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IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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ZACHARY HAMMON, et al

Plaintiffs

v. Civil No. 209957

MARYMOUNT HOSPITAL, et al Judge Sam A. Zingale

Defendants

- - - - - - - - - - - - - - - - - -x

Columbia, Maryland

Friday, December 4, 1992

Deposition of:

STUART C. EDELBERG, M. D.

called for examination by counsel for the Defendant El-Mallawany, pursuant to Notice, held at the offices of Jacobson, Maynard, Tuschman & Kalur, Suite 1150, 10440 Little Paxtuxent Parkway, Columbia, Maryland 21044; beginning at approximately 3:25 p.m., before Barbara Massengill, Registered Professional Reporter and Notary Public in and for the State of Maryland, when were present:

DEPOSITION OF STUART C. EDELBERG, M. D.
CONDUCTED ON FRIDAY, DECEMBER 4, 1992

ON BEHALF OF THE PLAINTIFF:

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DEPOSITION OF STUART C. EDELBERG, M. D.
CONDUCTED ON FRIDAY, DECEMBER 4, 1992

P R O C E E D I N G S

STUART CHARLES EDELBERG, M. D.

having been duly sworn, testified as follows:

EXAMINATION BY COUNSEL FOR THE DEFENDANTS EL-MALLAWANY, ABRAMS AND BROWN:

BY MR. SEIBEL:

Q Would you state your full name for the record?

A Stuart Charles Edelberg.

Q Doctor, I am going to go through your file for a second so bear with me.

Are these materials, you brought your entire file in this matter?

A Yes, sir.

Q What is your date of birth?

A May 12, 1937.

Q And your social security number?

A 251-30-8030.

Q Where do you live?

A In Baltimore.

Q What is the street address?

A 1309 Marguerite Avenue, it is Baltimore, Maryland 21286.

Q How long have you lived there?

A About three years now.

Q Where did you live before that?

A In Cleveland.

Q What was the street address?

A Parkland, I think 18495. I'm not sure of the number, Parkland Drive, Shaker Heights.

Q Who lives there with you currently?

A My wife.

Q Any children?

A Three children.

Q They live with you?

A They are all in college or various pursuits.

Q What is your current professional address?

A Mount Sinai Hospital, 2401 West Belvedere Avenue, Baltimore 21215.

Q How long has that been your professional address?

A Three years.

Q Did you assume that professional address immediately upon leaving Cleveland and coming to Baltimore?

A Yes, I did.

Q Do you have any other offices besides that?

A I have an HMO one day a week on the west side of Cleveland, I have no other offices.

Q Cleveland or Baltimore?

A Baltimore.

Q You understand your answers are under oath today?

A Yes, I do.

Q Doctor, can we agree that you will not answer any of my questions that you do not understand?

A Yes, sir.

Q Do you understand further that I will be relying upon your answers as I prepare for trial and evaluate this case?

A Yes, sir.

Q And you further understand that this is probably going to be my only opportunity to discover your opinions in this setting?

A Yes, sir.

Q Is there anything today that prevents you from hearing or understanding my questions?

A No, there is not.

Q Why did you leave Cleveland?

A I was running a residency program at Cleveland Metropolitan General Hospital and I was offered a job at Siani that I could not turn down. It put me back in a commuter state, the marriage. My wife is a professor at Cleveland State.

Q What do you mean back in a commuting state?

A When I lived in Tucson, Arizona she held a professorship at Cleveland State and commuted for a year.

Q And your wife commutes now?

A She does.

Q Did you solicit positions in other places to go practice?

A I had been recruited by a number of hospitals. We had preselected cities that we would move to if the right opportunity came up and Baltimore was on that list. I had interviewed, I looked at a number of jobs, but I turned them down.

Q Were you looking to leave Cleveland at that time?

A Only if the offer was something that warranted leaving for.

Q How many other cases have you reviewed as an expert witness for Mr. Kampinski or the lawyers in his office.

A I don't know exactly how many, maybe a half-dozen.

Q How long have you been reviewing cases for his office?

A Perhaps eight years.

Q Out of those cases how many of those has his office represented the plaintiffs in the case?

A I think they all have been.

Q Out of those cases how many of those did you express an opinion that there was negligence in the case?

A I don't know what percentage, but it is probably, it is probably in the neighborhood of half of them.

Q How many cases have you participated in as an expert witness?

A I average about two new files crossing my desk a month and this has been over the last, little less than ten years, maybe nine years, eight years.

Q And do you spend time reviewing all the files

that cross your desk?

A I have prescreened most of them by telephone conversation, and if I am asked to review them, if I accept it, then I will review it.

Q Out of the total number of cases that you reviewed per year, how many of those do you actually write reports?

A Of those that I find that either I am defending them or it is a plaintiff's case and I am accepting it, about half of those will ask me for a letter.

Q What does your prescreening process involve?

A It involves reviewing the chart, perhaps may involve reviewing literature and coming to some conclusion.

Q Of the plaintiffs cases that you are asked to review how many of those result in your determination of a legitimate claim?

A It certainly is under half, well under half.

Q Of the overall cases that you review, how many are plaintiffs, how many are defense?

A About four or five years ago I was cleaning my file out and at that point about a third were defense and two-thirds were plaintiffs. Since I have left Cleveland

those numbers have shifted and it is now probably 90 percent plaintiff and 10 percent defense.

Q How many depositions do you give on an annual basis?

A Ten, guessing.

Q How many times annually do you testify for trial?

A Rarely.

Q One or two times a year?

A Not even that. I have been to trial maybe seven times in my career, three for the defense and maybe four for plaintiffs. And I think two for defense was your firm.

Q Do you intend to testify live at the trial of this case?

A Yes, sir.

Q In the materials that you brought, would you tell me where you got those?

A Those were sent to me by Mr. Mellino.

Q Did they come accompanied by a cover letter?

A I am sure they had a letter that said here are the records. I'm not sure it is in here.

I don't see the cover letter in here.

Q Where is it?

A My secretary would possibly have had it. In other words, when I do billing, I take a letter, tell my secretary to make me out an open bill and I will take care of it. That is how the letters get lost.

Q So you have two files in this case, one of the medical records and one of the billing files?

A I have no billing file.

Q You are confident that these materials came with a cover letter?

A Yes, sir.

Q And you didn't bring the cover letter with you?

A I thought I had one. I saw one, I don't know where it is. If it is in the pile I am missing it.

Q Did you see it before you left your office today?

A Let me look. I might have given it to my secretary. And if it is, this is how they get lost. If they are in here.

I have got something here. Is that it?

MR. MELLINO: This is a cover letter, it is not the one though.

BY MR. SEIBEL:

Q You pulled out of your briefcase a letter from Mr. Mellino to you dated September 24, 1992, which enclosed the expert reports of Doctor Redline and Doctor Dierker. Are you familiar with any other letter?

A I am sure there was an original letter. I don't have it here.

Q Have you received any other correspondence from Mr. Kampinski's office besides the September 24th letter and the other letter which you didn't bring?

A I don't know. I can't tell you that.

Q Did you issue a statement to Mr. Kampinski's office for your review?

A Yes, I did.

Q You didn't bring that today with you?

A I don't have that. If that was paid, it is basically tossed and it is the end of it.

Q You don't keep track at all of the things you bill out for?

A No, we do not.

Q What is your fee for giving a deposition?

A I charge $300 an hour.

Q What is your fee for reviewing a file?

A I charge $250 an hour.

Q What is your fee for trial testimony?

A $300 an hour. And also, if I have to go out of town it's a minimum of $800.

Q So $2400?

A Correct.

Q What issues were you asked to address in this case?

A I don't believe I was asked to address issues, I was asked for my opinion and I rendered my opinion.

Q Well what I want to ask you is were the issues that you were asked to address in your review of the medical records limited in any way.

MR. MELLINO: He said he wasn't asked to address issues.

MR. SEIBEL: Apparently he was at some point, Chris, because he issued a report with a conclusion.

A I was asked to issue a letter. Certainly I would not render opinions outside of my area of expertise. So in terms of my area of expertise, I don't remember, I don't remember anybody ever saying I just want these

specific issues addressed.

Q What was your understanding of the purpose of reviewing the records?

A Whether there was negligence on anyone's part.

Q So the scope of the potential people involved was not limited in any way?

A No, it was not.

Q So you felt free to criticize anyone who was involved in the care and treatment of Rita Berardinelli and her son Zachary?

A Yes, sir.

Q How many hours did you put into your review before you issued your report?

A I would have to guess because I don't have those records, but perhaps six hours, it is possible, looking at the size of the records.

Q When was the last time that you reviewed these records before we sat down at this deposition?

A I started to review the records this week, but I don't remember doing much work on this case after the letter was issued other than having these other letters coming in and opening up the file to see if I agreed or

disagreed or what I considered my opinion stance to be in view of the letter.

Q What information did you get in this case after you issued your report?

A I believe these letters came in afterward.

Q Which letters are those?

A These are the letters from, one from Leroy Dierker and the other one is from Case Western Reserve, it is a pathologist's evaluation by Redline.

Q Did you get Doctor Kiwi's report?

A I just got that this morning or this afternoon.

Q Mr. Mellino showed it to you?

A Yes, he did. Did he show you any other reports in the case?

A There was one other that I looked at, I can't remember who it was.

Q Doctor Challup?

A I would have to ask Mr. Mellino. I don't remember the name.

Q Go ahead.

MR. MELLINO: I showed you Doctor Landon and Doctor Challup.

BY MR. SEIBEL:

Q Who is Doctor Landon?

A I forgot that one, I am not recalling who Landon was.

Q Was this case originally presented to you in a telephone conversation with someone from Mr. Kampinski's office?

A Yes, I am sure, most cases come that way.

Q Would that be before you looked at any materials?

A That's correct.

Q Did you make notes of that conversation?

A No, I rarely make notes other than if something is coming by Fed Ex to know when it is because the mail room isn't very efficient about bringing packages up.

Q What is the purpose of that initial conversation?

A Again, I can eliminate cases that I am not interested in or fall out of my area of expertise.

Q What was it about this case that caused you to be interested to read the materials?

A Basically it was a routine labor case and it

certainly fell within my area of expertise and it was a low Apgar baby that ultimately sustained global damage and I felt it was at least worth while reviewing.

Q After you reviewed your records did you have another telephone conversation with Mr. Kampinski's office?

A Yes.

Q Do you know who that was with?

A That was probably with Mr. Mellino.

Q What did you share with him during that conversation?

