THE STATE OF OHIO)
COUNTY OF SUMMIT)
IN THE COURT OF COMMON PLEAS

VICTORIA EINARSEN, a minor, *
by and through her next *
friend and natural mother, *
Angela Einarsen, *
Plaintiffs *
*
vs. *
* Case No.
DR. DAVID JACKSON, et al., * CV 98051884
Defendants *
* * * * * * * * * * * * * * * * *

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

* * * * * * * * * * * * * * * * *

Reported by:
Triminie M. Shelton, RPR-RMR

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)
216-241-5757 (Fax)

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

DAVID HANNA, ESQUIRE
Buckingham, Doolittle & Burroughs
50 South Main Street
P.O. Box 1500
Akron, Ohio 44309-1500
330-376-5300 (Voice)
330-252-5544 (Fax)

APPEARANCES (Cont'd.)

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

THOMAS P. MANNION, ESQUIRE
(via telephone)
Reminger & Reminger
113 St. Clair Building
Cleveland, Ohio 44114
216-687-1311 (Voice)
216-687-1841 (Fax)

P R O C E E D I N G S

Whereupon --

STUART CHARLES EDELBERG, M.D.,

being first duly sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION BY MR. HANNA:

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

A. Stuart Charles Edelberg.

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

What is your current business address?

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

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

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

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

A. Yes, I did.

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

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

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

A. That is correct.

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

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

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

Q. What hospital is that?

A. Maryland General Hospital.

Q. Where do you have privileges to practice now?

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

Q. What is your current affiliation with Johns Hopkins?

A. I am an assistant professor.

Q. And how long have you held that position?

A. Since 1990.

Q. Do you actually teach courses at Johns Hopkins?

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

Q. When was the last time you ever actually

taught a course at the School of Medicine?

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

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

A. Yes, I am.

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

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

Q. When did you last teach physical diagnosis?

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

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

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

Q. And that was in what department?

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

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

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

Q. Who were you contacted by?

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

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

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

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

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

A. It is possible.

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

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

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

A. Yes, sir, I did.

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

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

Q. So you have no record in the file you

brought with you as to when you were first contacted?

A. No, sir, I do not.

Q. Have you ever met the Einarsens?

A. No, I have not.

Q. Never examined the child?

A. No, I have not.

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

A. No, I have not.

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

A. No, I have not.

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

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

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

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

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

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

Q. From what time period?

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

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

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

Q. Who put the pink stickers on it?
A. I did, sir.
Q. Is there any handwriting on any of those records that you have added?
A. No, sir.
Q. Have you prepared anything in writing?
A. Well, sir, these are the notes I took when I originally reviewed the records.
Q. So we have a one-page yellow sheet with about eight or ten pieces of information on it.
A. And then, of course, the letter that I think you have.
Q. Right.
A. And here, someplace in here is a follow-up on the baby, its current status, from Dr. Buckley.
Q. That is the report dated June 25 of '99?
A. Correct.
Q. Okay. I have not read this report. Is there anything -- have you read it?
A. Other than the baby still has a

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

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

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

MR. MANNION: I did not hear the question.

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

MR. MANNION: Thank you.

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

Q. What is in the other notebook?

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

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

A. Yes, sir.

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

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

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

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

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

the text?

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

Q. Do we know who authored this section?

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

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

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

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

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

in the in utero injury.

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

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

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

A. No, sir.

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

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

A. No, sir.

Q. What about billings?

A. I do not have billings.

Q. But you have billed for services in case?

A. Yes, sir, I have.

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

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

MR. MANNION: I missed that question again.

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

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

Q. And where are your billing records maintained?

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

when it is paid, I bucket the bill.

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

A. No, I do not.

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

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

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

A. Yes, sir, I am.

Q. Tell me what those are.

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

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

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

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

Q. Mandatory under what?

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

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

actions in the delivery room.

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

A. That would basically be it, sir.

MR. MANNION: I missed that question as well.

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

A. That would basically be it, sir.

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

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

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

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

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

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

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

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

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

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

A. No, sir, I do not.

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

A. Yes, sir, I have.

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

A. No, sir, I do not.

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

A. By definition she was not a gestational diabetic.

MR. MANNION: What was the question?

