# ROBBINS VS. TIZZANO

**JOHN P. ELLIOTT, M.D.**

**8/21/01**

**LEA, SHERMAN & HABESKI**

**PHOENIX, ARIZONA (602)257-8514**

IN THE COURT OF COMMON PLEAS

OF WAYNE COUNTY, OHIO

ANGEL ROBBINS, etc., et al., )
Plaintiffs, )
vs. ) Case No. 00CV 0027
ANTHONY P. TIZZANO, M.D., et al., )
Defendants. )

Phoenix, Arizona
August 21, 2001
6:00 p.m.

DEPOSITION OF JOHN P. ELLIOTT, M.D.

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Certified Court Reporter
Certificate No. 50165



DEPOSITION OF JOHN P. ELLIOTT, M.D.,

taken at 6:02 p.m., on August 21, 2001, at Good Samaritan Regional Medical Center, Division of Maternal-Fetal Medicine, 1111 East McDowell Road, Phoenix, Arizona, before JENNIFER LLOYD, RPR, a Certified Court Reporter in the State of Arizona.

APPEARANCES:

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INDEX





JOHN P. ELLIOTT, M.D.,

called as a witness herein, having first been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. JACKSON:

Q. You are Dr. John Elliott; correct?

A. Yes, I am.

Q. Doctor, you've been identified as an expert in this case and I represent Dr. Tizzano and his group. It's my understanding that you're going to render opinions critical of Dr. Tizzano's care of Mrs. Robbins; is that a correct understanding?

A. Yes, it is.

Q. Are you going to opine that Dr. Tizzano fell below the standard of care in his care and treatment of Mrs. Robbins?

A. Isn't that the same question you just asked me?

Q. I think I asked you if you're critical, there is a difference.

A. Yes.

Q. At least I think there's a difference, how's that. What is your understanding of the standard of

care? How would you define it?
A. Standard of care is that which would be provided by a reasonably competent physician under the same or similar circumstances.
Q. Are you going to render opinions that anyone other than Dr. Tizzano fell below the standard of care?
A. Yes.
Q. Who?
A. Nurse Moats and Nurse Gwin.
Q. Anyone else?
A. No.
Q. Tell me in what way you feel Dr. Tizzano fell below the standard of care.
A. My criticisms of Dr. Tizzano are the following: Number one --
Q. Let me understand, Doctor, if you use the term "criticism"are you telling me that it is an act or omission that fell below the standard of care because I believe there's a difference between simply saying you're criticizing someone's act or omission and saying that that act or omission fell below tlie standard of care. So I would ask you if you're going to use the term "criticism," can we have the understanding tliat any time you use tlie term you are saying below standard of care?



A. Yes.
Q. If that's not the case, then tell me.
A. That's fine.
Q. Okay.
A. Number one, if Dr. Tizzano was aware that Mrs. Robbins was in labor, this patient should have been assessed by the physician certainly by **4:15** in the morning. He should have taken into account the prior Caesarian section, floating unengaged presenting part, and the large baby that was present, **9** pounds 3 ounces. A C-section should be performed or certainly highly considered at that point in the morning at **4:15.**
Second criticism, failure to perform at the standard of care or he was below the standard in his performance at 6:00. He was told at a minimum that she had been complete since **4:15.** This was one hour and **45** minutes that she was at minus 3 to minus **4** station, that she also did not want to continue with a potential vaginal birth after prior Caesarian. Standard of care at that time calls for immediate evaluation and to me that is **15** to 20 minutes time. C-section was absolutely indicated at this point in time. There was a large baby, failure to descend, prior Caesarian section. Dr. Tizzano arrived an hour and **44** minutes later, that is below the standard of care.



Next item, 3 or **4,** however you want to categorize them, rupturing her membranes at minus 2 station. This is an unengaged fetal head and then he apparently leaves the area, I'm not exactly sure what he did after that, but he was not immediately available after rupturing her membranes at minus 2 station.
And then the last criticism, failure to deliver in a timely manner. Membranes were ruptured at **7:44** at minus **2** station, patient develops nausea when it had not been present before and then the tracing basically disappears. Scalp electrode is placed at **7:59** and the tracing immediately is indicative of a very serious situation, either a prolapsed cord or a ruptured uterus, and the delay of delivery, calling the Caesarian section at **7:12** -- excuse me, 8:12 instead of at approximately 800 when it should have been called, if they had gotten to that stage, they never should have gotten there, but even at that point in time the delay was something that contributed to the outcome. Those are my criticisms of Dr. Tizzano.
Q. Are those all of your criticisms of Dr. Tizzano?
A. In broad categories, yes.
MR. MISHKIND: Can I just in fairness to you, just so you're aware, tliere is an issue with



regard to informed consent.
MR. JACKSON: That's what I'm asking, Howard.
MR. MISHKIND: Okay, I'll shut up, but tliere is.
MR. JACKSON: I get to ask him questions, but I mean if that's an opinion lie's going to render, I want to hear it, I'd prefer to hear it from him.
MR. MISHKIND: Absolutely.
A. Those are the ones that are clearly below the standard of care. The issue of informed consent is one that is not clearly documented and I do have opinions on that, but it's more difficult to establish what was said or wasn't said at what time.
Q. BY MR. JACKSON: Well, are you going to render opinions tliat Dr. Tizzano fell below tlie standard of care as it relates to informed consent issue, tlie informed consent issue with Mrs. Robbins?
A. I believe what is in the record and what was testified to in his deposition he would be below the standard of care in that regard.
Q. Based upon the group's medical records related to Mrs. Robbins?
A. Yes.
Q. Based upon tlie hospital records?

A. Yes.
Q. Based upon his testimony?
A. Yes.
Q. What about her testimony?
A. That would also enter into it, yes.
Q. Did you read the testimony of Nurse Nancy Morgan?
A. No, I did not.
Q. Did you ask for it?
A. When I was reviewing for this case it was yesterday and at that point I realized that I did not have that nor did I have the testimony of Alexus Robbins. And so I've asked for that, but I do not have that at this point in time.
MR. ROSSI. Alexus or Angel Robbins?
A. Did I say Alexus? I meant Angel.
Q. BY MR JACKSON: Let me start with the first opinion, Doctor, I want to explore these with you. You said that if Dr. Tizzano was aware at 4:15 of Mrs. Robbins' condition lie should have performed an examination and considered a C-section or perhaps even performed a C-section?
A. If he was aware of her condition at 4:15 he should have performed a Caesarian section, yes.
Q. Do you have any evidence that you can site



MR. MISHKIND: Objection, I think it's a different question.
MR. JACKSON: It is a different question.
A. It is a different question and, again, I get back to what he should have known as opposed to what necessarily was documented in the record and depositions.
Q. BY MR. JACKSON: I just want to be clear, though. There is no evidence now that he knew of her condition; correct?
A. I think we've said that three times.
Q. I know we have and I tried to say that as you sit here, then, there's no evidence that you know of that supports your first criticism of Dr. Tizzano; is that also correct?
A. Again, there's no evidence in the records that would support that, correct.
Q. Or in the depositions?
A. Or in the depositions.
Q. What other source of evidence do you have in this case other than the records and the depositions?
A. Well, I've got the nurse's -- again, we're going to have to decide who to believe, there's a conflict between what the nurse says that she did and what Dr. Tizzano says that happened. If the nurse is



me to which indicates that Dr. Tizzano did in fact have an awareness of Mrs. Robbins' condition at **4:**15?
A. In the record there is no evidence that the nurse contacted him at 4:15.
Q. Is there any evidence tliat you're aware of from any source that suggests that Dr. Tizzano was aware of Mrs. Robbins' condition at 4:15?
A. I think I -- I guess I didn't include the depositions.
Q. No, you didn't.
A. There's no evidence that I'm aware of, no.
Q. So would I be correct that as you sit here today you know of no evidence which would support your first criticism of Dr. Tizzano? Am I correct in that understanding?
A. Well, let me expound on that and why I feel that he should have known at 4:15.
Q. Please answer my question first. **As** you sit here today am I correct that you know of no evidence to support the position that Dr. Tizzano knew of her condition at 4:15 a.m.?
A. That is correct.
Q. So there is no evidence in the record or in depositions or in this case supporting your first criticism of Dr. Tizzano; is that a correct statement?



correct and she does call Dr. Tizzano and notified him that this patient, Mrs. Robbins, was present and that she was in labor and delivery laboring as the nurse states that she did at approximately midnight, then Dr. Tizzano would have an obligation to have different expectations, different orders for the nurse. Certainly he should be aware of the epidural placement and that apparently was not -- he was not made aware of that.
Q. Okay.
MR. MISHKIND: John, don't interrupt him.
MR. JACKSON: I am interrupting him because he just made a point I want to ask him a question on.
A. Can I finish my answer?
MR. JACKSON: You can. I want to ask you a question.
MR. MISHKIND: Let's not talk at the same time.
MR. JACKSON, We're not going to so don't interrupt and don't suggest testimony.
MR. MISHKIND: I'm not, John. I'm going to continue to talk because you cut the doctor off. I'm not suggesting anything.
MR. JACKSON: I didn't --
MR. MISHKIND: Please, if the doctor is

answering a question and you don't have the courtesy of letting him finish it, then you're not being fair to him. I'm not suggesting anything to the doctor.

MR. JACKSON: Howard --

MR. MISHKIND: Please.

MR. JACKSON: -- don't make those kinds of statements on the record I'm not being fair to him. I said I have a question of him, lie can finish his answer as he wishes. I would like to ask him questions without your interruptions. I know he knows how to do this and he'll do very well for you so please let me answer my questions and if he has something additional to say he can say it, and he apparently does. So that's where we're going to go. I'm going to ask him a question now about what he just said and he'll be allowed to finish what he has to say and that's how we are going to go.

MR. MISHKIND: Are you done?

MR. JACKSON: I am.

MR. MISHKIND: I'm not -- if you're going to interrupt him, so he can get his train of thought back if necessary we'll go back, we'll read where you interrupted him so he can finish his thought. I'm not suggesting anything to him, but if the doctor is answering questions you should let him finish his



that she was completely dilated and minus 3 to minus 4 station at 4:15 that he would have come in and done an evaluation. I would expect that he would have made the nurse aware of his desires to know when she was completely dilated. That is the indirect evidence that if the nurse is correct, then Dr. Tizzano should have made the nurse aware of his expectations of when he would be notified, that would have included 4:15 when she was completely dilated. Now I'm done.

MR. JACKSON: You're done, okay. Did you want to add anything?

MR. MISHKIND: You don't hear me talking, do you.

MR. JACKSON: I just wanted to be sure.

MR. MISHKIND: I appreciate that, but you don't have to do that after each question.

MR. JACKSON: I don't intend to.

MR. MISHKIND: Good.

Q. BY MR. JACKSON: Are you saying it's Dr. Tizzano's responsibility to tell the nurse, assuming that he knew about this patient being there at midnight or thereabouts, to specifically say to the nurse that if there's going to be an epidural you must call me? Is that what your testimony is?

A. I believe he said that he wanted to know



answer. If that's how you want to handle it, fine, I'll let you do it that way.

MR. JACKSON: If I'm going to ask him a question, I'll ask him a question. If you want to object, object and then let's stop there or we'll be here all night.

A. Let me say something now. I'm going to finish my first answer to you, then you can ask me whatever question you want. I'm not going to be interrupted in the middle of my answer, if you don't mind.

