practices obstetrics.

19 Q. Well, would the standard of care require
20 him to do that?

21 A. No, sir.

1 Q. Do you know if the Einarsens were late in
2 getting to the hospital?

3 A. No, I do not.

4 Q. How long after the doctor told them to
5 get to the hospital should they have arrived?

6 A. Depends on how long it takes them.
7 That is why I say you ask the patient, when do you
8 expect to be there.

9 Q. Well, let's assume they lived 45, no,
10 let's assume they lived a half hour away from the
11 hospital; what is a reasonable time frame for them
12 getting to the hospital?

13 A. 40 minutes, 45 minutes.

14 Q. Okay, so ten or 15 minutes over where
15 they live, correct?

16 A. Correct. Unless they are going to drop
17 off a kid someplace, you don't know. That is why
18 you have got to ask.

19 Q. And do you know if the Einarsens ever
20 told Dr. Jackson when they would get there?

21 A. I am not privy to that conversation, sir.

1 Q. Do you know whether Dr. Jackson ever
2 talked to Mrs. Einarsen on the telephone?

3 A. I don't believe so.

4 Q. And Mrs. Einarsen was the patient,
5 correct?

6 A. Correct.

7 Q. And you can't tell me what Mr. Einarsen
8 told Mrs. Einarsen about that conversation, can
9 you?

10 A. Correct.

11 Q. And certainly, if there was a resident
12 obstetrician and an in-house, board certified
13 obstetrician, Dr. Jackson has a right to rely on
14 them performing an examination, correct?

15 A. Correct.

16 Q. You cannot tell me how much Mrs. Einarsen
17 was dilated at her office visit, can you?

18 A. No, I cannot.

19 Q. In fact, you cannot tell me exactly when
20 active labor started, can you?

21 A. Pardon?

1 Q. You cannot give me a time when active
2 labor actually started?

3 A. No, I cannot.

4 Q. What is the definition of decreased fetal
5 movement?

6 A. It is in the patient's mind. It just
7 buys you a test. Patient comes in, it buys them a
8 ticket for a nonstress test or a biophysical
9 profile.

10 Q. Certainly there have been times that a
11 patient may raise a question about fetal movement
12 and after talking with the patient and determining
13 how much the fetus was moving, you have made a
14 determination that there was not decreased fetal
15 movement, correct?

16 A. Correct, but you don't write on your
17 chart, then, "decreased fetal movement."

18 Q. Well, could that be a comment that was
19 made by the patient and then after examination and
20 evaluation, you determine that it was not decreased
21 fetal movement?

1 A. It is possible, but then you wouldn't
2 order a nonstress test for the next day.

3 Q. Okay, and did it require that a nonstress
4 test be done in what time frame? How long?

5 A. As soon as it could be done.

6 Q. What time was that office visit?

7 A. I believe it was about 8 o'clock at
8 night.

9 Q. What do you base that on?

10 A. I think the attorney told me that, or
11 that was in the depositions.

12 Q. If Mrs. Einarsen would have went directly
13 to the hospital at 8 o'clock, had the nonstress
14 test been done then, how long would the test have
15 taken?

16 A. The test takes about a half hour to one
17 hour to run.

18 Q. And it is possible, Doctor, that she
19 would not have started active labor during that
20 time period, correct?

21 A. It is possible.

1 Q. And in fact, her water didn't break until
2 well after that time, correct?

3 A. That is correct.

4 Q. I missed most of your testimony, I didn't
5 want to keep interrupting so a couple of these
6 questions you may have answered, and if so, just
7 say so and I will rely on the transcript.

8 How many times have you testified as an
9 expert in the past?

10 A. I have done, over the last 17 years, over
11 150 depositions.

12 Q. And how many times, let's say over the
13 past year, have you actually been retained as an
14 expert regardless of whether you gave a deposition?

15 A. Well, I have reviewed about 25 new cases
16 over the last year.

17 Q. Is that a pretty fair average for the
18 past several years?

19 A. Correct.

20 Q. And out of those 25, how many of them
21 were for the plaintiff?

1 MR. MISHKIND: He did answer that

2 question. He did answer the question.

3 MR. MANNION: That is fine.

4 MR. MISHKIND: Okay.

5 Q. Doctor, what do you believe a biophysical
6 profile would have shown?

7 A. It would have been perfectly normal.

8 Q. And in fact, you cannot tell me that any
9 of the information that Dr. Jackson put on that
10 prenatal flow sheet is incorrect, can you?

11 A. That is correct.

12 MR. MANNION: I don't have anything
13 further.

14 EXAMINATION BY MR. HANNA:

15 Q. Just let me clarify something. The two
16 cases a month that you are talking about are the
17 ones you agree to review, right?