A Basically that I found negligence in the case and it would probably be pretty much along the lines of the letter that I wrote. And then I am sure he asked me would you please write a letter, and I subsequently wrote a letter. I'm not sure how much delay there was between the review and the letter.

Q In the materials that you were provided initially did you receive the prenatal records?

A I have not seen all of the prenatal records. As a matter of fact I reviewed some of the ultrasound this morning.

Q Films or reports?

A One report.

Q Do you remember the date of that report?

A No, I didn't write it down.

Q Is that in the pile of materials that you have?

A No, it is not, Mr. Mellino had that.

Q Did that particular report have an impact upon your opinions one way or another?

A None at all.

Q Have you changed your opinions at all since writing your report?

A No, I have not.

Q Either by expansion or contraction. Have you developed more opinions or have you reconsidered any of your opinions. I want you make sure when I use the word change I mean it in all respects.

A No, I read it the same way today as I read it then.

Q Does your report state all of your opinions in this case?

A A report never states every opinion, but I think the major opinions are in it.

Q Is it accurate to say that your report states

all the areas where you feel, at least my client in the case, Doctor El-Mallawany, breached the standard of care?

A I believe it covers all the major points.

Q Why don't we have this marked as an exhibit.

(Exhibit No. 1 was marked for identification and attached to the transcript.)

BY MR. SEIBEL:

Q Doctor, we are going to hand you what we have marked as Deposition Exhibit No. 1 for the record.

Just for the record, identify it if you would.

A That is my letter from Siani, that's correct.

Q And the date of the letter?

A The date is October 31, 1991.

Q For the record, how many pages is it?

A Three pages.

Q Have you issued any reports since this time?

A Not that I am aware of.

Q Was this your one and only report in this case?

A I believe so.

Q Did this report go through a drafting process?

A All my letters do. My secretary uses a word processor. I dictate the letter, she sends it back in

rough copy, I try to go back and verify all the data, basically recomposing the letter, send it back to her, she then types it up. Usually then there is a final reading for grammatical errors, and I make a fair number, and those are corrected and it goes out.

Q During the drafting process are you in conversation with Mr. Kampinski's office?

A Usually I am never in consultation on the letter, I am usually left on my own completely.

Q Before you issued the final report did you have a conversation with Mr. Kampinski's office?

A I don't believe so. If I were asked to give a letter, my standard is to do the letter and send it.

Q Are you an expert in pathology?

A No, I am not.

Q And do you consider yourself an expert in pediatric neurology?

A No, I am not expert, although I know a fair amount of it because I am in an area of medicine where I teach and we have joint conversations with pediatrics, so I am aware of many of the problems that the pediatricians face.

Q Do you feel comfortable commenting upon issues that fall within the realm of pediatric neurology?

A Only in the broad spectrum, what kind of damages would a child have to have for me to consider it an intrapartum event. What kind of damages are not related to an intrapartum event. So in this respect, yes. And I think even ACOG addressed that recently.

Q How?

A In terms of issuing bulletins on what constitutes neonatal brain injury that may be related do birth defects.

Q Do you have a particular cite to the bulletin?

A January bulletin of '92. But they have talked about that in the past in terms of brain injury. I have read the NIH study on brain injury. So I have a fair working knowledge of it. Do I examine babies? No. Other than the resuscitating a neonate, that is the end of my contact with the baby.

Q What NIH --

A Except for circumcision.

Q What NIH study did you refer to specifically?

A It is from about eight years ago and I believe

it is called Brain Injury. It is a book that is about an inch and a half thick of some 300 plus pages, and I have read that a few times.

Q Do you have an opinion that Doctor El-Mallawany's care during the labor and delivery of Zachary Berardinelli fell below the standard of care for an obstetrician?

A Yes.

MR. MELLINO: I will object. The name is not Zachary Berardinelli.

MR. SEIBEL: That is interesting because when I asked Mrs. Berardinelli that she said his name was Berardinelli, but it is Hammon?

MR. MELLINO: Yes.

MR. SEIBEL: From now on I will use the word Zachary to avoid the confusion regarding the name.

A That's fair.

BY MR. SEIBEL:

Q You do have an opinion?

A Yes.

Q What is the opinion?

A It fell below the standard of care in the

management of this woman's labor and in the delivery of Zachary.

Q I want you to state now specifically when and how Doctor El-Mallawany's care in your view was substandard.

A It became substandard when the patient walked in the door and he failed to evaluate the fetal weight. By deposition he had considered this an LGA baby of 9 plus pounds and therefore it is incumbent upon an obstetrician to put his hands or her hands on the abdomen and evaluate the size of the baby.

Secondly, he had noted in his records that she was 42 weeks gestational age. That also alerts a physician of potentially a macrosomic baby, it is a risk factor.

When meconium was noted and tachycardia was noted it was time to start considering fetal well-being. If this woman were in a teaching hospital, probably a scalp pH would have been done early on.

I think in view of the fact that it was considered that she had a temperature and she had good variability one could sit on the problem a little because the tracing early on was pretty normal. Some time later

the tracing turned abnormal with late decelerations greater than 50 percent of the contractions and I have that time as about 12:20.

At this point the physician has got to be alert or alerted that there is fetal stress, potential distress. And standards of care allow about a half-hour of observation, as long as it is not a catastrophic problem, that is bradycardia or a very smooth line, which didn't exist here.

Either this was unrecognized or they chose to ignore it, but these lates persisted and obviously they are indicating a progressive stress on the baby with burning up of reserves. The baby would be somewhat hypoxic although well compensated, and that is what variability means, the baby is compensated in utero, but the problem wasn't addressed.

And then she reached full dilatation, the tracing continued to be abnormal and ultimately at the +2 station with molding, which was documented by the pediatricians and not the obstetrician, a difficult mid-forceps was attempted.

Now, in view of the fact that there was

significant molding reported by the pediatricians, this baby was not at the +2 station but was at best +1, maybe zero station, which would make it a very, very high mid-forceps delivery, which we don't do today.

That was attempted. A severe shoulder dystocia was encountered, which was probably related to the use of the mid-forceps procedure. The shoulder dystocia was poorly managed according to the records themselves in that fundal pressure was employed, and that is just the item you are not to use because that further impacts the shoulders. There is no evidence in the records that McRoberts maneuver was used because the first maneuver that should be used is superpubic pressure and the second maneuver is McRoberts today.

So I find it a very inappropriate delivery, the baby was obviously stressed until that point, and that is the reason that, between the sepsis that the baby was subsequently documented with and the fetal distress which is evident on the record, is the reason that the baby, they had such difficulty in resuscitating the baby. The baby really had no reserves left. But I find no problem with the resuscitation.

Personally I feel that when the late decelerations began that was time to evaluate the mother carefully, start oxygen, place her on the left side, turn off the Pitocin, evaluate the baby. At the end of 30 minutes you still have persistent late decelerations, it is time to deliver the baby by the abdominal route.

I think it is possible that if this baby remained in utero much longer the baby would have demonstrated a terminal bradycardia and would have possibly have been damaged in that manner. In other words, we must assume based on the persistent lates that there is progressive fetal hypoxia -- not asphyxia -- hypoxia with developing acidosis, and it would have been accelerated at some time in the second stage and that's obvious on the monitor. At the +2 stage with molding it is unacceptable to attempt a forceps in this day. In 1970 it was standard of care; today it is unacceptable.

I think that is the way I read it.

Q Well, I have several questions to ask to you. I will try to go back to the beginning of your answer to the last question.

Do you know when Doctor El-Mallawany became

involved in this labor?

A I would have to look up that fact. I'm not sure exactly when he came aboard.

Q What is your understanding of how he became involved?

A I would have to look up that piece of data in the nurses' records?

I am looking to see if I noted it in my letter and I didn't in my letter. I would have to look up the nurses' records.

Q Are you saying that any time he became involved in the labor that he was obligated to evaluate the fetal weight?

A That's correct. Before you hang up Pitocin, if you have a 42 week gestational age baby then you are concerned about macrosomia so you must evaluate the fetal weight.

Q How should he have evaluated the fetal weight?

A Leopold's maneuver is the first one.

Q Describe that.

A Leopold's is using your hands, abdominal palpation -- some people consider it four, I consider it

five -- I use a vaginal hand to assess what the weight is. If I am suspect enough that I am going to evaluate that baby as a macrosomic baby -- which means nondiabetic, greater than 4500 grams -- I will get an ultrasound. If the ultrasound agrees with me, I will do an elective section on that patient.

Now that is not, there are a number of articles suggesting that it be done that way, there are a number of articles that say that is not what to do. I am a great believer in avoiding shoulder dystocia and so I am in the political area of do the section. And my residents know to come to me if they want that opinion.

On a diabetic baby I think we're all in agreement on a 4000 gram or more that is the cut off, you do abdominal delivery. But if you evaluate the baby as macrosomic or if you consider it potentially macrosomic, then based on Benedetti's work you don't instrument the baby because of the increased risk of shoulder dystocia using vacuum extraction or forceps delivery, mid-forceps particularly.

Q What were the risk factors for macrosomia?

A 42 week gestational age was the only risk

factor.

Q Do you have an opinion that an ultrasound done within the last 12 hours before delivery would have revealed macrosomia?

A In all probability it would have. Ultrasound is no panacea, it is not 100 percent accurate, certainly it has a 20 percent error, but if it agrees with your clinical opinion, that's fine. I tell my residents, if it doesn't agree, get another clinical opinion. And if the other clinician agrees that it is macrosomic, disregard the ultrasound because the ultrasound is in error.

Q How much did the baby weigh upon birth?

A 4700 plus grams, I believe.

Q How many pounds is that?

A That is 10 pounds. 4750 grams.

Q Do all 9 to 9-1/2 pound babies under these circumstances require delivery by Cesarean section?

A Absolutely not. That is exactly what I said.

Q That is why I want to probe that I little bit because you indicated that Doctor El-Mallawany thought this baby was 9 to 9-1/2 pounds?

A In the deposition he stated that. It is not in

the clinical records.

Q What I am asking you though if he had estimated that during labor knowing everything else we know about the condition of this mother, would that have compelled him to meet the standard of care to have done an elective C section at that time?

A No, not at all, even if he estimated 10 pounds, he still was not compelled to do the C section. But at the time you are estimating 10 pounds it requires discussion with the mother that there is a discrepancy in the record. Let's decide what to do. The baby is at risk for shoulder dystocia.

What it does indicate if he is considering the mother is 42 weeks and he is estimating an LGA baby and an LGA baby is greater the 4000 grams, then he has to be very careful at the second stage and not instrument the baby.