MR. JACKSON. What is it you want to say, Doctor, go ahead.

A. With a VBAC patient he should have had an expectation or a verbal order of nurse to call him with an epidural so that he would know at what particular station, what was going on, when she had the epidural. He also should have told the nurse a clear understanding that he should be called at the time she was completely dilated and that did not happen, so those things should have occurred. If the nurse called him the first time and he was aware that she was in labor, he should have made those things known, at least what his plan was when he wanted to be notified.

In his deposition he said that if he knew



when an epidural was being given.

Q. Is it your testimony, Doctor, that Dr. Tizzano had an obligation to tell Nurse Moats if they had a conversation at midnight that this patient was there that he should be called if there was going to be an epidural placed? Is that your testimony?

A. Unless he gave her different orders at midnight he needs to be called, yes, and he should tell her to call him if an epidural is placed, yes.

Q. That is true regardless of Nurse Moats' experience, that is true in your opinion regardless of his relationship with the staff and the nurses that man the labor and delivery suite, he should have under these circumstances if he knew that this patient was there at midnight when he talked with Nurse Moats specifically told her that she should call him regarding an epidural, is that your testimony?

A. Unless he told her at midnight it's okay for her to have an epidural at such-and-such a dilatation or whatever his parameters were, then he needs to be notified about that in a VBAC situation, yes.

Q. I agree with what you just said, Doctor, but that wasn't responsive to my question. My question was: Are you saying under the circumstances in this case with the experience of the people that were

involved here that it was the obligation of Dr. Tizzano to tell Nurse Moats if they had the conversation at midnight to affirmatively say to her you must call me if there's going to be an epidural placed in this patient? Is that your testimony?

MR. MISHKIND. Objection.

A. I think I've answered that twice.

Q. BY MR. JACKSON: You have not answered that.

A. I'm sorry, I have. I don't want to get into a confrontation with you.

Q. I don't either.

A. So I would like to maybe get a little more relaxed with this. I've answered this twice. You've asked the question twice and I've answered it. He has an obligation if at midnight she calls him and asked about an epidural, he has the obligation to say, yeah, you can have it at any time or you can have it at five centimeters or you can have it at two centimeters or call me before she gets the epidural, I'd like to know what's going on. He's got the obligation to tell her some parameters that would allow her to have an epidural placed.

Q. Doctor, I --

A. If there's a standard order that says -- and I don't understand why you don't understand what I'm



saying to you.

Q. I do understand what you're saying, you're not being responsive to my question because every time you've answered that question you have put an issue in there that is not a fact in this case. You say that he should be made aware if an epidural is going to be placed. You say that if she told him or suggested an epidural was going to be placed at some time that he should be made aware when that was going to be placed or if she talked to him about an epidural he should tell her he wants to be called, but none of those are tlie facts in this case and I'm asking under the facts of this case because what I heard you say a moment ago was that he fell below standard of care because when tlie telephone call, if it took place at midnight between Nurse Moats and Dr. Tizzano, that he had an affirmative obligation absent anything she said to tell her you must call me if an epidural is going to be placed. That's the question I'm asking you. Is that your testimony?

MR MISHKIND. Doctor, wait.. Before you answer let me object on the record and I'll leave it at that, John. I won't even state my multiple reasons for my objection, but go ahead.

A. No, not an affirmative action. Nurse Moats



in her deposition states that she brought up the issue of the epidural and so it is an issue that is brought up, it is not on the record, it is in the deposition. He does not have an affirmative action to tell her that, but she says she brought it up to him and that was why she didn't call him at 3:00 in the morning when she got the epidural, so it is an issue in the case. He does not have an affirmative action at midnight to say it's okay to give an epidural, but if she brought it up to him, then there is an affirmative action to make some parameters so she can operate under that.

Q. BY MR. JACKSON: Do you believe Nurse Moats had an obligation to call Dr. Tizzano before an epidural was placed?

A. Yes.

Q. And did she do that?

A. No.

Q. Whose responsibility was it for her to call?

A. Well, it was her responsibility to call.

Q. Do I understand you to be blaming Dr. Tizzano for her not calling him before the epidural was placed?

A. If you believe Nurse Moats who says I talked to him at midnight, I let him know she's there, told him what was going on, asked about an epidural and he



said it was okay to give it, then that would -- that would be one set of facts. And that would be if Nurse Moats did not say that, then he would not have an affirmative obligation.

Q. Do I understand you to also say in this first criticism that it was Dr. Tizzano's obligation if this phone call took place at midnight to tell Nurse Moats that when she's completely dilated you should call me?

A. In a patient that was floating when he saw her in the office that comes in in labor and is floating again at minus 4 station who is a VBAC with what should have been recognized as a large baby, he never went in and evaluated the size of the baby, he never went in and evaluated whether the patient was still minus 4, in that circumstance absolutely he's got an affirmative obligation to make sure of what she is at the time she's completely dilated.

Q. Do you believe it was Dr. Tizzano's obligation to tell Nurse Moats if they had a conversation at midnight you must call me when she's completely dilated?

A. I would be very -- I would have him go into the hospital because she's floating when he saw her in the office that day and she's floating when she comes

in and he never goes in and evaluates the size of the baby, there's never any indication of what the size of the baby is. Turns out the baby is a pound heavier than the prior baby that was a failure to progress for a C-section. And for him to stay at home and not want to come in and evaluate the patient and then to think that when she gets to be complete if she's still minus 4 station that he wouldn't want to be notified, that's not a normal thing, let me put it to you that way. He probably never should have let her labor, but he did, and to be floating at minus 4 station when you're entering labor is not a normal thing and for him to not want to be called, especially if she doesn't descend in a normal manner, would be below the standard.

MR. JACKSON: Jennifer, would you read back my last question to the doctor.

(Question read.)

Q. BY MR. JACKSON: Do you understand that question?

A. Yes, I answered it for you.

Q. Do you believe you just answered it with your discussion?

A. I believe I did.

Q. In a single word is your answer "yes" to



Q. BY MR. JACKSON: Do you understand the question?

A. Ido.

Q. Would you answer it?

A. I'm going to give you my best estimate because I wasn't there and I don't know. Based on what Dr. Tizzano said in his deposition that he usually is not asleep at that point in time, that he should have remembered a conversation if he was not being awakened in the middle of the night, based on that I am supposing that the conversation did not take place. Based on usual and custom I would expect the nurse to call and I think Dr. Tizzano expected the nurse to call. Based on how he responded after the nurse talked to him at 6:00 in the morning I don't know the answer because he didn't respond in an appropriate manner and so it destroyed whatever credibility I would give him based on your first question about the midnight phone call.

Q. Let me move to your second criticism and that involves the 6:00 phone call which is documented; correct?

A. Yes, it is.

Q. Is it your understanding that in tlie 6:00 call to Dr. Tizzano the conversation -- he called in as



that?

A. The answer is yes.

Q. Do you believe there was a conversation between Nurse Moats and Dr. Tizzano at midnight?

A. I don't know how to answer that, I have no way of knowing.

Q. Based upon what you saw in the case and how Dr. Tizzano reacted, what's in the records, how he dealt with this patient, do you believe there was a conversation? Based on the information you have, Doctor, do you believe there was such a conversation?

MR. MISHKIND: Let me just object and ask when you say how he reacted, I'm not sure what you mean by that, John.

Q. BY MR. JACKSON: Based upon everything that you know about this case, do you believe there was a conversation between Nurse Moats and Dr. Tizzano at midnight or thereabouts?

MR. MISHKIND: Including how he explained in his deposition?

MR. JACKSON: Read it back for Howard.

MR. MISHKIND: You don't have to do that.

MR. JACKSON: I said "everything."

MR. MISHKIND: I don't know --

MR. JACKSON: Did I say "everything?"



a matter of fact; is that your understanding?

A. The nurse says she called him so he says he called her.

Q. Is it your understanding that at 6:00 Dr. Tizzano was told or made aware that this patient was complete since 4:15?

A. Yes.

Q. And that's based upon what testimony, Doctor?

A. I believe his testimony.

Q. Would you show me? Do you have his testimony here?

A. Certainly the nurse's testimony. I've got his, I don't remember exactly what he said.

Q. I'd like to know the basis for the statement you just made, Doctor, because I don't believe that's in the records and if you can point it out to me, I'd appreciate it.

A. It's in the nurse's testimony and I think he says that he probably was told.

MR. JACKSON: Can I see it, Howard?

MR. MISHKIND: Sure.

MR. JACKSON: You're referring to?

MR. MISHKIND: The doctor's note at 6:00 a.m.

MR. JACKSON: This note doesn't reflect what you're just saying so maybe there's some other testimony.

Let me read the note into the record. This is Dr. Tizzano's note at 0600: "Labor and delivery was contacted. Report was gotten from the nurse in charge of Mrs. Robbins stating that the cervix was completely dilated; however, tlie vertex was at minus 3 to minus 4 station. Membranes were intact, reactive fetal heart rate tracing was present."

Q. BY MR. JACKSON: Is that what you're relying on, Doctor?

A. There's certainly that. I don't know what he said in his deposition.

Q. So that we're clear, Doctor, and we don't have any misunderstanding, your criticism of Dr. Tizzano that you stated when I first asked you all of them was that at 6:00 when he had the conversation with Nurse Moats he was aware or told that she was complete since 4:15 a.m. That's what I'm asking you to show me in the records or in testimony, that that information was transmitted to Dr. Tizzano.

MR. MISHKIND: Which deposition are you looking at, Doctor?

A. I'm looking at Dr. Tizzano's.



MR. MISHKIND: You want to know in terms of communication by Nurse Moats to Dr. Tizzano; right?

MR. JACKSON: That was his testimony, Howard.

MR. MISHKIND: Just asking.

MR. JACKSON: I want to know the basis for that statement.

MR. MISHKIND: Doctor, you may want to look, just to save some time, to page 73 of Nurse Moats' testimony.

MR. JACKSON: Can I see that?

MR. MISHKIND: You don't have that?

MR. JACKSON: I don't.

MR. MISHKIND: Actually page 72 and 73.

A. Okay. I guess what the nurse testified to in the question by Mr. Mishkind was "Dr. Tizzano --

MR. JACKSON: Excuse me, Doctor --

A. Page 72.

MR. JACKSON: What line are you starting?

A. Let's start at line -- let's start at 71, line 21, "did you feel that there was any significance at all in the difference in terms of station as demonstrated on the record from **4:15** at minus **3** station to 6:00 a.m. at minus **4** station?" Answer, "not given the fact that her membranes were intact." Question,



"now, Dr. Tizzano has already testified that you did not tell him that your vaginal exam at 4:15 showed that she was complete, 100 percent effaced and minus 3 station and at 6:00 a.m. complete, 100 percent effaced and minus **4** station. You just described that she had been minus 3 to minus **4.** If his testimony is to that effect, would he be accurate in that recollection?" Then there was an objection to what he said, "but go ahead, you can answer if you understand." "Can you rephrase the question?" Question, "Dr. Tizzano has testified, and if necessary I can direct you to the specific page, but to save time he indicated in his testimony that you shared with him that she had been minus 3, minus **4,** but did not indicate that she had -- from your vaginal exam at **4:15** had gone from minus 3 to minus **4** at **6:00.** Would that be an accurate recollection on his part?" Answer, "I really don't know."