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

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

Q. By what definition?

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

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

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

MR. HANNA: You better listen.

MR. MANNION: I am listening.

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

this at Kmart this afternoon.

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

MR. HANNA: All right.

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

A. No, sir, I am not.

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

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

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

A. No, sir, I am not.

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

A. I have read some of them for obstetrics

but not for family practice.

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

A. Okay, fair enough

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

A. No.

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

A. No, sir, I do not.

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

A. That is correct.

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

A. That is correct

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

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

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

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

A. That is correct.

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

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

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

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

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

Q. Okay, and that is basically my point.

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

A. It is different in every hospital

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

A. No, there is not.

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

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

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

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

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

house and explaining the situation with the patient?

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

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

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

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

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

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

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

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

A. That is correct.

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

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

sure on that.

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

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

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

to this patient until Dr. Jackson's arrival?

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

Q. That is the only criticism of the hospital?

A. That is correct.

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

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

Q. Was this baby macrosomic?

A. Depends on whose definition you use.

Q. Well, yours.

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

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

A. Correct.

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

A. That is correct.

Q. That was a function of the birth process?

A. Correct.

MR. MANNION: I missed the question.

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

A. That is correct.

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

A. That is also correct.

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

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

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

A. Correct.

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

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

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

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

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

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

towards prompt delivery.

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

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

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

A. Correct, the cord is being compressed.

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

A. Correct.

Q. That can result in brain damage?

A. Correct.

Q. And can result in death?

A. Correct.

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

A. Correct.

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

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

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

A. That is correct.

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

A. Or the posterior arm maneuver.

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

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

clavicles that I never wanted to fracture.

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

A. Oh, yes.

Q. How about fracturing the humerus?

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

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

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

Q. And you base that on what?

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

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

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

correctly.

MR. MISHKIND: That is correct.

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

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

A. Correct.

Q. Is that where that came from?

A. Correct.

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

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

Q. This child had a nuchal cord?

A. Correct.

Q. Wrapped tight around the neck?

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

It is a given.

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

A. Excellent.

Q. What was the child's Apgar?

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

Q. The baby was not breathing spontaneously?

A. That is correct.

Q. Required resuscitation?

A. That is correct.

Q. Had no spontaneous movement?

A. Correct.

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

in that position before suffering an asphyxic-type injury?

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

Q. And you base that on what?

A. The cord pH.

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

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

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

A. Probably none at all.

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

A. That is correct.

Q. Would it be fair to characterize the

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

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

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

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

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

A. Correct.

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

A. Correct.

Q. With its head facing to her right?
A. Correct.
Q. After the posterior shoulder is reduced such that the body is now delivered, what position is the baby going to be in?
A. The baby is out at that point.
Q. Well, not completely out.
A. The baby remains in relatively the same position as it comes squirting out. Sometimes there is a slight rotation more towards the stomach down and backside up. Depends on the design of the mother's pelvis.
Q. Is there a point in this delivery where the baby's head is going to be, the body is going to be turned such that the baby's head is looking straight up at the ceiling?
A. Should not be, but it could happen.
Q. How would that happen?
A. If you are twisting the baby as the baby is delivering, you can turn it so that it would be facing up. Statistically, they usually stay facing

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

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

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

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

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

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

A. No, it is not.

Q. Why not?

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

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

A. That is correct.

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

MR. HANNA: Would you read it back.

(The record was read by the reporter.)

PIR. MANNION: Thank you.

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

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

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

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

A. I don't remember, sir.

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

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

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

A. That is what it is supposed to do.

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

A. Correct.

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

A. That is correct.

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

A. That is also correct.

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

A. I am not critical of their employment or

methodology for the McRoberts maneuver.

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

A. No, I am not.

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

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

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

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

Q. Is there any other basis for that opinion?

A. No, sir.

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

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

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

A. In all probability, no.

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

A. Yes, it can.

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

A. Yes, it does.

Q. How does it happen in a cesarean delivery?

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

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

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

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

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

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

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

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

A. That is correct.

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

A. Correct

Q. Now --

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

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

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

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

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

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

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

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

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

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

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

A. That is just a precipitous delivery.

Precipitous deliveries often are not associated with shoulder dystocia.