Q Would it have met the standard of care to have estimated the fetal weight in this case by Leopold's maneuver?

A Yes, it would.

Q So an ultrasound wasn't compelled during labor of this child?

A Not even mandatory today.

Q What percentage of 42 week gestation pregnancies result in macrosomic infants?

A I don't have the number at the tip of my tongue, I believe somewhere between 10 and 20 percent. It would depend on your patient population. In your affluent white population it is going to be much higher.

Q Why?

A Because they are of better nutrition. It is going to depend on upon background, history of diabetes in the family. There are some women who have one abnormal glucose level, we know that is just one, although they do not have gestational diabetes will give you an instance of about 20 percent macrosomia. So there are a number of factors that come in, so patient population is very important.

Q Does that percentage of macrosomic infants at 42 weeks decrease as you subtract days from the days of gestation?

A I don't understand that question.

Q We used 42 weeks as sort of a precise time. What I am asking you as you subtract days of gestation from

the 42 weeks so it is 42 weeks minus 1 day or 2 days less 42 weeks, are you following me?

A Yes.

Q Does the percentage of macrosomic infants at that time decrease with the less time?

A It does in an imperceptible way. And that is why when some woman is at or around 42 weeks we follow them as 43 weeks. For example, if someone walks in the door and is 41 weeks, we probably begin checking for fetal well-being at that point because they are not overdue, quote/unquote, and we start to consider them, watch the size of the baby. If it goes on another week, no one can key one day less or more, you don't do anything. Although the standard of care says if by the 42 weeks you haven't tested for fetal well-being, you done wrong.

Q What effect does maternal alcohol consumption and/or smoking have on fetal weight?

A Smoking would decrease the weight; alcohol usually would decrease the weight.

Q When did the fetal monitor tracing in this case begin to be troublesome as far as you are concerned?

A The most troublesome part is where the late

decelerations began and I stated a time before. That was the 12:20.

Q Do you have the actual tracing in front of you?

A Not in front of me, I have them.

Q Would you pull them, please?

A I have them, sir.

Q Can you identify the first troublesome tracing by panel number?

A 10:00 we have fetal tachycardia developing. Good variability.

Q What I really want to know. I don't know if this makes it easier or harder, what I want to know is the first tracing in the fetal monitor that should have in your view compelled different action than was taken by Doctor El-Mallawany.

A This would be around 12:20. I don't have a number. Yes, I do; 109, 110.

What you see when you start looking at the fetal heart tracing there is periodic decelerations. There is one at the end of panel 109. There is one at mid-panel 110. And I am considering the beginning of the panel where the number is placed.

And then there is another deceleration at the beginning of panel 111, and so on. And when you start seeing periodic decelerations you got to look very carefully because it is late decelerations until proven otherwise. Could be earlies too, but you have to identify where the dips are with respect to the contraction and one dip does not make a late deceleration, it has to be obviously recurrent. And ACOG requires greater than 50 percent of the contractions should be associated with decelerations, late decelerations, before you call it a worrisome tracing.

Q Is this a worrisome tracing or not?

A Not for the first minute or two minutes, it is not a worsening tracing. But after you look at the tracing for about 10 minutes you continue to have the periodic decelerations just after the contraction.

Q What time is that?

A By 12:30 you can see another deceleration occurring, you see oscillations going up and down and the fetal heart is usually maximum before the contraction kicks in and decelerates as the contraction occurs and doesn't return to base line until the next contraction.

Q Are those early or late?

A Those are late. Early decelerations would return to base line before the contraction ends or when the contraction ends.

Q Do what you say is a pattern of late decelerations continue until birth or do they change in some way?

A They are present throughout the tracing. Again, we could go through them and mark which ones have lates and which ones do not. Not every contraction is associated.

Q I want you to tell me precisely where you see the late decelerations beginning at 12:20 p.m.?

A Would you like me to mark these?

Q How ever you can identify them for the record.

A Do you want me to mark them with the pen?

Q Why don't you, then we can mark copies.

A We have a contraction around 12:21 and there is deceleration associated with that.

Q Why don't you put your initial in the circle?

A Okay. And I will put, the contractions are obvious.

There is another deceleration with the next

contraction. We have another deceleration with the next contraction. There is another deceleration with this contraction. There may be a contraction here, I can't tell, this could be. I can't tell exactly. Again another contraction right here and another deceleration there.

Q The end of 112?

A The end of 112. We have the contraction at the beginning of 113 and there is a subtle but late deceleration there.

We have a contraction on the next page right here with a deceleration right there.

Q Panel 114 now?

A 114. And the end of 114 is another contraction with deceleration there. We have another contraction here and it looks like there is a late deceleration there too. And another contraction here with another late deceleration.

And then the next one I don't see any late deceleration. The next contraction here has a subtle late but nothing else there. The next nothing. The next contraction may or may not be a subtle late, but it is there.

Here it looks like no late deceleration.

Q Panel 120?

A 120. No late deceleration. Now we have variability, there is another variable, indicating a corresponding pattern. At the contraction at 1300 there is a light deceleration. And it looks like she is pushing now too. So she is fully dilated.

Q This would be at 1:00 p.m.?

A Correct. Another contraction and questionable subtle late. Another contraction and that looks like I late deceleration. Another contraction over here with subtle late, and possibly another subtle late here.

And then we have some variables and some subtle late there which is certainly below the base line prior to the contraction kicking in. Then a deep variable. Another late deceleration here. Next contraction I am not sure of. There is a deep variable, there is a late deceleration here. I am now at 12:20. That contraction looks okay.

Q 12:20 or 1:20?

A I'm sorry, 1:20. 1:20, that contraction is okay. At 1:22 there is another contraction with a late deceleration. I have another contraction beginning at

panel 128 with a late deceleration, and a big variable on the next one. And that is all the tracing I have. Good variability maintained along the way.

Q What is the significance of good variability?

A It means that your brain is still being adequately oxygenated, may be getting progressively acidotic, maybe burning up reserves or base deficit. And that is what we talked about in terms of why the baby tolerated the birthing event so poorly.

Q What is the significance of the late decelerations that you just circled for us?

A That means that there is progressive hypoxia. In other words, when a late deceleration occurs because there is, there is blood returning in the placenta bed that is short of oxygen, and when the baby's chemosensors sense that there is low oxygen they start to selectively shunt the brain, the amount to the brain, heart, adrenals and placenta. It slows heart rate but it still gets adequate blood to the brain. And that is why you see the late deceleration because during contraction there is pressure on the placental bed and maternal blood flow may cease, and that is late deceleration. If you contract the uterus long

enough and hard enough you will produce contractions that usually correlate with a late deceleration and with continued late decelerations with each contraction the baby becomes a little bit more acidotic and gets closer to decompensating. That is typically what you see.

If you follow the tracing out long enough you will see late decelerations with good variability and ultimately late decelerations with poor variability which means now you have started to decompensate brain wise, and then you get either the terminal bradycardia episode or a wandering base line, and a wandering base line is due to cardiac instability from hypoxia. Now you're dealing with hypoxia and asphyxia.

Q This baby was not asphyxiated?

A Not on this tracing.

Q Was he ever?

A At birth, yes.

Q According to the tracing, did this baby ever lose his ability to compensate?

A No, he did not.

Q Why did the late decelerations begin at 12:20 p.m.?

A Again, more likely, you see them develop in somebody who is post-date. Certainly a degree of infection is always going to decrease placental ability. Also you are dealing with somebody getting Pitocin. We don't know exactly why they are occurring, it is a combination of factors. The key things when you begin to get late decelerations, stop running the Pitocin, put them in the left recumbent position, if you had them on their left, put them on their right and start oxygen.

Q What is your opinion if you have one as to why the late decelerations began at 12:20?

A I can't tell you exactly why they occur and we often cannot.

Q Have you identified in your previous answer all the potential reasons why they could occur?

A No, no. The list is endless. I mean the mother can be hypoxic and that in turn gives diminished reserves for the placenta, so the list goes on and on and on.

Q What response should a reasonably prudent obstetrician/gynecologist have with the tracing that began at 12:20 p.m.?

A Again, after about ten minutes or so of

observation you stop the Pitocin, turn mother on the left side, start your oxygen, see what happens. If you are in a hospital that does not have anesthesia available around the clock, doesn't have the nursing staff, doesn't have assistance, you are going to have to call in your team to say we need an urgent section here, come on in.

You have the luxury of observing a strip like that for 30 minutes. At least that's what the standards say. If she was in a teaching hospital she would have gotten a scalp pH, but that is not mandatory standard of care by any means.

After 30 minutes observation, you can't correct the problem, it is continuing, then it is time to move towards rapid delivery.

Q Were any of the things done that you say should have been done beginning at say 12:30?

A Not that I am aware of, sir.

Q What effect did that have on this child's well-being?

A Again, in other words, this baby went into the delivery event with minimal reserves, and that was the problem, that probably the excess base which eats up acid

is already markedly diminished, the baby had a degree of hypoxia. And when it was subjected to significant trauma or decreased flow, then the baby became severely asphyxic and that is the reason the baby was so difficult to resuscitate.

The average baby if it went into the event and was in good shape prior to the event occurring, might have been very easy to resuscitate. But certainly the fact that sepsis is aboard, the fact that there was some degree of stress, fetal distress, that set up the baby to make the baby very difficult to resuscitate.

Q Well on the issue of the difficult resuscitation, what played the greatest role, the sepsis or loss of reserves?

A Loss of reserves.

Q To what extent?

A I think the major. Because again septic babies we usually resuscitate very well and treat the sepsis. As a matter of fact we are almost cavalier about treating in utero infection today. In other words, the pediatricians tell us don't worry about it for six hours or so, we will treat the kid when you deliver the kid. Now it

is a little different than the thinking was, for example, in '75 or thereabouts. We felt once there was infection, get the kid out. The data shows now it is not that important. And sometimes we will start antibiotics if we anticipate it is going to longer than six hours, but the antibiotics may not even get to the baby. But most of them resuscitate very, very nicely

Q Is it reasonable medical practice to, even when there is a suspicion of fetal infection, to allow labor to continue?

A Yes, sir, that is standard of care. As a matter of fact, if somebody did a Cesarean section for just fetal infection that would be wrong. Now granted if you spent six hours trying to get her delivered and you are making no progress, then it is very appropriate to start thinking about getting the baby out at that point.

Q Was there any reason in this case upon the suspicion of a fetal infection to do a Cesarean section?