Q. Those were questions, so that we're clear on the record, asked of the nurse by Mr. Mishkind; correct?

A. Correct. Now I was looking for where in Dr. Tizzano's testimony he talked about that and I couldn't find it quickly.

Q. But as Mr. Mishkind represented to the nurse



in his questioning of her taken after Dr. Tizzano's deposition, Dr. Tizzano indicated she did not tell him that; correct?

A. From that --

Q. If we believe what Mr. Mishkind said to the nurse.

A. From what I took from that he was talking about the minus 3, minus **4,** not whether there was a exam that she was complete at **4:15** or not. That's what I took from that, whether that's what was meant or what the nurse took from that I don't know.

Q. This is Mr. Mishkind's words to the nurse, line *3,* page *72,* "now, Dr. Tizzano has already testified that you did not tell him tliat your vaginal exam at 4:15 showed that she was complete," and then he goes on. Now, that testimony, if we believe what Mr. Mishkind said, and he was going to go to a specific line but he didn't have to, if we believe what he represented to her in her deposition without even going to Dr. Tizzano's testimony, Mr. Mishkind said Dr. Tizzano told him in deposition he wasn't aware or wasn't told about her being complete at 4:15; is that correct?

A. No, that's not how I read that. I read that as the minus 3 and minus **4,** not that he was not told

that she was complete at 4:15.
Q. Okay. So when you said "did not tell him that your vaginal exam at 4:15 showed that she was complete" --
A. **Keepgoing.**
Q. I understand there's more, but I'm talking about complete, she says "was not told that she was complete."
A. **That's not the whole statement.**
Q. That's true?
A. **I'm interpreting the statement, I'm just telling you how I'm interpreted it. How she interpreted and how the Court will interpret it may be a different matter. I looked at it being the minus 3 and minus 4, not that he was not aware that she was complete at 4:15.**
Q. The minus 3 and minus 4 is in his note. My question to you that started all this was that in your second criticism of Dr. Tizzano which I asked you about your first comment was that knowing that she was complete since 4:15 and then you went on to the minus 3, minus 4 and other things.
A. **Yes.**
Q. My question to you that started all of this was what's the basis for your saying that Dr. Tizzano



was made aware at the 6:00 phone call that this patient was complete since 4:15. Is that your only reference to that, what you just said, what we just read in Nurse Moats' deposition?
A. **I'd like to find what Dr. Tizzano says about it.**
MR. JACKSON: Take your time, Doctor.
A. **It's going to take all night.**
MR. JACKSON: That's fine, take all night because I consider this important. You made a statement, I want an actual basis for that. If there is none, say that, because I suggest to you there is none, he did not say that, and when you read her testimony as represented by Mr. Mishkind that's exactly what was the testimony. But go ahead, if you think you can find it, go ahead.
A. **I don't know where it is in here.**
MR. JACKSON: It's not there, Doctor. Maybe Mr. Mishkind can help you.
MR. MISHKIND: It's your deposition, you're going to represent it's not there.
MR. JACKSON: You represented it to her, Howard, that's exactly what it is.
MR. MISHKIND: It's your deposition, I'm not going to represent anything.



MR. JACKSON: You just take your time then, Doctor, because we're not going to do this on my representations. I want you to find where there's any evidence in these depositions that she told Dr. Tizzano that this patient was complete since 4:15 when she spoke with him at 6:00.
MR. MISHKIND: Which pages are you looking at?
A. **I'm at 133 now, and basically his answer is very general and vague and does not include what she told him exactly.** So **I guess other than his note in the chart, which does not detail whether he knew the 4:15 exam or not, there's nothing in his deposition that will tell us one way or the other, at least that I can find in quick perusal.**
Q. BY MR. JACKSON: If we rely on Mr. Mishkind's statement to the nurse in her deposition, then in his deposition somewhere is testimony that she didn't tell him that; would you agree with that?
MR. MISHKIND: Objection.
A. **I don't know how to agree with that or disagree with that.**
Q. BY MR. JACKSON: Can you tell me as we sit here today the basis for that comment that you made



that she told him at 6:00 that this lady was complete since 4:15?
A. **Well, number one, there would be no reason for her not to if he calls --**
Q. The question, Doctor, can you point me to --
MR. MISHKIND: Objection.
MR. JACKSON: I'm not going to play this game.
MR. MISHKIND: Let the record reflect you cut him off.
Q. BY MR. JACKSON: I asked you a specific question and I don't want to play games with you.
**As** we sit here today right now can you tell me what the basis is for your saying that she told Dr. Tizzano at 6:00 that Mrs. Robbins was complete since 4:15? Now, we've sat here for the last 10 minutes, Mr. Mishkind has gone through the depo, you've gone through the depo, and I'm asking you what's the basis for that statement in the records or the depositions? Can you tell me as we sit here, yes or no?
A. **In the records or the depositions I cannot tell you.**
Q. Okay. Is there anything other than the depositions or the records that you have relied upon in

formulating these opinions?
A. I've relied upon my experience in working with labor and delivery nurses and being a physician, doing Ob for the number of years that I've done it and that's where I'm going to come from here is that there's no reason for the nurse not to have told him. As a matter of fact it would be standard and below standard if she didn't tell him. We know there was a communication and if she didn't tell him it would be below standard for Dr. Tizzano not to ask, so if that communication didn't occur it's below standard for him not to say, well, how long has she been complete, five minutes, two hours, what's the story, I didn't even know she was here so I need to catch up on what's going on so --
Q. So your opinion --
MR. MISHKIND: Objection. You're cutting him off again. If you're going to do that I just want the record to reflect it.
MR. JACKSON: He was done, I wasn't cutting him off.
MR. MISHKIND: Yes, you were.
MR. JACKSON: Is there something else?
A. No, I'm done.
MR. JACKSON: Please complete your answer.



You had nothing else to say, did you? I don't want to play this game.
A. Can we go off the record?
MR. JACKSON: I'll be happy to do that.
(Discussion off the record.)
(Recessed from 6:47 p.m. until 6:58 p.m.)
MR. JACKSON: There was a conversation between the doctor and I, actually the three of us, Mr. Mishkind was involved.
MR. MISHKIND: Minimally.
MR. JACKSON: We don't have to get into that. After the doctor said "off the record" the doctor does not want that recorded in the transcript. We've agreed that that will not be a part of the transcript that goes to the doctor; however, it will be typed up and be provided to you. If the doctor wants to see it and wants a copy of it, wants to review it, he's welcome to do that, but it won't be a part of the official transcript per se; however, this agreement will be a part of the transcript.
MR. MISHKIND: And just one other comment and then we can move on. In addition to the doctor saying "off the record" you had indicated as well that it was to be off the record.
MR. JACKSON: I said "okay" or words to that



effect, it will be reflected in whatever she wrote up, but no one else said anything.
MR. MISHKIND: I was silent, as was Mr. Rossi, but our silence was not intended to mean a disagreement. The court reporter apparently felt that she needed to hear from everybody.
MR. JACKSON: The court reporter did her job. This is not the court reporter's fault.
MR. MISHKIND: I'm not suggesting anything, stop inferring things.
MR. JACKSON: I don't want that to be suggested, she did exactly what she should have done.
MR. MISHKIND: Go ahead, hopefully.
Q. BY MR. JACKSON: Doctor, as it relates to your second criticism of Dr. Tizzano that dealt with the issue of the 6:00 telephone call, do I understand your testimony now to be that if the nurse did not tell the doctor that the patient was complete since 4:15, it was incumbent upon the doctor to ask how long she'd been complete?
A. Yes.
Q. And if he didn't do that, is it your testimony that he fell below the standard of care?
A. Yes.
Q. You said in response to my question earlier



about that telephone call and what your criticisms were that Dr. Tizzano should have evaluated the patient immediately?
A. Yes.
Q. Would you explain what you mean by that?
A. You have a patient with a prior Caesarian section who has a large baby who has progressed to completely dilated and is still floating the presenting part. This is an unusual circumstance and represents clearly a failure to progress in labor. It requires an immediate evaluation and by "immediate" I would say 15 to 20 minutes.
Q. And had he evaluated the patient in 15 to 20 minutes as you suggested he should have, what do you say would have happened?
A. I don't think I can tell you what would have happened, I can tell you what should have happened to be within the standard of care would be that he would elect to perform a Caesarian section given the factors that I've already mentioned, the large baby, failure to descend, and prior Caesarian section, she'd already been -- if we give him 20 minutes to get there and evaluate her she would have been two hours in the second stage of labor at presumably a minus 3 or minus 4 station at that point in time and a C-section

was absolutely indicated at that time for failure to progress.
Q. Do I understand your testimony to be that if there was inforination such as the conipleteness or other information that was not transmitted to Dr. Tizzano by the nurse in the 6:00 phone call, he had an obligation by the standard of care to request, specifically request, all that information?
A. Yes. If you take his testimony that he did not know until 6:00 that she was there, he needs to get all the information essentially brand-new to him at that point in time and so he would have to go back to the heart rate tracing, looks, okay, she's now complete, when did she become complete, what's her station, membranes intact or not, what's her vital signs, those kind of things he would have to catch up on, how she got to where she is in order to comply with the standard of care.
Q. You reviewed Dr. Tizzano's note reflecting information he had at 0600?
A. Yes.
Q. Based upon the information reflected in that note is it your opinion that it was incumbent upon Dr. Tizzano to see that patient immediately?
A. Yes.



Q. Failure to do so was below standard of care?
A. Yes.
Q. Your third criticism of Dr. Tizzano dealt with the fact that lie ruptured the membranes at a minus 2 station?
A. Yes.
Q. Did I understand that correctly?
A. Yes, you did.
Q. What is your criticism there and the basis for that criticism?
A. You have an unengaged fetal head, he ruptured the membranes in a circumstance when the most common complication would have been a prolapsed cord. He is not in a position at that hospital and with the Facilities available to do an immediate Caesarian section, therefore it is below the standard to put this patient at a risk of a prolapsed cord without having the ability to proceed immediately with the C-section.
Q. What should he have done?
A. He should have called in the OR crew, the anesthesiologist, and eventually if he felt -- again, the standard would be to do a C-section. If he felt compelled to do a ruptured membranes at that point in time, he should have been ready to do a delivery immediately, within 10 minutes, of having a



complication such as a prolapsed cord, which did not occur in this case.
Q. Is it your opinion that the fact that Dr. Tizzano ruptured the membranes at 7:44 -- that's the time we're talking about?
A. It is, yes.
Q. -- was below standard of care?
A. Yes.
Q. Is it your testimony that that was a proximate cause of injury to Mrs. Robbins or her baby?
A. That's very difficult to say. Certainly nothing had happened prior to that and immediately with the ruptured membranes the rupture occurs so from certainly a timing standpoint it appears to be cause and effect, but I don't know that I can state to a degree of certainty that it is cause and effect.
Q. I need to know whether you can state to a reasonable degree of medical certainty or probability that the rupture of the membranes at 7:44 by Dr. Tizzano caused harm to Mrs. Robbins or her baby?
A. I can't be to a **51** percent medical probability; however, given the events that unfolded immediately after the ruptured membranes I believe that there was an association of the ruptured membranes with the uterine rupture.