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

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

Q. What is fundal pressure?

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

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

A. Either that or to cause some rotation.

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

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

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

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

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

Q. Well, fundal pressure is going to

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

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

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

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

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

A. That is correct.

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

A. Correct.

Q. An appropriate diagnosis?

A. Correct.

Q. Responded to appropriately with McRoberts and suprapubic pressure?

A. Correct.

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

A. Absolutely.

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

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

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

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

A. No, they do not.

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

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

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

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

Q. Brachial plexus injury?

A. Correct.

Q. Were you attending that delivery?

A. No, sir, I was not.

Q. Was a resident handling that delivery?

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

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

A. That is correct.

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

A. Correct.

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

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

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

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

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

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

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

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

A. I believe he or she only has to go

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

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

A. I have had one, sir.

Q. 1972?

A. You have done your homework.

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

A. Correct.

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

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

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

A. Well, I overcall them so it is really

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

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

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

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

A. No, sir, I do not.

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

What do you charge for your time now?

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

Q. When was your deposition last taken?

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

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

A. I have probably done three or four during

that time.

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

A. I see about two new cases a month.

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

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

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

A. No, sir.

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

A. No, sir.

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

A. It was around 70,000.

Q. Before tax or after?

A. That is before taxes. But not including

expenses.

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

A. No, sir, I do not.

Q. Have you ever done that?

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

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

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

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

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

Q. How many cases have you done for

Mr. Becker's office?

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

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

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

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

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

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

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

MR. HANNA: No, trial testimony.

MR. MISHKIND: Okay.

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

Q. Have you actually appeared?

A. Over an entire year, yes, sir.

Q. In the last year?

A. Yes, sir.

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

Q. What period of time are you talking about?

A. I am giving you an entire year.

Q. The last 12 months?
A. Correct.
Q. You have actually gone to court and testified five times?
A. It is around five times.
Q. In how many different states?
A. Two states, I believe.
Q. What states were these five in?
A. New Jersey, there was a number in New Jersey, and one, the other one was Illinois.
Q. Do you remember the name of the case in Illinois?
A. The firm was Power, Rogers. I don't remember the name of the case.
Q. During that time period, have there also been occasions where your testimony for use in trial has been taken by a court reporter, in other words, a deposition or videotape?
A. I don't think, I don't remember one video I have done for trial in a long time. It is possible. I don't know anybody who has read -- I

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

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

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

MR. HANNA: You can take a break.

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

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

EXAMINATION BY MR. MANNION:

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

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

A. Correct.

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

A. Correct.

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

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

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

correct?

A. Correct.

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

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

Q. I am sorry?

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

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

A. That is correct.

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

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

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

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

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

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

A. That is correct.

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

A. Correct.

Q. And on what basis do you question that?

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

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

A. That is correct.

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

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

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

A. That is correct.

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

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

Q. How is he supposed to determine that?

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

Q. What would a nonstress test have shown?
A. In all probability it would have been reactive and shown fetal movement.
Q. It would have shown fetal movement, correct?
A. Correct.
Q. Is that correct?
A. Correct.
Q. Okay. It would have been normal, correct?
A. Correct.
Q. Okay, and in fact, you cannot tell me to a reasonable degree of medical certainty what would have happened if a nonstress test had been done, correct?
A. That I am more certain about, because by the time she got tested, it would have been at least an hour or so later and at that point labor would have been picked up and she would have been kept in the hospital.
Q. Well, nowhere in your report or in your

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

A. No.

Q. Are you saying he did?

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

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

A. Yes, sir, I am.

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

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

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

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

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

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

Q So are you now altering that record?

MR. MISHKIND: Objection.

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

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

A. That is correct.

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

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

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

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

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

A. That is correct, also.

Q. When did you come up with that opinion?

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

about that early on.

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

A. Correct.

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

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

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

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

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

MR. MISHKIND: Well, take the deposition.

MR. MANNION: You are sandbagging.

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

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

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

MR. MANNION: I am asking my questions.

MR. MISHKIND: Go ahead.

Q. Doctor, when did you come up with these

opinions and why weren't they in this letter?

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

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

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

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

A. That is correct.

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

MR. MISHKIND: Objection, asked and answered

MR. MANNION: What is that?

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

answered.

Go ahead. Answer it again.