A No, there was not. And even antibiotics for the mother would be optional. It depends on the neonatal unit. Some would like you to use it, some do not use it. They would like to have cultures on the baby and get pure

cultures.

Q I believe you stated that this baby was not +2 station when the forceps were applied?

A That's correct.

Q Would you please tell me the entire factual basis for your statement.

A That is based on two statements or three statements or so in the pediatric records indicating molding, one saying marked molding. I believe that even the University Hospital confirmed that there was molding.

Q Is there anything else but molding that leads you to conclude that this baby was not at +2 station when the forceps was applied?

A That is the only thing. If there were no molding I would say that the +2 evaluation was correct, that is where the baby was. In other words, the leading part was at +2 in all probability, but the biparietal was not anywhere near where the obstetrician thought it might be.

Q Why do you say that?

A Because that is what happens with molding. In other words, what is moving into the pelvis is the top of

the head which is getting squeezed into an oblong shape and the baby may not be descending that much. It is just the head is elongated.

Q What percentage of vaginal births result in molding of the infant's head?

A Most nulliparous or somebody delivering their first full term there is marked molding. What is significant is when there is molding in an LGA, that is worrisome because you have to suspect cephalopelvic disproportionment and therefore you have to very careful that before you put mid-forceps on that you don't have molding. And it should be a fairly easy thing to determine because you do not feel any overriding structures. What you do feel is that the head has no room at the side. In other words, the kid has been squeezed into the pelvis. And when you see that you don't put the instrument on.

Q Who would be in the best position to determine whether this baby's biparietal was at +2 station before the forceps?

A The biparietal was not through, the leading part was at +2.

Q How do you know that?

A I am only going from what the doctor tells me, he says the baby was at +2 station. That means that the leading part of the head was at the +2 stage, which would put the biparietal 2 centimeters below the ischial spines.

Q Who would be, in terms of whether the baby was engaged, who would be in the best position to determine whether the baby's head was engaged before the application of forceps?

A The obstetrician and in all probability the head was engaged or at zero station. In other words, when the baby's head is at the zero station -- I made a misstatement before when I said the biparietal was at the ischial spines, that it is not true. It is above the ischial spines when at the +2. When the baby is at +2, the leading part of the head is 2 centimeters below the isthmus. When it is zero station it is considered engaged, but the leading part was at the ischial spines.

Q What is the risk of applying forceps, according to your view, to a child whose leading part of the head is at the +2 station?

A First of all there is a lot of pelvis that still has to be negotiated so that becomes a more difficult

forceps maneuver. And if the baby is molded it becomes increasingly difficult because it is that much higher in terms of where the biparietal position is. So those are the reasons that becomes a difficult mid-forceps. What my comment here is is that this is more of a difficult forceps, that is a high mid-forceps.

Q Why?

A Because of the molding.

Q Because you feel it was only the leading edge of head that was at +2?

A That's correct. Under the worst case scenario molding can be so severe that you can have the leading point at the vaginal outlet or vaginal inlet and yet the head is not engaged. That is the worst case scenario. That is not this case, but that is the worst case scenario.

Q Why was it inappropriate to apply forceps in this case?

A Because of the high head and the molding.

Q What injuries to the child occurred as a result of the application of forceps here?

A Not the application, the application did not cause the injury. It is the pulling that caused the

injury.

Q What injuries were caused by the forceps?

A The shoulder dystocia was caused by the forceps.

Q Explain that to me.

A What happens is you are dragging the head down and the shoulders don't have time to rotate into the appropriate position and they get hooked up above the pubic symphysis and you basically deliver the head and the shoulders are trapped above the pelvic ridge. That is why you get less shoulder dystocia if you permit spontaneous labor of large babies because it is a very slow process whereby the baby evolves and the shoulders rotate slowly into the proper position from forces from above.

Q Would it have been appropriate in this case for Doctor El-Mallawany to have allowed labor to progress further?

A In view of the fetal stress I would have expected the baby at some point to decompensate. So I think that the baby required delivery but not by forceps delivery. However, if talking about a normal tracing and he allowed a spontaneous delivery, I would have expected no shoulder dystocia to have occurred. And that is based on

Benedetti's work.

Q Are there any reasons for shoulder dystocia other than the application of forceps in this case?

A Well shoulder dystocia we don't fully understand why it occurs. We know when it occurs. We can usually make the appropriate diagnosis. But even normal size babies may experience shoulder dystocia and every obstetrician must be trained in the management of shoulder dystocia. But clearly in the large for dates baby what happens is the shoulder diameter is much larger than the biparietal diameter. And if the head comes through okay the shoulders get trapped, you do the maneuvers of either reducing the shoulder diameter by using superpubic pressure, fracturing the clavicle or expanding the pelvis with the McRoberts maneuver.

Q What you think happened here? Was the shoulder dystocia a result of tugging by the forceps or was it due to the size of the shoulders?

A Both.

Q Was there any way for Doctor El-Mallawany to have reasonably foreseen shoulder dystocia in this case?

A I think he should have definitely anticipated

shoulder dystocia. There is certainly enough in the record to anticipate it. One is --

Q I don't mean to stop you, I do mean to stop you because I want to make sure I will get you geared into my question.

We know that shoulder dystocia is a risk for babies at this gestational age period, correct?

A Correct.

Q Now is there anything particular about this labor that would have alerted Doctor El-Mallawany that shoulder dystocia was even more likely to occur in this particular delivery?

A One could expect it in a long second stage. And obviously the patient did not make great progress in the second stage. But even some material that has been published by Metro and some other people show there are very few factors to hang your hat on in saying this is a risk factor. In other words, if this happens you have got to suspect shoulder dystocia. We have no good predictors other than to suspect shoulder dystocia and that is why macrosomia is so important but certainly in the slow descent of the head one would worry about the possibility

of cephalopelvic disproportionment and subsequently shoulder dystocia.

Q Is the answer to the question yes or no?

A It is yes and no.

Q Is it more yes or more no?

MR. MELLINO: What question?

He originally said yes and you stopped him and asked a different question and wanted a yes or no answer.

MR. SEIBEL: No, I didn't.

A I am somewhat confused about the question. That is why I said yes and no, cover both bases.

BY MR. SEIBEL:

Q I think the question was was there anything particular about this labor and delivery that would have alerted Doctor El-Mallawany to a greater likelihood of shoulder dystocia?

A The problem was there was interference at the second stage so I can't tell you that this is a catastrophically long second stage because there was instrumentation. It was one hour or second stage which for a nullip is normal.

Again we are told in the records that it only

came down to +2. So there wasn't descent in the first hour. Again, I wasn't there, I can't tell you. If we were looking at a three and a half hour second stage I could sit here and say yes, that is a long second stage and you ought to expect cephalopelvic disproportionment and ought to expect shoulder dystocia.

Q Was it reasonable for Doctor El-Mallawany to attempt to effect a delivery at the time that he did?

A Delivery should have been effected but not by the means that were used.

Q You made a comment about the management of the shoulder dystocia, is there an order in which either superpubic or McRoberts maneuver ought to be used?

A The simpler is superpubic pressure. If that doesn't work, then one ought to go directly to McRoberts maneuver.

Q What is superpubic pressure?

A Superpubic pressure is merely applying a fist above the pubic symphysis and trying to depress or contract the shoulders and push them into the pelvis.

Q Where is the pressure applied?

A It is applied at the mons pubis, the hairy area

just above the bone of the pubic symphysis.

Q With a fist?

A With a fist. It is not mandatory, it could be the palm of your hand too. Most people would apply a fist.

Q Contrast that with fundal pressure.

A Fundal pressure is applied at the top of the fundus which would be at that point probably just above the umbilicus and that would literally apply pressure on the fetal buttocks which would only force the shoulders to impact more against the pubic symphysis because you were not decompressing the shoulder diameter.

Q Does fundal pressure play any role in the management of shoulder dystocia?

A I have only seen one article that misquoted and said use fundal pressure. Every article specifically talks about superpubic pressure and I have seen recent articles that condemn fundal pressure.

Q What do you think?

A I think superpubic pressure is the only way to go in any situation and I don't allow residents to apply fundal pressure under any circumstances because of the risk of rupturing the uterus, although I have never seen it

happen.

Q You have never seen it happen?

A No, I have not.

Q And do you use fundal pressure in the management of shoulder dystocia?

A No, I do not.

Q What is superpubic pressure designed to do specifically?

A Specifically to contract the fetal shoulders and push the anterior shoulder which is trapped above the pubic symphysis, push that below the pubic symphysis so that the shoulders can slide out.

Q How long is it appropriate to attempt superpubic pressure during a shoulder dystocia case?

A Probably 30 seconds because it feels like an eternity when that happens. Because you know the head is trapped. I have on occasion even when alone in the delivery room at 3:00 in the morning put a nurse down below to guide the head out. I had to apply the superpubic pressure, I have got a shoulder dystocia and because I know I can apply more pressure in the right area than a 90-pound nurse. Because I don't want to apply, because of brachial

plexus injury, I don't want to apply pressure on the head.

Q What is McRoberts maneuver?

A It is maneuver where you flex the thighs, they come up over the abdominal wall and extend the legs and it literally does open up the pelvic walls. As a matter of fact I just saw it misdrawn in one of Benedetti's throw away articles, it was misdrawn in that the legs were not extended, they were flexed. That is wrong, the artist got it wrong. But the original work showed flexion and extension and it is an odd position and the family thinks you are out of your mind if they are in there watching the delivery.

Q Have you been able to fully discuss the areas where you feel Doctor El-Mallawany's care was substandard?

A I believe I have.

Q When did Zachary's brain damage occur?

A Probably occurred during the shoulder dystocia itself and possibly a little bit afterward when they had trouble resuscitating.

Q All right, how soon before delivery did the brain damage occur?

A I don't have enough tracing to tell you to

pinpoint. In other words, terminal fetal distress could have started a long period of time, I'm not sure. All I can do is say that we know there was a difficult shoulder dystocia and based on what we are looking at that is the only thing I see. I mean standards of care suggest that if you have got a fetal distress or any patient you are monitoring you monitor them into the delivery room until you do the delivery. That wasn't done here.

Q Is that substandard?

A That is substandard certainly when there is a fetal distress, and that is a nursing obligation to bring the monitor along as well as the obstetrician saying bring along the monitor.

Q Is that another area?

A No, because there is an alternative according to the American College where oscultation after every contraction is appropriate in second stage. In other words, we cannot based on ACOG's bulletins, suggest that fetal monitoring is mandatory, although I take great exception to that.