Q. Do I understand you to be saying that you are unable to state that it is more likely than not a fact that the ruptured membranes at 7:44 or the rupturing of the membranes at 7:44 was a cause of injury to Mrs. Robbins or her baby?
A. I can't state that it is the only cause of injury, I can state that it is a contributing cause. Was it to a degree of probability that that was the cause, I can't say that, no.
Q. Can you say that it is more likely than not a cause of injury to Mrs. Robbins or her baby?
A. I would prefer to say it was a contributing factor, not that -- and I'm distinguishing between that and a cause. I guess it's a cause, okay, I'll state it's a cause.
Q. I need to explore this with you, Doctor, because it's important. The fact that it is a cause in your opinion may not be enough legally because it is necessary that you hold that opinion that it is more likely than not a cause of injury and that's what I'm trying to understand here. And I don't want to get into a word game with you, I want to know if -- because you've told me you can't hold that opinion more than 50 percent, but I need to know is it your opinion in this case that more likely than not the fact that

Dr. Tizzano ruptured the membranes at 7:44 caused injury to Mrs. Robbins and/or her baby?
A. Let me try to restate it for you. I can to a degree of medical probability say that it was a contributing factor. Is it the only cause of the rupture, I can't state that to a 51 percent, but I can to a degree of medical probability, meaning 51 percent or greater, that it contributed to the rupture, yes.
Q. When you talk about contributed to the rupture are you referring to the ruptured uterus?
A. Yes.
Q. What else do you say contributed to the rupture? If this was not the proximate cause but a proximate cause, what else contributed?
A. The other factor that I think contributed to it was laboring this patient for three hours and -- let's see, from 4:15 to 7:44, approximately three hours and 30 minutes in the second stage with a floating presenting head.
Q. Forgive me, Doctor, if I don't understand what you're saying to me, but you're saying that the fact that he ruptured the membranes in your opinion was not a cause of injury, more likely than not, or more than to a reasonable degree of medical certainty or probability, is that what you said?



A. No.
MR MISHKIND: Objection. For the record, objection. That's not what his testimony was. His testimony was -- I'm not going to state what his testimony was, but his testimony is on the record.
MR. JACKSON: I think I had the preparatory comment that perhaps I'm not understanding it, okay. You've objected, he said, no, now he can explain it. That's how it should work, don't you think?
MR. MISHKIND: I absolutely agree with you.
MR. JACKSON: Let's let it go like that. Go ahead, Doctor.
MR. MISHKIND: I'm totally in agreement with you for once.
MR. JACKSON: Good, thank you.
A. My opinion is that I can't say to a degree of medical probability that that is the major cause, the 51 percent or greater cause of the rupture. I can say to a degree of medical probability that it was a contributing cause. The other cause that probably has more than a 51 percent contributory factor was laboring this patient with a floating presenting part in the second stage of labor for three-and-a-half hours approximately.
Q. BY MR. JACKSON: Is it your opinion that



laboring this patient for that period of time was more likely than not a cause of injury to her?
A. More likely than not it was the major factor that caused the rupture, yes.
Q. Your fourth criticism of Dr. Tizzano was that he failed to timely deliver this child?
A. Yes.
Q. And you talked about the membranes being ruptured at 7:44 and then at 7:59 with the scalp monitor placed the tracing were such that delivery should have occurred immediately. Do I understand that criticism correctly? Did I state that correctly or not?
A. Yes. There's a little more in there, please.
Q. Go ahead, please, I want to know what more there is.
A. The scalp electrode should have been placed sooner than that and they would have picked up the nonreassuring fetal tracing, but definitely when they did place the scalp electrode this should have been recognized instantly as either a cord prolapse or a ruptured uterus and a C-section should have been called at that time. You must presume something bad and if something not so bad happens you can always say, okay,



everything recovered and we're okay, but to presume that it's going to recover in a circumstance when you can't respond quickly is the wrong glass half full/glass half empty supposition. So they needed to recognize the potential for a disaster and not assume something is going to recover when it has every possibility of not recovering.
Q. When should the scalp electrode have been placed?
A. When they lost the tracing which was pretty much right after the ruptured membranes. It should have been placed somewhere around 7:55.
Q. At what time do you say the C-section should have been performed?
A. Well, he should have recognized immediately when the scalp electrode went on the big prolonged deceleration that was occurring at 7:58 but certainly by 8:00, in the range, they should have been calling for the troops to come in. If things had gone back to normal they can always say thanks very much and everything is okay, but given the prolonged deceleration that's present when the scalp electrode is first placed in a patient that had not had a single deceleration until that point in time, this should have been a very ominous finding, as I said, either a

prolapsed cord or a ruptured uterus.
Q. So the team should have been called in your opinion at 8:00?
A. By 8:00, yes.
Q. Had the team been called by 8:00 in your opinion how long would it have taken for the C-section to be completed?
A. Making an assumption that the team would have been available in the same amount of time that they were in this case, it would have cut 12 minutes off of that delivery time.
Q. How long was it from the time the decision was made to do a C-section until the incision was made?
A. The decision was at 8:12 and the incision was at 8:34 so that would be 22 minutes.
Q. Is that a reasonable amount of time from the decision to the incision?
A. Given the circumstances of a small hospital and having to call people in from the outside, yes.
Q. Am I correct in understanding, then, if the same period of time would have been required, rather than happening at 8:34 it would have been like 8:22 incision?
A. Yes.
Q. That is your opinion in this case given a



A. I don't know, it was not obtained.
Q. Is there a way to compute under these circumstances how the Ph would change over time?
A. Not -- no.
Q. Are you able to say how much of a difference in the Ph there would have been had this baby been delivered 12 minutes earlier?
A. No.
Q. When do you believe the injury occurred to the child?
A. The injury occurred sometime after -- I can't really tell you precisely. Usually I can go to the literature and that's about what I can tell you based on a study out of University of Southern California that looked at uterine ruptures, if delivery occurred within 18 minutes of doing the -- of the heart rate going down they found no permanent neurologic injuries or death. When delivery occurred greater than that time there was the occurrence of neurologic injury and death, so that if we -- I don't know when the heart rate was completely down so sometime after 8:02 or something in that range, 18 minutes of that would have been about 8:20, in that range.
Q. The study that you refer to says within 18 minutes of what event?



reasonable scenario given recognizing and calling a team and proceeding as it eventually did proceed after the team was called?
A. If we get to this point in time and then the ruptured membranes occurs and all of this happens, then the delivery would have been 12 minutes sooner or about 8:22 I think.
Q. So do I understand that you're talking about in your criticism of a failure to timely deliver a delay of approximately 12 minutes?
A. Yes.
Q. Was the delay of 12 minutes in your opinion a cause of harm to the child?
A. There's no question that that was a cause of harm to the child, yes.
Q. Why do you say that?
A. The baby was born profoundly acidotic. Subtracting 12 minutes from that would have improved the acidosis. Whether the baby would have ended up living or not, I think the baby probably would have lived if we had saved that 12 minutes. The overall outcome I can't possibly tell you, but it would have been less acidotic than it was.
Q. What was the Ph when the baby was born from your understanding?



A. Of a bradycardia. This is not technically a bradycardia, it's preterminal tracing but not technically a bradycardia.
Q. Do you believe that that literature and that study would apply to this circumstance?
A. It's the only literature that I'm aware of that can give us any insight into length of time that babies can go. That's presupposing that it's not a complete cord occlusion or a complete abruption, and I don't know how to tell. This does not look like a complete cord occlusion immediately but it's the only data I'm aware of that gives us any kind of length of time. So I can't tell you the answer in this particular case. Does that data apply to this particular case, since it's not technically a bradycardia per se I don't know that I would say that it absolutely fits the criteria that they were looking at.
Q. Would that mean that there would be more or less time in this case than what this study would involve?
A. Again, theoretically it would give them more time.
Q. Give the doctors in this case more time?
A. Give the baby more time.

Q. Excuse me, the baby more time?
A. Yes.
Q. If I understand you by saying "theoretically," theoretically based upon the conclusion from the study that it's 18 minutes from bradycardia?
A, Yes. If the heart rate was normal prior to the bradycardia that's what they found. The first author on that is Leung, L-e-u-n-g.
MR. ROSSI: Leung?
A. Yes, sir.
MR. ROSSI: Thank you.
Q. BY MR. JACKSON: Do I understand theoretically in this case using the information from that study the baby would have had more time because it wasn't technically a bradycardia at 8:02?
A. Yes.
Q. Is it your opinion that the baby suffered the injury between 8:02 and 8:34?
A. Yes, but let me -- I can't necessarily say that because the baby was acidotic into the neonatal period also so it certainly was within that time frame plus what went on in the neonatal period.
Q. Are you talking about after birth?
A. Right. So in other words I don't want to



limit it to just that period of time, until the time of delivery, but I'm not critical of anything after the delivery.
Q. So the care and treatment this child received after birth was within standard of care in your opinion?
A. I did not evaluate it and I'm not critical of it.
Q. Do I understand you to be saying that if the child had not suffered a period of acidosis or a level of acidosis between 8:02 and 8:34, in your opinion the result would have been different?
A. If the baby did not suffer acidosis?
Q. Here's what I'm trying to understand, Doctor, and then you can tell me how you explain it. If I understood you a moment ago, you said that you believed the baby suffered some injury between 8:02 and 8:34; however, you said the baby also had acidosis in the neonatal period which was a factor in the outcome. Did I understand that correctly?
A. Yes.
Q. My question to you is: Is it your testimony that the situation the baby experienced regarding acidosis between 8:02 and 8:34 was such that it caused the eventual outcome?



A. Yes.
Q. And are you able to quantify what role the acidosis in the neonatal period played?
A. No.
Q. Is there any question in your mind that it did play a role?
A. The knowledge that we have of acidotic injuries at or around the time of birth, simplistically put, the lower the Ph and the longer the baby remains at the low Ph, the greater the risk of harm. So that having been said, the baby was acidotic at birth presumably, although a Ph was not obtained, but based on the Apgar score and everything else we have in this case the baby was acidotic at birth. If the Ph had been higher, would the outcome have been different, well, it's based on the level of the Ph, the lower the Ph, the greater the risk of harm and the greater length of time it stays there. If we have 12 minutes we're able to cut off from that, the depth of the Ph will be less and the length of time will be saved by 12 minutes given the same resuscitation afterwards.
Q. At what level of Ph is there damage?
A. The best article I know about to assess that also comes out of usc by a perinatologist named Murph Goodwin in which he looked at the neurologic



outcomes of babies born with various Ph on the cord gas and what he found basically was that above a Ph of **7** that there was no risk of neurologic damage. Once you get below **7,** how low you go, the risk of neurologic damage in the survivors increases and what he found was if the cord Ph was between **6.90** and **6.99,** the risk of neurologic -- of a bad neurologic outcome was 12 percent. If the Ph was **6.80** to **6.89,** the risk went up to 30 percent. If the Ph was **6.70** to **6.79,** the risk went up to **60** percent. And if it was **6.60** to **6.69,** it went up to 80 percent. So the lower the Ph, the greater the risk of neurologic injury in that particular study.
MR. ROSSI: Could you spell the first name and last name?
A. G. Murphy Goodwin, G-o-o-d-w-i-n.
MR. ROSSI: G period Murphy, M-u-r-p-h-y?
A. I believe so, yes.
Q. BY MR. JACKSON, Is there any other explanation for this child's outcome than the acidosis between 8:02 and 8:34 in your opinion?
A. No.
Q. In Goodwin's study is there any parameter as to the amount of time that is in these ranges?
A. No, they did not look at that.