18 A. That is correct.

19 Q. How many more do you get, on average, a
20 month, calls?

21 A. I get at least double that number that I

1 reject.

2 Q. Why do you do so much of this?

3 MR. MISHKIND: Objection, but you can
4 answer the question.

5 A. Well, first of all, I find it very
6 educational, and it doesn't take a good deal of my
7 time, fortunately.

8 Q. Are you paid in your capacity as vice
9 chief of obstetrics and gynecology at Maryland
10 General?

11 A. I get no extra compensation for that.
12 Just problems.

13 Q. Do you have an active practice in
14 gynecology?

15 A. Yes, sir, I do.

16 Q. What percentage of your income is derived
17 from this kind of work?

18 A. About 20 percent.

19 MR. HANNA: I think that is it. Is this
20 my copy of the CV?

21 MR. MISHKIND: It is actually the only

1 copy. You want to attach it? I don't have a copy.

2 (Whereupon, Edelberg Deposition
3 Exhibit No. 1, curriculum vitae, marked.)

4 (Whereupon, Edelberg Deposition
5 Exhibit No. 2, Precis article, marked.)

6 EXAMINATION BY MR. MANNION:

7 Q. Doctor, you mentioned that the standard
8 of care required Dr. Jackson to be at the hospital
9 because he promised the patient, correct?

10 A. That is correct.

11 Q. Now, what time frame did he have to be
12 there? Did the standard of care then require that
13 he get there before them or at the same time or
14 within a short time thereafter?

15 A. You try to time it for when you
16 anticipate the patient's walking in the door. So
17 if you are within ten minutes, I would say you have
18 met your promise.

19 Q. And if you are within 15 minutes?

20 A. It would probably still meet your
21 promise.

1 Q. And how long did it take him in this case
2 after the patient got there?

3 A. I did not look at that data, sir.

4 Q. And in fact, if 15 minutes would meet the
5 standard of care but this patient delivered in 13
6 minutes, then there was no proximate cause, was
7 there, Doctor?

8 MR. MISHKIND: Let me object to your
9 hypothetical because it is not based upon the facts
10 in terms of time in this case, plus we don't know
11 when the doctor arrived because there is no note as
12 to when he did arrive.

13 MR. MANNION: I understand the objection.
14 Maybe the question was unclear.

15 Q. If this patient -- let me back up,
16 Doctor. You mentioned if the doctor arrived within
17 15 minutes after the patient, that that would fall
18 within the standard of care?

19 A. That is correct.

20 Q. This patient, however, actually delivered
21 within 13 minutes, correct?

1 A. I am not sure what time she hit the door
2 and what time she actually delivered. I don't have
3 those times written down.

4 Q. Okay, well, I will refer you to your
5 report that said she was admitted at 11:25 and at
6 11:38 delivered. That is 13 minutes, correct?

7 A. Correct, but admission doesn't mean when
8 she hit the door. There sometimes can be a
9 half-hour delay from the time a patient walks into
10 the hospital until admitting papers are done or
11 nurses see them.

12 Q. Well, there is no evidence of that in
13 this case, is there?

14 A. I don't have any evidence either way.

15 Q. Okay. The point is she delivered within
16 13 minutes of admission, correct?

17 MR. MISHKIND: You are talking about
18 admission to labor and delivery?

19 A. Of the officially timed admission, yes.

20 Q. What is the outside time frame in which
21 Dr. Jackson could have arrived at the hospital

1 after the patient did and still fall within the
2 standard of care?

3 A. Well, from the time she said she is going
4 to be there, and that is an important question that
5 you have to ask.

6 Q. Okay.

7 A. You want to be there within 15 minutes of
8 that time.

9 Q. Twenty minutes is outside the standard of
10 care?

11 A. I would think so.

12 MR. MANNION: I don't have anything
13 further.

14 MR. MISHKIND: Okay.

15 THE REPORTER: Doctor, do you elect to
16 read and sign or waive?

17 THE WITNESS: I would like to read.

18 THE REPORTER: Mr. Mannion, do you want
19 to take a copy of the transcript?

20 MR. MANNION: Yes, I would like an ASCII
21 as well.

1 THE REPORTER: Mr. Mishkind?

2 MR. MISHKIND: A copy, yes.

3 MR. MANNION: Normal delivery is fine.

4 MR. MISHKIND: I would like the

5 Min-U-Script.

6 MR. HANNA: I just want the regular

7 transcript and the exhibits.

8 (Examination concluded -- 3:50 p.m.)