Q Continuous fetal monitoring is not standard of care?

A It is standard of care by obstetricians. ACOG would have us believe that it is no better than oscultation.

Q What is ACOG's role in determining the standard of care for obstetricians and gynecologists?

A I had for years stated that ACOG truly set standards of care because their bulletins were extremely well written based on accurate literature. And in the last three or four years there have been bulletins which contradict each other. There are bulletins that are flatly wrong, misquoted literature. There have been bulletins that have actually done a disservice to the medical community by not taking a stance. So something has happened in their writing in the last three or four years.

Q To what point do you feel comfortable in relying upon ACOG to set the standards for obstetricians and gynecologists?

A Probably about four years or so. There are still some very good bulletins produced; some markedly deficient, particularly the one published on neonatal newborn injury, it absolutely misquotes the literature and is based on literature that is 25 years old.

Q You are you a member of ACOG?

A Yes, I am.

Q Specifically with respect to the date of this birth which was September of 1988, do you feel comfortable that the ACOG standards then prescribed good and reasonable standards for practicing obstetricians/gynecologists?

A Yes, I think they were very reasonable up to then.

Q I want to make sure that we fully discuss the issue about when the brain damage occurred. You are saying, give me a time between when and when you feel that it occurred.

A Between the time that the monitor was removed and the time that the baby was delivered. And a little bit may have occurred in the first 10 minutes of life because with the Apgar remaining zero you were not going to have much blood and oxygen circulating to the baby.

Q When was the monitor turned off?

A The monitor was removed at 1326 or 1:26.

Q And when did the delivery take place?

A Delivery took place at 1:53 p.m. and the baby really didn't have any blood circulating until ten minutes.

Q What occurred between 1:26 and 1:53 to cause the brain damage?

A We don't know. In other words, if there were a significant fetal distress, we have missed it on the monitor.

Q Are you satisfied to a reasonable degree of medical probability that before 1:26 this baby did not have a significant brain injury?

A Yes, I am.

Q When did Zachary's brain injury become permanent?

A Probably after he was resuscitated. In other words, the damage was already done.

Q When did that damage become fixed?

A I don't know that the damage -- I don't quite understand how to answer that question.

Q Do you believe that he has a permanent brain injury?

A Yes, based on what I have read, yes.

Q What have you read to lead you to conclude that he has permanent brain injury?

A That he has global brain damage. In other

words, there is motor impairment, mental impairment, that goes along with a global injury.

Q What have you read that leads you to conclude that? I am asking specifically.

A I know I asked Mr. Mellino the status of the child and I have looked at some of the records. I believe I made a couple of marks. The molding comments from University Hospital.

And I have, there was a page in the records that talked about a brain damaged child. And again I haven't pinpointed that one and I apologize.

Q What information do you have about the current status of the child?

A Other than the baby is badly brain damaged, that is all I have, and that it appears to be global damage.

Q Are you using those facts as part of your basis for your opinion that he had permanent brain injury between 1:26 and 1:53 p.m.?

A Yes, sir, a global damage would fit. I know it is in the records someplace and I didn't mark the page.

Q EEG?

A No, I am looking at here he is seen in 1990.

And I know there was something towards the end of this record and I didn't mark the page where it talks about brain injury.

MR. MELLINO: I am going to object to this as I think you are getting outside of Doctor Edelberg's area and also a lot of outside area opinions that we are going to be eliciting from him on direct examination which is I think all you are entitled to during the discovery deposition.

BY MR. SEIBEL:

Q Doctor, are you going to give any opinion at trial about the nature of Zachary's brain injury?

A No, not the nature of it. Only to say that if a baby has global damage, then it fits the characteristics of an in utero asphyxic event.

Q By global you mean what?

A Water shed type damage, we are not talking about specific and only cerebral palsy. We are not talking about pure mental retardation. We are not talking about one isolated motor function. We are talking about damage which you can't really pinpoint which areas are damaged because it appears to be global. That is what we see from the perinatal or the in utero insult. So if the baby had pure

cerebral palsy, I wouldn't be there. If the baby had pure mental retardation, I wouldn't be here.

Q By mental retardation, what is your definition of that?

A Again, I don't treat in this area. The pediatrician has made a diagnosis of retarded infant, low IQ infant and that is all that is seen. That is in all probability not related to at least a labor insult.

Q And the same with just cerebral palsy?

A That is more true. That is more related for example, to prematurity than to labor insult, although there have been some documented cases of pure cerebral palsy.

The baby gets compensatory, a lot of systems down and out and then there appears to be some rehab process and a good deal comes back and the kid is left with pure cerebral palsy. Those cases are few and far between.

Q You were at least satisfied that if it was just a case of cerebral palsy that would not lead to the conclusion that there was an asphyxic delivery?

A That's correct. Unless there were lots of other factors. In other words, if the baby had very, very low

Apgars, was very acidotic, hypotonic, spent a month and a half in the nursery getting rehabed and eventually appears to be below normal intelligence but CP, that may be related to the birthing event and even the NIH study agreed with that, but that is rare.

Q Let me ask, if it is just cerebral palsy would that lead you away from the conclusion in this case that there was birth asphyxia?

MR. MELLINO: Let me object. I think you are getting into an area the doctor treating the child will testify to, he is the one testifying as to causation in this case, and Doctor Edelberg is not going to be called in direct examination to give any opinion testimony in this area, and I don't think you are entitled to delve into that any further than you have.

MR. SEIBEL: The reason I am asking, Chris, is that because he did say that the nature of brain injury does relate to his opinion that there was birth asphyxia.

A Again I gave the one case scenario, low Apgars, asphyxia, hypotonia, poor behavior in the nursery, seizures, and then if this baby had been left with just low normal intelligence and cerebral palsy I think I would say

that that is one of the exceptions.

BY MR. SEIBEL:

Q Exceptions to what?

A The pure cerebral palsy not being a birthing event because the birthing events were so clearly asphyxic. But those are very rare cases.

Q Did you consider any other potential explanation for Zachary's brain injury other than birth asphyxia?

A I always look for other reasons.

Q What else did you consider?

A Genetic, what the baby looks like. You look for prenatal events that may affect it. You look for past history. There are a number of factors you look at and I found nothing that clearly explains why this baby did what it did other than an asphyxic event.

Q What effect does E. coli sepsis have on the fetus?

A Again, babies usually survive without problem. Not premature babies, but term babies.

Q What at least are the potential effects on term fetuses who have E. coli sepsis?

A Babies can die with sepsis, no question about

that, but most survive and survive uncompromised by risk factor.

Q For death or other things?

A Usually death. If a baby is in septic shock and they are having trouble aerating the baby, the baby may also then suffer a brain insult.

Q Can you be any more specific about the timing of Zachary's brain injury than between 1:26 and 1:53?

A Actually it could be later than 1:53 because of the difficulty of resuscitation. No, I can't be more specific because I don't have enough tracing. If there weren't fetal distress here I might be able to be more specific. But it was because of the fetal distress that the baby was so difficult to resuscitate.

Q In terms of your opinion about when this brain injury occurred, what about 1:27 for instance?

A No, it is more likely that it occurred during the shoulder dystocia and at the time of the resuscitation.

Q How long did the shoulder dystocia last in this case?

A About six minutes, five to six minutes.

Q Is that an unreasonable time to resolve?

A It is a long time.

Q Let me ask you if it is the standard of care to resolve shoulder dystocia within five minutes?

A There is no standard of care. You are suppose to resolve it as quickly as possible. This is a long, long delivery. In other words, this is considered an obstructed delivery by anybody's standards, but there are no standards and there is nothing that says you must have the shoulders out in so many minutes or you are going to do this, this and that.

Q Is it your opinion that the time of the shoulder dystocia is when in all probability the brain injury occurred?

A Or began. In other words, it is a continuum, it doesn't say normal, normal, and boom we have the entire injury. It depends on how long the brain experiences asphyxia and it becomes progressive and the monkey data is very clear on that.

Q What would the baby's condition be if born just before the shoulder dystocia occurred?

A Again assuming the tracing did not worsen, if born just before the shoulder dystocia occurred it would

have been somewhat acidotic but it would have been a quality survivor.

Q What do you mean by quality survivor?

A Normal neonate. If there was terminal bradycardia that was missed, again this tracing could go onto that, that baby may have suffered an in utero asphyxic event prior to the shoulder dystocia and the shoulder dystocia compounds it.

Q Do you think there was a terminal bradycardic event before the shoulder dystocia?

A I can't tell you that. But whenever you have fetal distress on the monitor you know that it can progress.

Q When between 1:26 and the time of the shoulder dystocia do you believe that there was a terminal bradycardia?

A I can't tell you that. Between 1:26 and the time of the shoulder dystocia.

Q What effect does fetal body tone have on over coming shoulder dystocia?

A I don't know how to answer that. I don't really know what you mean.

You mean lack of tone or no tone?

Q Lack of tone.

A I would think it would be easier to depress the shoulder if the baby lacked tone. I have never seen a study. That is speculative based on no scientific fact.

Q When did the chorioamnionitis develop in this case?

A I'm not sure when it began.

Q When did it present itself?

A It presented itself when the mother had the tachycardia.

Q When was that?

A We read that when I was talking about the tracings, I think it was 10:30 if I remember correctly. I am looking at my notes. I think about 10:00 she demonstrated a fetal tachycardia and by 12:40 she was febrile and that sort of confirms the diagnosis. When it actually began, I can't tell you.

Q Do you have any opinion whatsoever how long it took for the presence of the chorioamnionitis to exhibit itself in a maternal response?

A There are so many variables there.

Q Was it most likely hours, days, weeks?

A It is usually hours. We deal with that all the time that people prematurely rupture membranes and observing signs of chorioamnionitis, uterine irritability, maternal tachycardia, fetal tachycardia, maternal fever, white count; and if any one goes up we start thinking about emptying the uterus promptly and that means usually within 12 hours of the time we make the diagnosis.

Q What is asphyxia?

A Asphyxia is a definition that people interpret a little differently. Asphyxia to me means low oxygen and significant acidosis; whereas hypoxia means low oxygen and increasing acidosis but not pathological acidosis. All babies in labor suffer from a little bit of hypoxia because we know that pH drops even in a normal labor.

Q What is the normal range of a low pH for a normal delivery and labor?