Q. So time is not a factor per se?
A. Of that study, no.
Q. Is there any other study of which you're aware that factors time into these levels?
A. Nothing specific, no.
Q. Is there any other literature that you can site that would support the proposition that a 12-minute delay under these circumstances would cause permanent injury or death to a child?
A. There's nothing that's going to address specifically a 12-minute delay. And we're only going backwards from we know this baby was acidotic at birth, we don't know what level, we know it was at a Ph of 6.5 at 27 minutes of life. Cut 12 minutes off is going to make some difference, it might be a tremendous amount of difference, it might be only a tenth of a Ph unit, so I can't quantitate for you exactly the difference, but there's no question there would be a difference. 12 minutes is not an inconsequential amount of time.
Q. Those were the four initial criticisms you had and then there was a comment early on about informed consent?
A. Yes.
Q. Are you going to render an opinion in this case that Dr. Tizzano fell below the standard of care



A. Again, when I went to review this case, which is my habit and custom, prior to this I looked at the three depositions that I had and today told Mr. Mishkind that I did not have the depositions of the nurse practitioner nor of the mother.
Q. What representations did Mr. Mishkind make to you regarding the mother's testimony that would cause you to -- what representations did he make to you?
A. That there were probably two occasions that there was some discussion with Mrs. Robbins about VBACs, that on the first occasion she talked with the physician and with the nurse practitioner, she was given the ACOG information pamphlet concerning VBAC, that she was basically asked if there was any questions that she had and that she was encouraged to have a VBAC. She also -- it was represented that she was not informed of specific risk of rupture or harm to her baby and that she was again encouraged to have a VBAC and that if anything did happen that they could proceed to Caesarian section and deliver the baby that way.
Q. Are you critical of the encouragement to her to have a VBAC?
A. No.
Q. Did you find any of the comments about what



relative to informed consent of Mrs. Robbins?
A. I'm going to render an opinion that there is a discrepancy in what was told. Based on what he says in his deposition and what's in the records there is not enough information to say that he gave adequate informed consent. Based on what Mr. Mishkind has represented to me is the testimony of the mother it would be consistent with a lack of informed consent. So, again, I'm not the finder of fact in this, but given what's in the records, given what's in the deposition and given what has been reported to me to be in the mother's deposition I believe that he failed to give adequate informed consent.
MR. MISE-IKIND: John, before he answers let me just indicate on the record that for some reason the depo was sent but didn't reach Dr. Elliott. I do intend to send him the depo and if there is any change at all in his opinions based upon reading it as opposed to accepting my verbal representation I will notify you immediately. But go ahead.
Q. BY MR. JACKSON: You have not read the parents' deposition?
A. No, I have not.
Q. Did you ever ask for the parents' depositions?



they told her to be issues with which you found criticism?
A. I find criticism that there is no specific representation either verbally or in the deposition of specific risks given to the mother of VBAC both to herself and to the baby versus repeat Caesarian section, so there is certainly nothing documented in the record and the deposition testimony states what Dr. Tizzano's habit and custom would be, but even in that he did not state that he would tell her that there is approximately a one percent or whatever percent he would use risk of a uterine rupture and that there is a risk of catastrophic rupture, which occurred in this case, and that there is a risk that the baby cannot be delivered in time to prevent a catastrophic injury or death and those things are the most important part of a consent form and I don't believe that without documenting that that you can have given the patient fully informed consent.
Q. Are you familiar with the VBAC pamphlet from ACOG?
A. Yes.
Q. Did you review that in this case?
A. I've looked at it, yes.
Q. You saw the one that they received?

A. I believe so, the one that was revised in '95.
Q. When did you --
A. Or reviewed in '95.
Q. Did you review that just in preparation for this depo also?
A. Yes.
Q. Was that just before we came here today?
A. Yes.
Q. Prior to that you'd not seen tlie pamphlet that she was given in terms of this case?
A. In terms of this case, correct.
Q. When did you form your opinion about informed consent? Was that just today?
A. No.
Q. When did you form that opinion?
A. That was something that I -- since it was not fully in the records I was not putting it down in my opinions because it was an issue of what the patient said and what the physician said with not much documented in the records. I left that until I heard at least what the patient had to say about it. And if I find something in the deposition that is contrary to that, then I may change my opinion.
Q. Forgive me, but the opinions that you just



told me about regarding informed consent, when did you first formulate those opinions?
A. When I read through this and read through the depositions so after I received the depositions.
Q. Can you be more specific time-wise? Was that this week, was it last week, was it a month ago, a year ago?
A. It was -- I read the depositions yesterday and the day before.
Q. So it was within the last couple of days that you formulated the opinions about informed consent that you just described?
A. Yes.
Q. And I raise that question, Doctor, because we were told in a letter from Mr. Mishkind on February 16th of2001 that you were going to be testifying about the issue of informed consent and you just formulated those opinions --
A. Well, from a final standpoint. I just reviewed the depositions so that was an issue that was raised and I as of the last day or two was able to feel that that was a real issue and something below the standard of care.
Q. What responsibility do you feel the patient has as it relates to informing themselves about the



risks of a procedure?
A. I believe that the patient should talk with her physician about the procedure and expect that she is going to get a realistic view of the risks and benefits of the procedure.
Q. You're familiar with the ACOG pamphlet we've talked about?
A. Yes.
Q. And you understand that Mrs. Robbins was given a copy of tliat?
A. Yes, I am.
Q. What's your understanding as to whether or not she read it?
A. I don't think that she read it thoroughly. She may have glanced at it, but she certainly did not read it thoroughly I believe is her testimony.
Q. Did she have an obligation to do that?
A. I think that she -- that would be supplemental information to the discussion with the physician or the nurse practitioner, whoever is giving the informed consent. Does that substitute for the physician or nurse giving adequate informed consent, no. That pamphlet does not go into the risks of uterine rupture or the incidence of uterine rupture so it really is not an informed consent document. It



gives some information about what a VBAC is and some terms that they can look at but it's certainly not an informed consent document.
Q. What's tlie purpose of the pamphlet as you understand it?
A. I believe it's to give information that you can hand to your patient, would give some information about VBACs and some of the alternatives and kind of go through a general discussion of the issue.
Q. Does the patient have an obligation in your opinion to read that information?
A. Again, I think that the patient can certainly look at that, it's a source of information. I think the number one source of information comes from her physician.
Q. I understand that. My question is whether you believe, and maybe you don't, that when you give a pamphlet like that to a patient that the patient has some obligation to read it?
A. If I expected her to read it I would tell her so. If I gave it to her and said here's some information, if you want to look at it at home or talk it over with your husband, it depends on what my purpose of giving it to her is. It's certainly not informed consent.

Q. What is your expectation when you give written material to your patients, do you expect them to read it?
MR. MISHKIND: Are you talking about the VBAC pamphlet or any documents?
MR. JACKSON: Any documents.
Q. BY MR. JACKSON: When you give written information about procedures or about what's going to be happening with your patients to the patient why do you do that and what is your expectation?
A. If I were to give written information like that I would then say here's a pamphlet that contains everything you need to know, please read it and we'll talk about it at your next visit or I would say, look, we've talked about VBAC or we've talked about amniocentesis or we've talked about whatever we've talked about and here's some additional information that you can have and use it at your discretion. So sometimes it would be specific that I want you to read this and we'll talk about it, most of the time it's here's some extra information, we've already talked about this, but I want you to have this so you can look at it at home.
Q. Is it your expectation that they will look at it and read it at home?



A. If I tell them to do that, it's my expectation that they will do that. If I don't tell them to do that, I'm not expecting them to read it, I'm giving it to them for extra above and beyond what I've already talked about.
Q. So if you don't tell them specifically read it, you do not expect them to read it?
A. That's correct.
Q. And is that true with all the literature that you give -- do you give your patients literature?
A. We have available many pamphlets, yes. I don't expect the patients to read and figure it out for themselves so I will always have a discussion with them about the particular topic in question and I will often give them something extra that they can read. They'll ask for something, is there something I can have to read later or is there more information about this, then I will go through and give them what I can, whether it's articles from the literature, pamphlets, ACOG handouts, whatever it may be.
Q. If you give it to them and say words to the effect here's some information, take a look at it, if you have any questions let us know, would that give you the expectation that they would do that, read it, ask questions if they had questions?



A. No, not unless I said I want you to read this and we're going to discuss this later because we haven't talked about this yet, I would not have that expectation of a patient, no.
MR. MISHKIND: Let's go off the record.
(Recessed from 7:43 p.m. until 7:47 p.m.)
Q. BY MR. JACKSON: Doctor, have we discussed all the criticisms you have against Dr. Tizzano or his group?
A. I think contained within the informed consent is the failure to address her issues of wanting to have a C-section at 6:00 when certainly at 6:00 the nurse was aware of her wanting to have a C-section and I believe Dr. Tizzano was also aware of that. And, again, I don't know what was said by who to whom, but he apparently failed to take into account her desire to abandon the VBAC trial and proceed with a C-section.
Q. And do you find that to be a deviation from standard of care?
A. Oh, yeah, absolutely 100 percent. The patient has every right to change her mind in the middle of a labor and delivery process and move to a C-section.
Q. What harm did that cause the patient?
A. She should have been delivered by C-section.



She had an obstetrical reason to be delivered by C-section at 6:00 or 6:20, whenever he got in to do it. She also apparently revoked her consent and did not want to continue so that in and of itself, even if there was not an obstetrical reason, he should have immediately performed a C-section.
Q. At 6:20 or thereabouts, whenever he got to the hospital?
A. Whatever time he evaluated and found she did not want to continue with a VBAC.
Q. Had that occurred it's your opinion that it would have been a different outcome?
A. If at 6:20, whatever time he got in and assessed things and made his decision, by doing what he should have done and performed a Caesarian section for the reasons mentioned delivery would have occurred presumably within 30 minutes in which case it would have been before uterine rupture and this baby would have been to a degree of medical probability a healthy, normal newborn.
Q. Any other criticisms of Dr. Tizzano or his group?
A. No.
Q. Doctor, we have a copy of your CV here and I assume that's your most current CV?

A. **I believe it is, yes.**
Q. Do you have a copy in front of you also per chance?
A. **I do now.**
MR. ROSSI: Do you want this back, John?
MR. JACKSON: I just want to have him refer to it.
Q. BY MR. JACKSON: Have you authored any articles which you consider pertinent to the issues in thiscase?
A. **As far as VBAC goes, no VBAC articles, no.**
Q. Are there any other articles that you've authored which you believe are pertinent to the issues in the case understanding that you have not authored any VBAC articles?
A. **Directly, no.**
Q. Are there any presentations or any other references in your CV which you believe are pertinent to the issues in this case?
A. **I talk about VBACs, I lecture on them.**
Q. Which presentations are you referring?
A. **Page 21,145 and 146.**
Q. For the record, 145 is a presentation given at the 16th Annual Beaver Creek Perinatal Conference in Beaver Creek, Colorado in January of this year entitled



"VBAC (very bad alternative choice?)"; correct?
A. **Correct.**
Q. What was your position in that presentation?
A. **Basically it went through the history of VBACs and kind of how we got to where we are, looked at risk factors that increase the risk of uterine rupture, and basically the conclusion is that VBAC can be a successful procedure, but we need to be aware of the risks of uterine rupture and certainly should not increase the risks of uterine rupture by some of the obstetrical things that we do.**
Q. Did you write a paper on that or was that just some type of talk?
A. **There was no paper, it was a talk.**
Q. And you gave the same talk at the Obstetrical Challenges of the New Millennium in Scottsdale, Arizona in April of this year?
A. **Yes.**
Q. Did you have handouts from that presentation?
A. **At both of them there was an outline, yes.**
Q. Do you still have that?
A. **I probably do, yes.**
Q. Would you dig out a copy of that and give it to Mr. Mishkind?