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

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

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

A, Depends on what I tell a patient.

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

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

Q. Okay, Does the standard of care require

that an obstetrician immediately go to the hospital --

A. No.

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

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

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

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

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

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

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

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

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

MR. MISHKIND: Objection, go ahead.

A. It certainly possible.

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

MR. MISHKIND: Objection.

A. It is possible.

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

A. No, I cannot.

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

care in not being there, correct?

A. That is correct.

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

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

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

A. No, I do not.

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

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

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

A. No, sir, I do not.

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

A. No, sir, I do not.

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

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

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

A. No, that is correct.

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

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

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

A. No, sir.

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

A. No, I do not.

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

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

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

A. 40 minutes, 45 minutes.

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

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

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

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

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

A. I don't believe so.

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

A. Correct.

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

A. Correct.

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

A. Correct.

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

A. No, I cannot.

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

A. Pardon?

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

A. No, I cannot.

Q. What is the definition of decreased fetal movement?

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

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

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

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

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

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

A. As soon as it could be done.

Q. What time was that office visit?

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

Q. What do you base that on?

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

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

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

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

A. It is possible.

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

A. That is correct.

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

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

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

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

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

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

A. Correct.

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

MR. MISHKIND: He did answer that question. He did answer the question.

MR. MANNION: That is fine.

MR. MISHKIND: Okay.

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

A. It would have been perfectly normal.

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

A. That is correct.

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

EXAMINATION BY MR. HANNA:

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

A. That is correct.

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

A. I get at least double that number that I

reject.

Q. Why do you do so much of this?

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

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

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

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

Q. Do you have an active practice in gynecology?

A. Yes, sir, I do.

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

A. About 20 percent.

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

MR. MISHKIND: It is actually the only

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

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

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

EXAMINATION BY MR. MANNION:

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

A. That is correct.

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

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

Q. And if you are within 15 minutes?

A. It would probably still meet your promise.

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

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

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

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

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

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

A. That is correct.

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

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

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

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

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

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

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

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

A. Of the officially timed admission, yes.

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

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

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

Q. Okay.

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

Q. Twenty minutes is outside the standard of care?

A. I would think so.

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

MR. MISHKIND: Okay.

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

THE WITNESS: I would like to read.

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

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

THE REPORTER: Mr. Mishkind?

MR. MISHKIND: A copy, yes.

MR. MANNION: Normal delivery is fine.

MR. MISHKIND: I would like the Min-U-Script.

MR. HANNA: I just want the regular transcript and the exhibits.

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

STATE OF MARYLAND

SS:

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

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

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

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

My commission expires: _____

October 1, 2002 Notary Public

AL BETZ & ASSOCIATES, INC.
Administrative Offices
P.O. Box 665
Westminster, Maryland 21158
VOICE- (410)752-1733 FAX- (410)875-2857
e-mail- albetz@ix.netcom.com

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

Dear Sir or Madam:

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

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

READING AND SIGNING PROCEDURE

The Deposition of **STUART CHARLES EDELBERG, M.D.,** was taken in the matter, on the date, and at the time and place set out on the title page hereof.

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

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

C E R T I F I C A T E

STATE OF _____

COUNTY/CITY OF _____

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 _____ 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.

PAGE/LINE	CHANGE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SIGNATURE:_____DATE:_____

STUART CHARLES EDELBERG, M.D.

PAGE/LINE	CHANGE	REASON

SIGNATURE:_____ DATE:_____

STUART CHARLES EDELBERG, M.D.

I N D E X

DEPOSITION OF STUART CHARLES EDELBERG, M.D.

FRIDAY, JULY 16, 1999

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

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

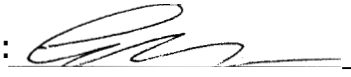
I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request that the changes noted on the following errata sheet be entered upon the record for the reasons indicated. I have signed my name to the Errata Sheet and the appropriate Certificate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

PAGE/LINE	CHANGE	REASON
51/7	~~document~~ Doctor.	Typo

SIGNATURE:_____ DATE:_____

STUART CHARLES EDELBERG, M.D.

PAGE/LINE	CHANGE	REASON

SIGNATURE:  DATE: 8/11/99

STUART CHARLES EDELBERG, ***M.D.***