A Well, we look at above 7.25 is perfectly normal. Abnormal is 7.20 and then there is controversy on what we call between 7 and 7.20. And certainly below 7 we consider that a catastrophically low pH. Whereas most babies in the 7 to 7.20 range survive and it really depends how long they

sustained the acidosis what damage there is. For example, if it is an acute event, pH below 7.0, they are resuscitated quickly, they are perfectly well because it was really a short, acute event.

Q What is the expected result to resuscitation for a child who is delivered after five minutes of shoulder dystocia?

A Usually they do rather well as I think I stated that earlier. Certainly if they go into the event with good reserves they should sustain without compromise whatever and be easy to resuscitate.

Q I would like you to assume just for purposes of my question that the tracings which you have identified as showing a diminishing of reserves in fact show just the opposite, they show normal reserves. All right? If that is true, then is this child's response to resuscitation abnormal?

A It is still abnormal and it could be again because of the infectious process. Again that is a very stressful event. As I said, most babies respond nicely that are septic.

Q Do you have an opinion as to how much of

Zachary's brain injury occurred during the shoulder dystocia versus the resuscitation period?

A That is impossible to quantify.

Q When could Zachary have been delivered without permanent brain injury?

A Based on these tracings up until the time that those tracings end.

Q And then probably sometime thereafter, correct?

A Correct, depending on how long the tracing was normal, not normal but how long variability persisted.

Q Is there an expected response on fetal monitor strips to a term infant with sepsis?

A Other than seeing tachycardia, that is one of the responses. And sometimes if the baby is really ill in utero you will see the fetal tachycardia and increased variability and those are the babies that you really worry about and that would prompt me to cut the time down leaving the baby in utero. If I couldn't assess fetal well-being in that particular baby then get the baby out promptly.

Q Does a septic term fetus always show those kinds of responses on the fetal monitor?

A In medicine nothing is 100 percent.

Q What percentage of septic fetuses at term show that type of response?

A Most have normal tracings, albeit mild tachycardia, but that is with maternal fever but without maternal fever based on the in utero stress of infection. It is without variability that it becomes worrisome.

Q Is there a difference between post-date and post-mature?

A Yes, there is.

Q What is the difference?

A Post-date means that the mother is greater than 42 weeks. Post-mature means that the baby is beginning to show signs of dysmaturity from a failing placenta. It could be loss of subcutaneous fat tissue. It may be a loss of weight, it may be peeling skin. It may be placental insufficiency. Those are all the signs of a post-mature baby.

Q Was this baby post-mature?

A There was no evidence that it had a post-maturity syndrome.

MR. SEIBEL: Those are all the questions I have at this time.

EXAMINATION BY COUNSEL FOR THE DEFENDANT MARYMOUNT HOSPITAL:

BY MR. ALBERT:

Q Doctor, I represent the hospital.

In your report in the first paragraph you recite certain things that you have reviewed. And then you today indicated that you have reviewed some additional materials?

A Yes, sir.

Q Is there anything that you have reviewed other than that which you recited in your report, paragraph one, and that which you outlined when you were being examined earlier, have you reviewed anything other than those things?

A No, other than looking at literature of the time.

Q What literature did you look at?

A I looked at shoulder dystocia. I was really looking for somebody to come up with why kids that have impacted shoulders decompensate or become acidotic and I have yet to find that. I mean everybody agrees with it. Dierker said yes, I would expect it. We all expect it. I have seen three babies die in my residency when I was in

training who had shoulder dystocia and can I tell you what happens during that or what gets impinged? I'm not sure.

Q What literature specifically did you review?

A There is a review article on shoulder dystocia in the clinics, in Clinical OB/GYN, it is a yellow book that is produced and it talks about McRoberts.

I looked at Creasy and Resnick. I looked at Williams Obstetrics. Those are the main things on shoulder dystocia that I looked at.

Q How many occasions have you had to manage a shoulder dystocia?

A Over my career? Depends on how you define it. I probably have had maybe five or ten very significant shoulder dystocias and maybe 50 mild shoulder dystocias, certainly with the residents. As a matter of fact only a nonsevere shoulder dystocia. I happened to be on the labor floor and used the McRoberts. It's amazing how the kids fall out.

Q How do you define severe to mild to moderate?

A Nobody has ever done that.

Q You are using the term.

A You sweat more with severe, you are sure you're

going to have an injury and you worry. Where the other, apply pubic pressure, decompress the shoulders and that's the end of it. If you start using maneuvers beyond superpubic you are probably faced with very significant shoulder dystocia.

Q How did you make the diagnosis?

A You make the diagnosis on the delivery of the head. And what happens, the fetal head literally tries to suck back up into the vagina and presses tightly against the mother's perineum and it's frightening. You suspect a macrosomic baby and suddenly you're looking at a large head and you know the shoulders are even larger than that.

Q How do you have to be positioned in order to make the diagnosis?

A I don't understand that question.

Q What position do you have to be in to make the diagnosis?

A I can make it across the room by watching what is going on.

Q Do you have to have visualization of the head in the outlet?

A The baby is already out. You don't diagnosis

shoulder dystocia until the head is out.

Q I see.

A And it is a frightening feeling as you deliver the head and it just sucks sort of back up and gets sort of trapped at the outlet of the vagina.

Q You have outlined criticisms of Doctor El-Mallawany, do you have any criticisms that you suggest are deviations from accepted standards of care of any other health care providers in the delivery of this child?

A Only that the nursing staff did not alert the doctor about the fetal distress. Because labor management is today a team effort and often the nurses are reading the monitor, the physician is reading the monitor or the physician depends totally on nursing reading the monitor, residents may read the monitor. And whoever sees the fetal distress has to alert somebody else I am finding fetal distress, come look.

Q Where were you referring to the fact that the nurse also failed to alert the physician of a fetal distress?

A I don't see a description of late decelerations.

Q At what point?

A At any point.

Q The time period therefore I assume you are talking about is from when the late decelerations first appeared?

A Correct.

Q Let me then clarify a few things with respect to that. It is intermittent late decelerations that you were referring to in your testimony earlier today?

A These were considered fetal distress because it is greater than 50 percent of the contractions.

Q Well, I will restate the question again.

Was it intermittent late decelerations that you were referring to?

A If they don't occur with every contraction. They were nearly, they were with most but not every so by the definition you are using it has to be intermittent since there is an occasional contraction not associated with a late.

Q So you would describe these late decelerations as intermittent?

A No, I did not describe them. I used your definition.

Q I am trying to ask you if you are describing them as intermittent.

A These are persistent lates.

Q You are aware in your report that you talk about intermittent late decelerations?

A I am aware of that.

Q Is that in error?

A It is not in error. It depends on how you define intermittent. If it is greater than 50 percent I believe I state two-thirds of the contractions are associated with late. Then by definition, that is an ominous tracing.

Q Now, you have indicated that a physician has the right to observe the patient for 30 minutes from the onset of these late decelerations before making a decision?

A For Cesarean section yes.

Q Is that correct?

A Depending on what is showing. If there is good variability then you have the option of watching her for 30 minutes. Obviously doing certain maneuvers; stopping Pitocin, which is a nursing obligation; starting oxygen, which is nursing obligation; putting on the left side,

which is a nursing obligation.

Q Well, so I am clear, would those things be done during that 30 minute term?

A Early, probably 10 minutes being sure that this was a developing pattern.

Q Now factually speaking are you aware that Doctor El-Mallawany was at the patient's side by about 12:50 or 12:55?

A I don't have the exact time.

Q The record says that.

A I will take that as a given.

Q I guess what I am trying to understand, do you believe that this criticism that you have of the nursing staff proximately caused any injury to the child?

A Yes, I believe that is where the reserves became depleted to help the baby to sustain any delivery trauma. Because the reserves diminished is why he was difficult to resuscitate.

Q You are saying that at 12:20 the nurses should have done something or a nurse should have done something?

A 12:20 is when this event began. So probably about 12:30 was time to start your treatment plan.

Q What should the nurse have done without a physician's order?

A Stopped the Pitocin.

Q Without a physician's order?

A Absolutely.

Q What else?

A Start oxygen.

Q What else?

A Put the patient in the left lateral recumbent position.

Q All of which should have occurred without a physician's order?

A Absolutely.

Q And what would you have expected would have happened?

A Also notify the physician, we have a potential fetal distress, please get here as soon as possible.

Q Now, at 12:50 the physician is there in this case, correct?

A Correct.

Q Were any of those steps taken thereafter?

A I didn't see them taken at any time.

Q Now, let me explore with you if I may your understanding of the nurse's responsibility.

What in your history has given you the information to indicate that the nurses should have done those things at 12:30?

A Well, in basically any hospital, this is standard nursing obligation that when there is fetal distress you do the following things that I have mentioned, notify the physician, turn on left side, et cetera, et cetera, et cetera.

If the physician does not respond appropriately, then you have to notify your nursing supervisor to get help. And you get a second opinion or you call the head of the department, but you get somebody else to help.

Q Do you expect that the nurse who was there should have been able to interpret the fetal monitor strip in the same way you were able to interpret it?

A I think a nurse must be able to recognize late decelerations.

Q And should she have been able to read that strip the way you read the strip?

A I think first of all there was fetal tachycardia

long before. So she should have been alerted to problems brewing and at that point she probably should have told a physician to come in because it is an obvious problem and that wasn't done.

Q How do you know that?

A Only because the physician wasn't in. In other words, if the physician doesn't come in, then you got to notify your nursing supervisor that the physician is not responding to an emergency call.

Q Well, should the doctor have come in before 10 to 1:00?

A Of course.

Q What time?

A Meconium was noted, fetal tachycardia, that is when you are alerted, probability of a post-date patient. He has to be there. Certainly in many hospitals if you hang up Pitocin there are rules and regs that the doctor must be there. I have practiced in hospitals where they have the rule about other physicians being available supposedly to bail you out if there is some major league event that occurs.

Q Are you suggesting then that the doctor at the

first signs of those things you indicated, the meconium and the other things outlined, should have been continuously with the patient until delivery?

A Or been aboard on the labor floor.

Q Not left the hospital floor until the child was delivered?

A That's correct.

Q You are aware that Doctor El-Mallawany was in at 9:00?

A I'm not sure exactly what time.

Q You are aware that he was contacted and given information at 10:30?

A I believe so.

Q Are you aware that he was contacted again at 11:30?

A I believe there was some indication of that, yes.

Q Do you believe that the nursing personnel who were involved in the care during that time period deviated from any accepted standard of care with respect to the communication with the physician?

A I don't see where they recognized fetal distress

and communicated that to the physician.

Q Well, if the doctor was there and didn't examine are you suggesting that the nurses had an obligation to communicate that?