A. **I will.**
MR. JACKSON: Would you forward us a copy of that?
MR. MISHKIND: I will get it and I don't see any reason why you're not entitled to it. I'll take a look at it, if I do have an objection, I'll let you know.
Q. BY MR. JACKSON: Other than the handouts are there any slides or anything of that nature, statistical results, that would go along with that study?
A. **The handout is basically my slides.**
Q. That's everything?
A. **Yeah.**
Q. Any other items in your CV which you believe would be relevant to this case?
A. **No.**
Q. Is this your file that you have in front of you?
A. **Yes.**
Q. I see a three-ring binder. Is that the medical records that you reviewed?
A. **It** is.
Q. As far as you know is it a complete set of the medical records?



A. **As far** as **I know, yes.**
Q. There's some notes?
A. **These are my notes.**
Q. There's some correspondence. You've made a copy of your notes for us, is that what this is --
A. **Yes.**
Q. -- that you've just handed me?
A. **Yes.**
Q. Doctor, you've given me eight pages Xeroxed which are apparently from a yellow pad?
A. **Yes, sir.**
Q. When did you prepare those notes?
A. **They were -- the initial notes were prepared, the kind of factual things, from my initial review of the record, the other notes were prepared after I reviewed the depositions of Dr. Tizzano, Nurse Moats and Nurse Gwin.**
MR. JACKSON: Why don't we number the ones that you gave Jennifer and then we can identify them that way.
MR. MISHKIND: Off the record.
(Discussion off the record.)
Q. BY MR. JACKSON: Doctor, I'm marking these just as they were banded to us and I'm going to write at the bottom numbers with a circle around them 1

through 8.
A. **I hope they're in reasonable chronological order.**
Q. If you'd go through those for me and tell us, referring to the numbers on the bottom of those pages, when you generated those notes, I'd appreciate it.
A. **Page 1 would be after I initially reviewed the medical records. Page 2 the same --**
Q. Excuse me. When was that, do you recall?
A. **It would have been sometime after August 14th of 2000, which is the date that the cover letter was dictated. When it was sent out I can't tell you and when I reviewed it I can't tell you.**
Q. You don't keep records of when you do the various things on a particular case?
A. **Not when I get it.**
Q. Timerecords?
A. **Just in general, not in detail.**
Q. How about page 2, when was that?
A. **Again, with the initial review.**
Q. Okay.
A. **3 with the initial review, 4 with the initial review, 5 was I believe after I read the depositions so that would have been -- 5, 6, 7 and 8**



**would have been yesterday.**
Q. Are these all the notes that you generated in your review of this case?
A. **Yes.**
Q. May I see the correspondence that you have there? Is there any correspondence between you and Mr. Mishkind or his office which is not contained in the materials you just gave me?
A. **No.**
Q. Was there any written communication of any nature, not necessarily a letter, but perhaps notes written or typed, a communication between you and Mr. Mishkind that is not contained in these five letters?
A. No.
Q. Do I understand from you that the first time that you read the depositions that were sent to you was yesterday?
A. **And the day before.**
Q. And the day before?
A. **Yes.**
Q. And if I'm clear from what I have in front of me in terms of the materials that were sent to you the only depositions that you reviewed in this case were the depositions of Dr. Tizzano --



A. **Yes.**
Q. -- Nurse Moats --
A. **Yes.**
Q. -- and Nurse Gwin?
A. **Yes.**
Q. Did you request any other depositions?
A. **As I said, at the time when I reviewed it I didn't realize that I didn't have the other depositions and I talked with Mr. Mishkind today about that and I would like to review those depositions.**
Q. What other depositions did you request?
A. **The mother and of the nurse practitioner.**
Q. Any others?
A. **No.**
Q. The medical records you reviewed were the Wooster Community Hospital records of the previous delivery?
A. **Yes.**
Q. Wooster Clinic prenatal records?
A. **Yes.**
Q. Wooster Community Hospital labor and delivery records?
A. **Yes.**
Q. Wooster Community Hospital newborn records?
A. **Yes.**



Q. Children's Hospital Medical Center of Akron discharge summary and placental path report?
A. **Yes.**
Q. And the autopsy?
A. **Yes.**
Q. Were there any other records that you reviewed?
A. No.
Q. Those were apparently sent to you August 14, 2000?
A. **Yes.**
Q. You're referring to what you handed me?
A. **Yes.**
Q. Did you review any other materials of any nature, doctor? Did you review any literature? Did you review any type of information other than what we've talked about already in preparation for the opinions that you're rendering today?
A. No.
Q. This is your complete file, the notes, those five letters and the three-ring binder?
A. **And my notes, yes.**
MR. MISHKIND: And the depositions.
A. **And the depositions.**
MR. JACKSON: And the depositions.

Q. BY MR. JACKSON: Has anything been removed from your file before the deposition today?
A. No.
Q. Is anything missing?
MR. MISHKIND: Other than the two depositions we talked about?
MR. JACKSON: He hasn't Seen those.
A. I've not gone back through to see if there's something missing. I'm assuming it's a complete set of records.
Q. BY MR. JACKSON: Your first contact from Mr. Mishkind or someone in his office was when, do you recall?
A. I would assume it would be sometime prior to August the 14th.
Q. Do you make a request as to what you would like to see when you agree to review a case?
A. No.
Q. Do you remember that initial contact?
A. No, I do not.
Q. Is it your custom to get some review of the facts and circumstances of the case?
A. It depends on what the attorney wants to tell me. Some attorneys want to tell everything, some attorneys are I'll say not very expansive on the



matters of the case.
Q. What was the circumstance in this case?
A. I don't really -- I don't care what the attorney's opinion is so I don't necessarily want to hear it, but if they want to talk to me I'll listen.
Q. DO you --
A, I have no recollection of the initial phone call so I can't tell you.
Q. Were there any notes that you prepared that you did not keep?
A. No.
Q. Doctor, would you go to your notes for a second.
A. Yes.
Q. Do you have a note there 0744, it's in the middle of page 2?
A. Yes.
Q. I don't understand, what are the two words there at the beginning, something dash?
A. "Complete minus 2."
Q. What's below that?
A. AROM, artificial rupture of membranes.
Q. Under the 0834 on page 2 --
A. Yes.
Q. -- about incision --



A. Yes.
Q. -- "cord and arm prolapsed into the ruptured uterine" --
A. "Scar."
Q. "Scar"?
A. Yes.
Q. Is that of significance, the extent to which the baby is into the uterine scar?
A. In an indirect way, the more important is the cord.
Q. Explain the significance of tlie cord.
A. There are two ways that a baby can be hurt by a ruptured uterus; one is if there's a placental abruption that occurs and the other is if the cord is compressed, and in this particular case it was most likely cord compression. The cord was documented to be herniated through the scar and occlusion of the cord can occur in that anatomical circumstance.
Q. On page 3, would you read your last entry there?
A. "Baby died at three weeks of age, cause of death" -- I think I meant to write "anoxia," but I wrote "an."
Q. A-n?
A. Yes.



Q. Page 4 there are four times, 0758 and then 0802, 0806, 0812?
A. Yes.
Q. Is the first statement "prolonged decel"?
A. Yes.
Q. And the next statement?
A. "Preterminal tracing."
Q. 8:06, "O2 started"?
A. "02 started, C-section called."
Q. Are you critical of when the 02 was started?
A. Yes.
Q. Why?
A. It was delayed. We had a prolonged deceleration at 7:58 and they waited eight minutes to start the oxygen.
Q. It should have been started when?
A. As soon as they saw the heart tone was down when they put the scalp electrode on.
Q. Is the paragraph that's contained in writing on page 5 your recitation of the facts as you understand them in this case?
A. Did I miss -- mine is different. Yes.
Q. Your answer was "yes"?
A. Yes.
Q. Page 6 is apparently a continuation of that?

A. Yes.
Q. The opinions that are listed apparently -- page 7 says "areas below standard" and then 7 has Nurse Moats and 8 has Dr. Tizzano. These were notes that you just prepared in the last two days or three days; is that correct?
A. Yes.
Q. Is that when you formulated these opinions?
A. No.
Q. Is that the first time you put them in writing?
A. Yes.
Q. Had you shared these opinions with Mr. Mishkind before these notes?
**A. Yes.**
Q. When was that done?
A. My initial review of the records and discussion with him.
Q. What's the nature of your practice, Doctor?
A. I'm a partner in a large perinatal group that practices in Maricopa County, Arizona called Phoenix Perinatal Associates.
Q. You personally, what's your normal workweek in terms of days and hours?
A. I don't know that there's a normal workweek.



obstetrics and gynecology I am responsible for the curriculum and some of the lectures regarding high-risk obstetrics for the residents. There's a family practice residency here also and I'm not responsible for their curriculum but I teach probably four or five hour sessions a year to the family practice residents. I am involved in medical student education from the University of Arizona doing clinical education on our patients and also didactic education in their third year clerkship in Ob/Gyn and also I'm the head of the fourth year elective rotations for medical students both from the University of Arizona and from other medical schools that want to take rotations here at Good Samaritan.

We have a Fellowship in maternal-fetal medicine that is through the University of Arizona and we are a partner in that Fellowship in which we participate in the education and training of that Fellow for variable periods of time. Somewhere between three and **27** months of the fellowship is spent at Good Samaritan and the remainder is spent at the University of Arizona. So I have an educational role in medical students, family practice residents, Ob residents, nurses and Fellows in maternal-fetal medicine.



Q. What's your schedule for a week?
A. I usually will begin, if I'm in the clinic seeing patients, start probably about **7:30** in the morning and reviewing charts and getting ready to see patients. Basically see patients all day until **5:00, 5:30, 6:00,** depending on work-ins and emergencies and things like that. If I'm in the hospital I arrive at about **7:00** in the morning until I get relieved in the evening which is usually sometime around **6:00,** I would be dealing with hospitalized patients.
Q. How many days are you in the clinic?
A. I'm either in the clinic or the hospital five days a week, then there's night call.
Q. Do you have any administrative responsibilities in your group?
A. I do. I'm the Director of Maternal-Fetal Medicine in the Department of Obstetrics and Gynecology here at Good Samaritan Medical Center.
Q. How much time does that take weekly?
A. Probably three to four hours.
Q. Do you teach?
A. Yes.
Q. Whom do you teach?
A. We have a freestanding residency here at the hospital with six residents at each level. In



Q. What kind of a time commitment per week is that for you?
A. On a per week basis it would probably be -- well, with the Fellow it's more so I would say total maybe three to four hours.
Q. All the teaching responsibilities that you've just described would be included in that?
A. I'm approximating for you, yes.
Q. How many patients do you see in the average week, you personally?
A. Again, I don't know how to tell you that because if I'm in the hospital I would see -- well, maybe I'd see more in the hospital. We have an average census in the hospital of anywhere from 30 to 50 patients, if I'm in the hospital I would see the majority of those patients on a daily basis, sometimes more than once a day. If I'm in the clinic my responsibility would probably be to see and evaluate between ultrasounds and office visits and consults probably **30** patients a day. So if I was in the clinic it would probably be **120** or more patients a week, if I was in the hospital it might be upwards of 180 or **200** patients in a week.
Q. How many partners do you have? I did not ask you that.