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1 STATE OF MARYLAND

2 SS:

3 I, T.M. Shelton, RPR-RMR, a Notary Public
4 of the State of Maryland, do hereby certify that
5 the within named, **STUART CHARLES EDELBERG, M.D.**,
6 personally appeared before me at the time and place
7 herein set out, and after having been duly sworn by
8 me, was interrogated by counsel.

9 I further certify that the examination was
10 recorded stenographically by me and this transcript
11 is a true record of the proceedings.

12 I further certify that I am not of counsel
13 to any of the parties, nor an employee of counsel
14 nor related to any of the parties, nor in any way
15 interested in the outcome of this action.

16 As witness my hand and notarial seal this
17 27th day of July, 1999.

18

19

20 My commission expires: _____

21 October 1, 2002

Notary Public

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7 DATE: JULY 28, 1999
8 JOB NUMBER: SO21290E
9 CASE CAPTION: EINARSEN vs. JACKSON
10 COURT: SUMMIT COUNTY, OHIO, COURT OF COMMON PLEAS
11 CASE NUMBER: CV 98051884
12 DEPONENT: STUART CHARLES EDELBERG
13 DATE OF DEPOSITION: JULY 16, 1999
14 ATTORNEYS/FIRMS:
15 HOWARD D, MISHKIND, BECKER & MISHKIND CO., L.P.A.
16 DAVID HANNA, BUCKINGHAM, DOOLITTLE & BURROUGHS
17 THOMAS P. MANNION, REMINGER & REMINGER

18 Dear Sir or Madam:

19 Bound herewith is the transcript of the
20 above-referenced deposition, including the original
21 certificate page and notary page. Please read the
22 transcript and sign the certificate page before a
23 notary public for authentication of your signature.
24 Any additions or corrections should be listed on
25 the errata sheet provided. Please remove the
26 signed certificate, notary pages, and the completed
27 errata sheets, and return them to the address
28 listed above for processing.

29 *If this process has not been completed*
30 *within (30) thirty days from the date of this*
31 *letter, we will assume that the right to read the*
32 *deposition has been waived. This is in accordance*
33 *with Rule 30(e) of the Federal Rules of Civil*
34 *Procedure and Rule 411 Section (a) of the Maryland*
35 *Rules of Procedure.*

1 **READING AND SIGNING PROCEDURE**

2

3 The Deposition of **STUART CHARLES**

4 **EDELBERG, M.D.**, was taken in the matter, on the
5 date, and at the time and place set out on the
6 title page hereof.

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

10 It was agreed by and between counsel
11 and/or the parties and/or the Deponent that the
12 Deponent will read and sign the transcript of
13 said deposition.

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STATE OF _____

COUNTY/CITY OF _____

SUBSCRIBED and SWORN to before me this _____ day of _____, 1999 in the jurisdiction aforesaid.

My Commission Expires _____ Notary Public _____

DEPOSITION ERRATA SHEET

RE: Al Betz & Associates, Inc.

FILE NO.: SO21290E

CASE CAPTION: Einarsen v. Jackson, et al.

DEPONENT: STUART CHARLES EDELBERG, M.D.

DEPOSITION DATE: Friday, July 16, 1999

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

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SIGNATURE: _____ DATE: _____

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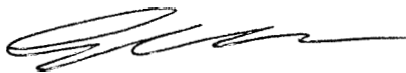
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C E R T I F I C A T E

STATE OF Maryland
COUNTY/CITY OF Baltimore

Before me, this day, *STUART CHARLES*
EDELBERG, M.D., personally appeared, who, being
duly sworn, states that the foregoing transcript of
his/her Deposition, taken in the matter, on the
date, and at the time and place set out on the
title page hereof, constitutes a true and accurate
transcript of said deposition.

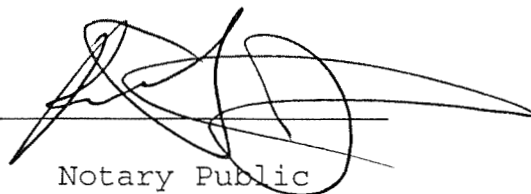


STUART CHARLES EDELBERG, M.D.

SUBSCRIBED and SWORN to before me this
11 day of August 999
in the jurisdiction aforesaid.

5-1-2002

My Commission Expires


Notary Public



1 DEPOSITION ERRATA SHEET

2 **RE:** Al Betz & Associates, Inc.

3 FILE NO.: S021290E

4 **CASE CAPTION:** Einarsen v. Jackson, et al.

5 **DEPONENT:** STUART CHARLES EDELBERG, M.D.

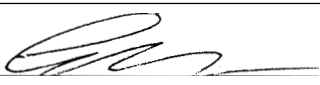
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