A Of course, that happens all the time.

Q And your position is that if the doctor did not take certain steps, that the nurse should have contacted the nursing supervisor, that was the next step?

A That's correct.

Q Has that ever happened to you?

A Not to me but I have had nurses call me in the middle of the night in private practice and present me a scenario and I gave instructions and at the end of the instructions she said uh-huh, we need you in there. And I got my tush out of bed and in I went. And there are certain things they would say to me, one thing is meconium, I'm going in. Or fetal tachycardia, or there is a question of fetal distress, I'll be in.

If they called me and said there was fetal distress, prepare the operating room I'm coming in. The worst I will do is anger people for setting up a room that wasn't needed.

Q And you didn't leave the hospital until the child was born?

A On those occasions, of course, unless the reading was totally wrong by nursing.

Q I see. Now at 1:20 or thereabouts you say that the C section could still have been done?

A Yes, sir, because there is normal variability on the fetal monitoring strip.

Q And if that had occurred there would have been no injury to the child?

A That's correct.

Q Is any of the nursing personnel involved with respect to the decision on a C section?

A No, they are not. They can prod a physician and I have seen that done.

Q You are talking figuratively I assume?

A Yes, it has nothing to do with sexual harassment. That is the biggest thing now in all of the hospitals, what constitutes sexual harassment. Prodding is not allowed, at least with your finger, unless you charge for it.

Q In any event by 12:02 a decision could have been

made to do a C section?

A Yes, sir.

Q And that was a decision to be made exclusively by the physician?

A That's correct.

Q You would not fault the nurse for not prodding the doctor to do a C section?

A No, but I think the nurses should have alerted him to the fact that there is an abnormal tracing.

Q I understand, but the doctor, you are aware, at 1:00 was there and you are aware factually speaking having reviewed Doctor El-Mallawany's testimony that he reviewed the tracing?

A That's correct.

Q So what I am trying to get at, should the nurse have done anything at 1:20 or before with respect to the C section issue that you have outlined here in order to comport with an accepted standard of care?

A I can't tell you that these tracings are somewhat catastrophic, that they must at that point go over his head.

Q Okay. So that we can agree that your criticism

of the nursing does not relate to the decision not to do a C section?

A That's right. It is my opinion that had they demonstrated to him an hour earlier that there is fetal distress in this pattern I think a reasonable physician knowing that there is meconium, knowing post-date would have opted to do a Cesarean section.

Q Doctor, you are aware that Doctor El-Mallawany reviewed the strips?

A Yes.

Q By 1:20?

A Yes, I am.

Q So there again just because your answer seemed to, I want to make sure that your answers are consistent, you are not suggesting that the nurse had any responsibility with respect to the decision to do a C section?

A Not to do a C section but to help the physician interpret the tracing correctly, yes, they had a part in that.

Q Are you suggesting that Doctor El-Mallawany would have done a C section if the nurse had said to the

doctor that these tracings in my opinion are demonstrating fetal distress?

A He may have, yes.

Q Are you suggesting that that is probable?

MR. MELLINO: How does he know?

A I can't get into your doctor's mind.

BY MR. ALBERT:

Q So fine, you have no way of knowing what the results of that communication would have been?

A No, I don't. I can only attest to what my behavior is. If the nurse demonstrated I don't like the tracing, come look at. If I looked and said what are you talking about?

This, this, this. And I have had nurses pick up things because I run a testing unit.

What are you talking about?

This and this.

You're right. Subtle late decelerations are there. Let's go on and test some more. Nice pick up.

Q Doctor, if a nurse came to you and said I think there is fetal distress here from these tracings, and you said to her looking at the same tracing, I don't agree with

you, would you expect that nurse in order to comport with accepted standards of care to notify her nursing supervisor?

A Depends on the degree of abnormality. In this case, no.

Q You would not?

A Not in this case.

Q So if Doctor El-Mallawany did not feel that there were abnormalities of this tracing you would not expect the nurse to notify the nursing supervisor?

A No, I would just expect her to be able to read these tracings and prod him to relook at the tracing.

Q I understand, but if the doctor didn't believe that the tracings were abnormal you wouldn't expect the nurse to go beyond that to meet the accepted standard of care?

A Not in this case, they are not abnormal enough.

Q I am just dealing with this case.

You have reviewed Doctor El-Mallawany's testimony?

A Yes, I have.

Q Do you have memory as to what his opinion was

with these tracings?

A I have it written down some place.

I didn't note what he said about the tracings. But if you refresh my memory or refer me to the page that would be fine.

Q I could not possibly do that, but I would like you to assume that Doctor El-Mallawany did not feel that the tracings were abnormal for purposes of my question.

A That's fine.

Q Then did you believe that the nurses in any fashion deviated from an accepted standard of care in not going to a nursing supervisor in this case?

A In this case they did not have to go to the nursing supervisor.

Q Other than talking about the doctor and the strip that we have just discussed, what other departures from the standards of care did you observe with respect to the nursing personnel?

A That would be because of fundal pressure. Although I am critical of it, if instructed by the physician to give fundal pressure I would expect them to do that.

Q So you have no criticisms other than the strip communication in this issue?

A And the failure to stop the Pitocin and the other items.

Q Well, what other items?

A Oxygen, left lateral recumbent.

Q Given the fact that the C section could have been done up to 1:20 or perhaps beyond, do you find that the failure to stop the Pitocin in any way contributed in and of itself to an injury to the child?

A It probably did, sir.

Q In what way?

A In that your contractions on Pitocin are going to be stronger and produce more placental bed hypoxia. That is the reason you stop the Pitocin.

Q Can you quantify how much more placental bed hypoxia occurred as a result of having Pitocin running for those 20 minutes or whatever than not?

A I can't give you that.

Q Without the ability to quantify it how can you determine it caused an injury?

A I didn't say cause, I said contributed.

Q How can you say it even contributed? Doesn't it become a mere speculation?

A We know that when you are driving the uterus with Pitocin you are going to increase pressure, you may increase uterine tone between contractions and that is why there is fetal distress. You stop Pitocin. Does it get better every time? No. Does the uterus continue contracting? Often times just as strong perhaps, but without stopping it you don't know what effect the Pitocin has. That is why the standard of care says stop the Pitocin.

Q Can you say in this case that it is probable that the continuation of the Pitocin contributed to the injuries to the child?

A I think it contributed to an extent. I can't quantify whether it is 3 percent, 20 percent or 50 percent. I can't give you a number.

Q What type of injury would it have contributed to?

A It contributes to the fetal hypoxia which then burns up your base excess.

Q Was the Pitocin stopped by Doctor El-Mallawany

when he got to the hospital?

A I think it was decreased. I don't believe it was stopped. If I remember correctly I had a note that it was decreased. I didn't have a note that it was discontinued. If I am incorrect on that, I will accept that.

Q I would like you to accept that Doctor El-Mallawany's position is that the Pitocin should be running. Would you expect that the nurse should disregard the order of the physician?

A Yes; in that case, yes.

Q And in that incidence you believe that the nurse even with the physician there should have stopped the Pitocin?

A Yes.

Q Have you ever had a situation where nurses attempted to intervene and stop -- what would you call Pitocin, medication?

A Pitocin is a very potent medication.

Q Have you ever had an incident where a nurse has attempted to intervene and stop medication that you have ordered?

A Not that I have ordered but it happens frequently in a teaching unit where the resident will order something and the nurse says no way, I am not hanging that up. I am not giving it to the patient. You get the chief resident or call Edelberg to review this.

Q In this incident we are not talking residents, we are talking about a trained and experienced obstetrician?

A And talking about trained and experienced nurses on the labor floor.

Q Let me ask you, given those types of people, have you had instances where a nurse stopped medication in front of the doctor that the doctor has ordered to continue?

A Yes.

Q You say that happens frequently?

A No, it happens more frequently in a teaching hospital where you have residents giving orders. But I have seen nurses say no, I am not giving that drug, you want that drug given, you come in and give it. Most frequently when that happens it is somebody with a penicillin allergy and the doc called in over the phone,

cephalosporins cross react.

No, I am not hanging it. If I hang that up you be in here and be ready to treat the anaphylaxis. I am not hanging the drug.

Q Other than the stopping of Pitocin and turning the patient on her side?

A Left side.

Q Do you know whether that was done?

A I don't see it in the notes.

Q Do you know the position of the patient during that time period 1:20 to 1:00?

A No, I do not.

Q Do you know the position of the patient until taken to the delivery room?

A I do not.

Q Why is it that you believe the patient wasn't turned on her left side?

A They would write it down if that was a particular maneuver in response to fetal distress; oxygen started, Pitocin stopped, patient left side, physician notified, on the way. That is a standard note.

Q Can you quantify in any way the reduction in the

injury to the infant if the patient had been on the left side for 20 minutes?

A I cannot tell you what the reduction would be.

Q Can you say that it is probable that if the patient had been on the left side that there would have been no injury to the patient?

A I can't say that.

Q Can you say that it is probable that that contributed in any way, this left side maneuver?

A It is all a combination, it is not just left side. We have to analyze them.

MR. MELLINO: No, we don't.

MR. ALBERT: As independent things?

MR. MELLINO: No.

A Not really because it is a combination. Slow down the contractions, improve blood flow, increase oxygen. It is all part of the same thing, each has its own effect. Turning on the side may have no effect. If you put her on the left side and find things got worse, so you put them on the right side. Oxygen continues running, that doesn't get worse. Stop the Pitocin and usually the contractions slow. There are options today that people will give subcutaneous

Trabutalin to stop the contraction.

Q We're talking 1988.

A It was still used in '88, as early as '85 in emergency situations where we would give subcutaneous Trabutalin preparing for a crash to stop the contraction.

Q So that should have been done?

A That is not standard of care.

Q Let's talk about this case then.

In any event we would agree that if the C section had been done sometime around 1:20 or shortly thereafter there would have been no injury?

A That's correct.

Nursing also failed to bring the monitor into the delivery room too.

Q Are you familiar with the term tweet heart?

A No.

Q You don't know that as a type of apparatus?

A No, sir.

Q You are not familiar with that?

A No, I have never seen it.

Q Is there a type of apparatus or instrument that is used to monitor the fetal heart other than a fetal

monitor?

A Well, one can use a Doppler or Doptone.

Q What else?

A One can use a oscilloscope which is a fancy stethoscope.

Q What else?

A One could, those would be the standard ones.

Q Are there any other instruments that can be used to monitor the fetal heart?