A. There are ten other perinatologists. There are **11** perinatologists in our group.
Q. How many deliveries have you personally made in the last year?
A. We do about in excess of **1500** deliveries for the group and I would do one-eleventh of those approximately so **130, 135,** whatever that works out to.
Q. Those are the number of babies you personally deliver?
A. It wouldn't be babies, those would be mothers. I do a lot of high-order multiples so I get two or three or four babies for each delivery so it would be more babies.
Q. How many of those were VBAC?
A. I don't know any way to estimate it for you. About **50** percent of our patients will attempt a VBAC, I don't know how many have a scar so I would assume that given the statistics roughly 20 percent of patients undergo Caesarian section so probably 20 percent of my patients would have a scar, so that would be **135** times **20** percent.
MR. ROSSI: About 26.
A. Okay. So **50** percent of that would undergo a VBAC, so figure **13.**
Q. BY MR. JACKSON: The decision by Dr. Tizzano



to allow Mrs. Robbins to attempt a trial of labor was appropriate, was it not?
A. If she had been adequately informed of the risks, yes, it was appropriate. She had no contraindication per se to not attempt a VBAC.
Q. What areas of medicine do you consider yourself to be an expert?
A. I'm not quite sure how to address that. I'm a specialist in maternal-fetal medicine which relates to all areas of obstetrics so I would consider myself to be an expert in all areas of obstetrics.
Q. Any other areas of medicine in which you consider yourself to be an expert?
A. I guess you'd have to tell me specifically. There's some things that --
Q. I just need to know from your point of view in what areas do you, Dr. Elliott, consider yourself to be an expert? You've told me all areas of obstetrics and I'm wondering --
A. I'm also a Board-certified gynecologist so I will throw that in there. I've not specifically practiced gynecology for **18** years, but I'm still Board certified in it.
Q. You would consider yourself an expert in areas of gynecology?



A. I wouldn't say I was 100 percent up to date because I don't follow all the gynecological literature, but I think basically I am an expert in most areas of gynecology, yes.
Q. Any other areas of medicine --
A. It would depend --
Q. -- in which you consider yourself an expert?
A. You'd have to go through everything. There's some areas that I know an awful lot about yet are not necessarily related to obstetrics.
Q. That's what I'm asking, I want to know what you feel you're an expert in. You've told me all areas of obstetrics.
A. Do I know an awful lot about anesthesia, yes, do I know an awful lot about other things that affect my practice, yes.
Q. Do you consider yourself an expert in those?
A. I'm not a Board-certified anesthesiologist. If that's the criteria, then I'm not an expert. Having gone through medical school and residency I'm certainly more qualified than somebody who hasn't done that to talk about any aspect of medicine. I don't hold myself out to be an expert in anesthesiology, but I know an awful lot about it so I don't know how to address your term "expert," if you want to define that for me.



MR. MISHKIND: Object on the record. I think the term "expert" also has a legal connotation. It sounds like the two of you may be referring to different definitions.
Q. BY MR. JACKSON: What areas of medicine do you hold yourself out to be an expert other than all areas of obstetrics and most areas of gynecology, if there are other areas?
A. I don't hold myself out to be an expert to anybody unless they ask me.
Q. Do you consider yourself to be an expert in all areas of obstetrics?
A. Yes.
Q. Do you consider yourself to be an expert in most areas of gynecology?
A. Yes.
Q. Do you consider yourself to be an expert in any other areas of medicine?
A. I've answered that. There are certain parts of medicine that I consider myself to be very well informed on and would be considered an expert, there are other areas I don't. You'll have to go through it one thing at a time.
Q. I'm not asking the question other than that. What do you consider yourself to be an expert in,

that's all I'm asking you. If you can't tell me, then don't and if you can, just tell me what areas you think.
**A. I think I've answered the question. I've told you my answer and that's the best explanation I can give you.**
MR. MISHKIND: Doctor, if you think you've answered the question, that's fine.
Q. BY MR. JACKSON: How many cases do you review per year for medical/legal matters?
**A. I would say roughly 32 to 36, somewhere in that area.**
Q. How long has that been the case?
**A. Probably several years. I don't remember exactly, but for a couple of years anyway.**
Q. Several or a couple? Just give me a number if you can.
**A. I just gave you -- I don't know.**
Q. You gave me two. "A couple" means two to me and "several" means as many as a lot.
**A. Several to me means three, two to three years.**
Q. That's all I was asking, Doctor.
**A. I gave you that.**
Q. How many reports do you issue per year



generally' written reports? Of the *32* to 36 cases that you review how many do you issue reports on?
**A. I would say very few, most attorneys don't want a written report.**
Q. How many depositions do you give per year?
**A. I would say in the range of 15 to 18, 20, any given year.**
Q. How long has that been the case?
**A. Two to three years.**
Q. How many times do you testify in court per year?
**A. I'd say that varies by year, anywhere** from one **to four to five.**
Q. How many times have you actually testified in court?
**A. I would say 30 plus, something in that range.**
Q. Over how many years?
**A. Since 1981 I believe was the initial time that I did any medical/legal review.**
Q. Has your frequency of testifying in court increased or decreased over the past five years?
**A. I would say it has probably slightly increased.**
Q. Define "slightly" for me.



**A. Again, it varies by year so I can't say that it's absolute.** So **it does fluctuate, but I would say overall there's probably a slight increase from two to three to maybe three to five.**
Q. How many times have you testified in court this year?
**A. I don't know that I can give you an exact answer. It's probably been three or four.**
Q. Any of those cases involve VBAC issues?
**A. I don't believe so,** no.
Q. How many depositions have you given this year?
**A. I have no way of knowing. Probably 12, 13, somewhere in there.**
Q. How many have you given this month, this month being August?
**A. This is the second I've given in August. I was going to go on vacation for three weeks and** on **vacation for two weeks prior so everything is sort of crammed in.**
Q. When was your last depo?
**A. Last week,**
Q. How many depositions did you give last nionth?
**A. I think one.**



Q. Can you tell me how many medical/legal cases you currently have pending?
**A. These things run on for years so I would say probably** 50.
Q. Do you keep records of your cases?
**A. Not after they're settled or go to trial, no.**
Q. Do you keep any kind of a listing of the cases in which you're an expert?
**A.** No.
Q. Where do you keep your records and the things that -- you must keep some kind of system of record keeping of the files that you have of perhaps these 50 or so cases?
**A. Ongoing cases I've got the files, yes.**
Q. Where do you keep that stuff?
**A. Atmyhome.**
Q. Old cases, you don't keep any records of the cases, your depositions, any of that stuff?
**A. I have no reason to do that.**
Q. Have you ever worked with Mr. Mishkind or anyone in his office before?
**A. I believe this was the first case.**
Q. Do you have any other cases with Mr. Mishkind and/or his office?

A. I think I've reviewed another case for him so I think there was one other case, yes.
Q. Does that involve issues of VBAC?
A. I don't know. I don't remember.
Q. Do you know the name of the case?
A. No.
Q. Do you know where it's venued?
A. No.
Q. Have you agreed to act as an expert in that case?
A. To be honest with you I don't even remember.
Q. Have you given a deposition in that case?
A. No.
Q. Have you ever worked as an expert in Ohio in a medical/legal case before?
A. Yes.
Q. Do you know where in Ohio, venue?
A. I've done several cases in Columbus, Toledo. I think there have been others but I don't specifically recall them.
Q. Have you ever given court testimony in Ohio?
A. Yes.
Q. Do you remember the last time you did that?
A. It was last year.
Q. Do you remember where?



A. I don't remember, no.
Q. Do you remember the names of any of the attorneys you've worked for in Ohio?
A. Other than Mr. Mishkind?
Q. Other than Mr. Mishkind.
A. I have worked for it's a defense firm in Columbus, Lane, Alton and Horst. Am I saying that right?
Q. There's a Lane, Alton and Horst, they do both plaintiff and defense work.
A. I've only done defense work for them.
Q. I believe they do both. You've done defense work for them'?
A. Yes.
Q. Who else?
A. There are a couple other attorneys, I don't remember though.
Q. Any other cases in Cleveland?
A. There was another case and I don't remember it specifically that I think was from Cleveland.
Q. Who did you work with?
A. It was Mr. Corbett.
MR. MISHKIND: Corbett?
A. That may be the firm.
Q. BY MR. JACKSON: Plaintiff or defense?



A. Plaintiff's case.
Q. The cases that you worked in Columbus other than Lane Alton, was it only with them that you worked with in Columbus?
A. I've done four or five cases for them.
Q. How about Toledo?
A. I don't remember specifically. Corbett was the name of the case, that's what it was.
Q. Do you remember the name of the attorney?
A. I'll keep thinking.
Q. Did you do any medical research relative to this case?
A. No.
Q. Did you review any articles for this case?
A. No.
Q. Do you belong to any groups or associations which provide experts?
A. No.
Q. Have you ever belonged to such a group?
A. No.
Q. Do you advertise your services?
A. No.
Q. How did Mr. Mishkind come to you, do you know?
A. I don't remember.



Q. You'll notice that for all the talking he's done he didn't volunteer there, did he.
What are your fees, Doctor, for reviewing matters?
A. I charge $1800 to review the case initially and discuss my opinions with the attorney, I charge $400 an hour for other work on the case, $400 an hour for deposition testimony, $5,000 per day plus expenses for testimony at trial.
Q. How long has that been your fee structure, what you just outlined?
A. I think approximately two years.
Q. You said that you have not authored any articles regarding VBAC in your CV; correct?
A. That is correct.
Q. Are there any articles that are not contained in your CV that would deal with VBAC which you authored or contributed to?
A. No.
Q. Are there any pending articles or studies that you're involved with regarding VBAC or the issues in this case?
A. I am currently pulling data on VBACS at Good Samaritan Medical Center, Desert Samaritan Medical Center and Thunderbird Sainaritan Medical Center with

one of our residents.
Q. What's the purpose of your collecting that data?
A. We were interested in looking at the question of the number of layer closure in the uterus. There's been a trend to go from a two-layer closure of the Caesarian section scar, the initial section scar -- classically we've closed it in two layers and there's a trend now to go to one single layer closure and we wanted to look and see if we had enough data to look and see whether that had an influence on the risk of rupture with the VBAC.
Q. Where are you in your research?
A. We are really to the point of starting to collect data, but we have recently sent a letter to the head of the IRB and we have permission to do it at Good Samaritan from the IRB, but at the other two hospitals we're awaiting permission from the IRB to pull charts and gather this data anonymously.
Q. Have you formulated any hypothesis for the study?
A. The hypothesis was single-layer closure is less secure and that there's a higher risk of rupture with a single-layer closure.
Q. How long have you been engaged in this



collection of data?
A. We haven't collected anything yet.
Q. You're just starting. Any other --
A. Let me go back. Each resident has to have a research project in order to graduate and so this particular resident was interested in this question so that's how we got onto that.
Q. Any other pending studies, articles?
A. No.
Q. Have you ever been sued?
MR. MISHKIND: Objection, but you can answer the question, Doctor.
A. I've been personally sued three times.
Q. BY MR. JACKSON: You qualified that meaning that your group has been sued perhaps on other occasions?
A. Yes.
Q. On any of those occasions were you involved personally in the care of the patient where you were not personally named?
A. In one case I was involved in the care of the patient but I was not named.
Q. You've been personally named three times?
A. Yes, that I'm aware of.
Q. Where you were involved in the care of a