A You could use ultrasound, most people would not.

Q Anything else?

A Not that I have seen other than some research tools where you can electronically pick up the signal, the heart signal.

Q What was the significance of not having the fetal monitor after 1:20 or thereabouts when it was disconnected other than for your benefit of not being able to determine the status?

A Other than the catastrophic fetal distress develops.

Q Well in this case, how does it relate to this case, what significance did that criticism have as to the

outcome in this case?

A I don't think this doctor would have done a crash Cesarean section even if there was fetal distress.

Q So you are not suggesting that the nurses' failure had anything to do with the outcome?

A No, standards of care suggest continue monitoring the patient.

Q Are you suggesting that any criticisms you have made of the nurses would have resulted in something different in this case in probability?

A Not being able to get in the doctor's mind I can't tell you.

Q Doctor Edelberg, you just did in the previous question, so I will invite you once again into his mind.

Given what you know of this case, do you think it is probable that any of criticisms that you have of the nursing care would have resulted in any different result?

A Only if they had recognized the fetal distress early on and pointed it out to him, then I think he may have done a Cesarean section. I can't tell you he probably would have.

Q If Doctor El-Mallawany says he wouldn't have

done anything different, would you agree that it is probable that none of the criticisms which you have made of the nurses would have contributed in any way to the injuries?

A I think when a doctor becomes aware that there is a sustained fetal distress, he is more apt to consider rapid delivery of the baby and had she not been fully dilated, he would not consider doing a forceps delivery and therefore would have opted for Cesarean section.

(The last question was read by the court reporter.)

MR. MELLINO: I object to the question because I don't understand the context you are talking about. Are you saying that if he testified to that in his deposition or if he says this subsequently, because neither the nurse or Doctor El-Mallawany has said that they thought there was fetal distress.

MR. ALBERT: I can only go on what the facts are in this case and Doctor El-Mallawany has testified under oath that he would not have done anything different.

MR. MELLINO: Yes, but --

MR. ALBERT: Let me finish the question.

BY MR. ALBERT:

Q And therefore I am asking you, sir, that with Doctor El-Mallawany's position that he would not have done anything different, even if the nurse had believed there was fetal distress and we have gone through all of that, you don't expect that the nurse should have gone to the head nurse with the type of strips that we have here, we have already covered that have we not?

A Yes, we have.

Q We don't want to revisit that?

A Okay.

Q I am asking you to accept what Doctor El-Mallawany has said. That he didn't believe there was fetal distress, he reviewed this matter, he looked at it at the time and he didn't believe it.

Do you believe that any of the criticisms that you have of the nurse in this case, it was a nurse, contributed in any way to the injuries?

MR. MELLINO: I am going to object again because what you are saying and he is saying are two different things.

He is saying that the nurse should have told

Doctor El-Mallawany she felt there was fetal distress, the nurse didn't do that.

MR. ALBERT: I understand that.

MR. MELLINO: It's not in the same context.

MR. ALBERT: You made the objection.

A I listened to the question and I feel I answered it the first time correctly and I stand by that answer.

BY MR. ALBERT:

Q Now, let's get back to the, I will have to do this again.

You believed the nurse should have pointed out to the doctor her belief that there was fetal distress?

A That's correct.

Q And that was based on the strips?

A That's correct.

Q But you do not believe that if Doctor El-Mallawany thought that there was no fetal distress that the nurse should have gone to the head nurse, the next step?

A That's correct.

Q Now, I want you to assume for purposes of my question, that Doctor El-Mallawany did not believe there

was fetal distress at the time, okay?

A Okay.

Q Whether he was talking to you or anybody else, he didn't believe there was fetal distress period. Okay, no matter who was talking to him.

Now, under those circumstances do you believe that the nursing care which you have criticized contributed in any way to the injuries which this young man suffered?

MR. MELLINO: Objection.

A I stand by my first answer. In other words, had Doctor El-Mallawany been told by nursing that the nurses considered this fetal distress for the following reasons, and they had responded by stopping the Pitocin, starting oxygen, putting her on the left side, the patient was not fully dilated, I think if Doctor El-Mallawany was made aware of all of that, as a prudent physician, with a baby with known meconium and infection would have opted for a prompt Cesarean section. One could argue that in second stage if there is fetal distress should one attempt to do a forceps delivery, I say not a difficult one ever, ever.

Q Let me understand you correctly, you are suggesting that the nurses, or the nurse in this case

should have gone to Doctor El-Mallawany and said, this baby is in fetal distress and Doctor El-Mallawany should have agreed with the nurse?

A I think he would have.

Q You think he would have?

A Yes, I do.

Q Now, I am asking you, you understand the word hypothetical, I am asking you hypothetically if he did not, just on a hypothetical.

MR. MELLINO: How can you ask hypothetically since he was never told this?

BY MR. ALBERT:

Q We will find out what Doctor El-Mallawany will have to say.

What I want to know from you, Doctor, assuming all you just outlined and he did not believe that there was fetal distress, do you, sir, believe, that the criticisms that you have made of the nursing care contributed in any way to the injury?

A I think if he were told by nursing that they read this as fetal distress, and he misread the tracings by not considering it fetal distress, I would not consider

that a violation in terms of nursing going above him to go to the supervisor because there is variability. That wouldn't necessitate the continuation of that monitor until the baby is out.

Q We have agreed that you don't believe past that point that Doctor El-Mallawany was going to do a crash C section in any event, you said that haven't you?

A Because if he was going to do a difficult mid-forceps later on he probably would have done one earlier in full dilation for fetal distress.

Q I understand that, but you are not suggesting in your answer that the failure to keep the monitor strip on had any significance with respect to the injuries?

A No.

Q When you were in Cleveland were you familiar with Marymount hospital?

A I really don't know exactly where it is.

Q Therefore, should I conclude you therefore had never been to the hospital?

A I don't know if I have.

MR. SEIBEL: It might not be very memorable.

A I don't remember ever going to the hospital. I

don't know if I had a defense case involving it. I have been on the plaintiff's side.

Q Against Marymount?

A I believe so.

Q Can you give me the name of the patient?

A I can't remember.

Q You are not suggesting that with absolute certainty, you have vague recollection of testifying against Marymount Hospital?

A Correct.

Q And you do not remember the patient's name?

A No.

Q Year?

A No.

Q Do you remember anything about it?

A No, I don't even know where the hospital is located. I have a feeling it is on the east side, but I'm not sure.

Q If I were suggest to you that it is on the south side does that assist you in refreshing your recollection?

A Then I don't know where the hospital is.

Q And you would agree that you may not even have

had a case against the hospital?

A That's correct.

Q Are there any other documents which you requested from Mr. Kampinski's office to review that you have not been provided?

A No, there are not.

Q Are there any other documents that you feel would be important in formulating your opinions?

A None at all.

Q I therefore conclude that the documents which you reviewed are the only documents that you feel are pertinent to the opinions which you hold?

A That's correct. I may be asked to review a deposition prior to trial. I don't know.

Q From what I am gathering, you don't feel any other depositions would be important for you to see in terms of formulating your opinions; is that correct?

A That's correct. But some attorneys feel very differently.

Q So although Mr. Kampinski or Mr. Mellino or his office may feel differently, you don't feel the necessity?

A No, he is not a crate lawyer.

Q Crate being work?

A You don't send crates of materials.

Q You know that from your previous experience in dealing with Mr. Mellino and Mr. Kampinski?

A That's correct. Their charts tend to be lean.

Q Do you know whether that has anything to do with your hourly rate or not?

A No, I think each attorney behaves differently.

Q Do you have any criticisms of any other health care providers in this case?

A No, I do not.

Q And you have had an ample opportunity to review the entire record?

A Yes, sir.

MR. ALBERT: I have no further questions

EXAMINATION BY COUNSEL FOR THE DEFENDANT EL-MALLAWANY, ABRAMS AND BROWN:

BY MR. SEIBEL:

Q Is there a consensus among obstetricians and gynecologists that shoulder dystocia does produce some depression of the infant after birth?

A If it is prolonged, yes.

Q How do you define prolonged?

A I think probably greater than a minute. There is no absolute definition in the literature.

Q At least one of the reasons why there was a difficult resuscitation in this case is because of the presence of E. coli sepsis?

A That is one of the contributing factors.

Q Through my questions and through Mr. Albert's questions have you been able to state all of your opinions in this case and discuss them fully, the basis for those opinions?

A I think we have.

MR. SEIBEL: I have nothing further.

(Off record discussion.)

MR. SEIBEL: Just for the record, we are going to give to the court reporter copies of the fetal monitor strips which I asked you to circle the late decelerations beginning at 12:20 and continuing to the end of the strip. Okay, Doctor? Is that in agreement among everybody? And the court reporter is going to copy these, attach copies to our copies of the deposition and return the original to Doctor Edelberg.

I am also giving to the court reporter a copy to attach to the deposition of your handwritten notes that you have made, Doctor Edelberg, through your review.

Would you for the record identify what those are? I think you are fairly legible, but tell what they are and what they are notes from?

A We have notes from Doctor El-Mallawany deposition, two pages. I have a single page of notes with no number on it. And then I have notes on the medical records, and I believe they are numbered one through five. And then I have a summary sheet, and then I have some information on the pediatric records.

BY MR. SEIBEL:

Q One final thing, the only deposition that I saw in your records was the deposition of Doctor El-Mallawany?

A That's all I have seen, I believe.

MR. SEIBEL: I have nothing further.

(Signature having not been waived, the deposition was concluded at 5:50.)

DEPOSITION OF STUART C. EDELBERG, M. D.
CONDUCTED ON FRIDAY, DECEMBER 4, 1992

ACKNOWLEDGMENT OF DEPONENT

I, STUART D. EDELBERG, M. D., do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct and complete transcription of the testimony given by me, and any corrections appear on the attached Errata sheet signed by me.

_____ (DATE)

_____ (SIGNATURE)

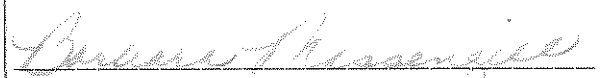
DEPOSITION OF STUART C. EDELBERG, M. D.
CONDUCTED ON FRIDAY, DECEMBER 4, 1992

CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

I, Barbara Massengill, Registered Professional Reporter, the officer before whom the foregoing proceedings were taken, do hereby certify that the witness whose testimony appears in the foregoing transcript was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my supervision; that said transcript is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 18th day of December 1992.

My Commission expires: November 1, 1993



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THE STATE OF MARYLAND