patient where the group was sued but you were not personally named?
A. Correct.
Q. So there have been four lawsuits involving medical care and treatment of patients that have been filed against you?
MR. MISHKIND: He said that he's aware of.
A. And I'm also -- I mean it was not filed against me so my care was never questioned.
Q. BY MR. JACKSON: In the one?
A. Correct.
Q. I was going to explore that. When you say or when Mr. Mishkind says that you're aware of --
MR. MISHKIND: It wasn't my statement, it was his.
MR. JACKSON: I know and then you repeated it. I'm trying to understand what that means.
Q. BY MR. JACKSON: You certainly would know if you've been sued?
A. Those are the ones that I know about, yes.
Q. Can you tell me what the allegations against you were in the three lawsuits? Before I ask that question, the one lawsuit against your group, what was the claim?
A. It was a patient who had a vaginal delivery,



had a placental accreta that was handled by one of my partners, he did a D&C, conservatively managed her, eventually took her to the operating room when he couldn't stop the bleeding, I received a call at 3:00 in the morning that he needed help in the OR and I came in and spent eight hours trying to save this woman's life, and eventually she walked out of the hospital with a hearing loss and incurred a million dollars in medical costs and sued.
Q. What was the resolution of the case or is it still pending?
A. No, it went to trial and we lost the verdict so we lost at trial.
Q. What was the verdict?
A. It was for $4.5 or $5.5 million.
Q. Was that here in Phoenix?
A. Yes.
Q. Do you remember the plaintiff's name?
A. Mary Prator.
Q. Were there expert opinions that you deviated from standard of care in that case?
A. No.
Q. The experts were focused on your partner's care?
A. Yes.

Q. Did you testify in that case?
A. No.
Q. The three lawsuits where you were personally named, tell me, if you would, the claims in those cases.
MR. MISHKIND: John, let me just show a continuing line of objection to any questions relative to claims against the doctor. Go ahead.
A. First one involved an amniocentesis that I did in the hospital down in radiology in a patient who was diabetic and at 38 weeks and wanted to establish fetal lung maturity prior to induction of labor. Put the needle in under ultrasound guidance, had to go through an anterior placenta, the baby moved, unfortunately the needle was located through a placental artery and when the baby moved it dragged the needle and lacerated the artery. We had an indication on the ultrasound that the heart tones went down, came back up again, we immediately rushed her to labor and delivery and delivered her within **12** minutes of the first decrease in the heart rate and the baby essentially bled to death in that period of time.
Q. What was the resolution of that suit?
A. I settled it the day before we were to go to trial for **$25,000.** I was told that that would not



result in anybody making any money and so I agreed to settle it.
Q. Was there an expert that said you were negligent in the case?
A. Yes.
Q. Were you?
MR MISHKIND: Objection.
A. No. My expert was the person who this expert referred his amnios to so I was very anxious to go to trial.
Q. BY MR JACKSON: Tell me about the next or the other two.
A. The second case involved a placental abruption in a patient who was in labor. The allegation was that we failed to diagnose the abruption and intervene in a timely manner. We performed a Caesarian section and delivered a baby that was not reaching its milestones.
Q. How did that case resolve?
A. It was, I guess, dropped with prejudice.
Q. Was there any payment?
A. No.
Q. The third case?
A. Third case is currently pending.
Q. What are the allegations against you in that



case?
A. That I failed to ensure that a Rhogam shot was given to a patient who was Rh negative who delivered an Rh positive baby.
Q. Is there an expert that believes your care was below standard of care?
A. I don't know the answer to that. They're supposed to disclose experts this week, we're anxiously awaiting the name of such a person.
Q. Do you believe your care fell below the standard of care?
A. No.
MR. MISHKIND: Objection.
Q. BY MR. JACKSON: Who was the expert against you, Doctor, in tlie first case you told me about?
A. I don't remember. He was an Ob/Gyn in a suburb of Los Angeles.
Q. What is the incidence of uterine rupture?
A. The quoted incidence in the literature is somewhere between **.8** and **1.5** percent.
Q. How about uterine rupture with VBAC?
A. I'm sorry, that is with VBAC.
Q. Have you had uterine ruptures in your practice?
A. I've had myself one uterine rupture. I've



had -- I guess I can't say that, excuse me. I've had one potentially catastrophic uterine rupture. I had one complete opening of the scar that I found on examination after delivery but the baby delivered vaginally without any consequence.
Q. How about the other rupture that you had, the potentially catastrophic one?
A. The other rupture was a patient in the second stage of labor that was pushing and she had a bradycardia and we immediately delivered her and the baby did well. There was a complete rupture of the uterus.
Q. How long did it take to deliver that child?
A. I don't know that I remember the exact amount of minutes, it seemed like an eternity, but the heart tones were down for about four minutes and then it took probably **10** minutes to get the C-section done to delivery so I'm going to say about total of 14 minutes from when the heart tones went down.
Q. Doctor, have you ever practiced at an address on North Tatum in Phoenix?
A. No.
Q. Are you familiar with the experts who have been retained by the defense in this case?
A. I'm not sure I know -- I think Bruce Flamm

is one of them. Bruce was a resident at UCI when I was a Fellow there. The other experts I'm not familiar with.

Q. You're not familiar with their names?

A. I'm not familiar with their names or with them.

Q. You do know Dr. Flamm?

A. Yes, I do.

Q. What do you think of him?

A. I think Bruce is a very bright individual.

Q. You said you know him through some training?

A. He was a resident when I was a Fellow.

Q. Did you know him other than to know that he was there at the same time? Were you friends, were you colleagues, you just knew he was there?

A. He was a resident. I participated in some of his education, but we were never close friends or anything.

Q. Would you consider him to have a special expertise in VBAC?

A. Bruce has written some very good papers on VBACs, yes.

Q. Would you consider him to have a special expertise in that area?

A, I know that he's written very good



literature on it. I don't know -- that gives him certainly a -- he's looked at statistics and that's been very helpful to the medical literature and us as practitioners.

Q. Would you consider him an expert in VBAC?

A. I think that he has good qualifications in that, yes.

MR. JACKSON: Doctor, I'm going to let Mr. Rossi go because I think I'm done, but rather than just sit here and page through notes to make sure of that I will let him go. And if I have more questions I will ask them, but I think I've completed what I wanted to ask.

A. Thankyou.

EXAMINATION

BY MR. ROSSI:

Q. Doctor, my name is Greg Rossi, I represent Wooster Community Hospital in this case and I do have some questions for you. I'll try not to repeat anything that we've covered already, but in light of the factual testimony there may be some carry-over.

A. Yes.

Q. You've gone through already everything that you've reviewed. I take it based on your testimony



you've not reviewed any policies or procedures from Wooster Community Hospital; is that true?

A. No, I have not.

Q. Is it your intention to do that in this case?

A. I don't think I need to do that to form my opinions, but if I'm asked to do that I would.

Q. Is it your intention to render any testimony tonight or at a later time in this case that the policies and procedures of Wooster Community Hospital were deficient or below any accepted standard of care?

MR. MISHKIND: Let me just object because he hasn't reviewed any, but go ahead.

A. It's not my intention to criticize the policies and procedures, I believe there's certainly an issue of communication, I don't know if there's a policy that addresses that. I am aware that they changed their habits after this case so I don't know how all that fits together, but my criticism is really the lack of communication and if that translates to a policy, as it apparently did, or at least a behavior change, then I guess that does affect what you're asking me.

Q. BY MR. ROSSI: Let me just conclude this section by saying this: If Mr. Mishkind gives you the



policies and procedures and you have some criticisms of those procedures, will you let him know that?

A. Yes.

MR. ROSSI: And then, Howard, will you agree to reconvene the deposition at that time either by phone or in person if necessary?

MR. MISHKIND Yes.

Q. BY MR. ROSSI. You've reviewed the discharge summary from Children's Hospital for Alexus, but as I understand it you've not reviewed the entire chart for her; is that correct?

A. That is correct, yes.

Q. As part of your review of the Wooster Community Hospital records did you review baby's chart?

A. Yes, I did.

Q. As I understand your earlier testimony you were not going to be rendering testimony at trial that the care and treatment provided to Alexus by anyone at Wooster Community Hospital was below accepted standards?

A. Correct.

Q. Finishing up on some of your testimony regarding VBAC deliveries, would you agree, Doctor, that there are no randomized trials in the literature which established that maternal and neonatal outcomes

are better with VBAC delivery than repeat C-section and vice versa?
A. Yes, I would agree with that.
Q. Would you agree that uterine rupture can occur at any time during labor?
A. Yes.
Q. Would you agree that it can occur unexpectedly?
A. It's hard to disagree with. I think it is -- I don't know that anybody ever expects it so I guess it would be unexpected.
Q. And you would agree that poor fetal outcomes, including death, can occur in a VBAC after uterine rupture even with the best care and treatment?
A. Yes.
Q. Generally you would agree that Angel Robbins was an appropriate candidate for VBAC?
A. I think in general, yes.
Q. You sort of qualified that. Is there something that troubles you about her undergoing a trial of labor?
A. Yes.
Q. What?
A. I don't like the floating presenting part at term in an unproven pelvis. She otherwise is an



appropriate candidate for a VBAC.
Q. When did her health-care providers become aware that there was a floating presenting part'?
A. At her last prenatal visit.
Q. January 16th of '99?
MR. MISHKIND: That's the date.
A. I believe so.
MR. ROSSI: I just want to make Sure that he *thinks* that's the date.
MR. MISHKIND: Sorry.
MR. ROSSI: That's okay.
A. January 16th record says "vertex floating, desires VBAC."
Q. BY MR. ROSSI: Beyond that you would agree there were no contraindications to her undergoing a trial of labor?
A. I would agree, yes.
Q. You made some remarks earlier about informed consent. Would you agree with me that there was no obligation upon the nurses at Wooster Community Hospital to go through any informed consent discussion with Angel Robbins on the night she presented) 1-16-99?
A. No, there were no obligations to do that, no.
MR. JACKSON: Can we take a quick break?



MR. ROSSI: Sure.
(Recessed from 8:52 p.m. until 8:55 p.m.)
Q. BY MR. ROSSI: Doctor, would you state for me each and every criticism you have of the Wooster Community Hospital nurses and/or employees.
A. I've got three criticisms of Nurse Moats. The first is -- I guess maybe I have four. The first is the failure to communicate with Dr. Tizzano at the time of an epidural in a VBAC patient. I think that that is a different issue than a patient that is unscarred and wants a VBAC because part of watching a VBAC patient has to do with pain and it has to do with the risk of rupture and so I believe the physician needs to know about the circumstances at the time of placement of a VBAC.
Q. I don't want to cut you off. What time are we talking about with that first criticism'?
A. When the epidural was placed.
Q. At or about 3:00?
A. 3:00 in the morning so just prior to that.
Q. Continue, please.
A. Let me start with the disputed initial evaluation and phone call at or around midnight. If Nurse Moats did make that phone call, then she would not be below the standard of care. If she did not make



it, then she would be below the standard of care. And the reason for that is that this is a VBAC patient who has a floating presenting part and the physician absolutely needs to be aware of this. This is a special circumstance, not a routine patient in labor.
The third area is failure to communicate her examination at 4:15 when she was complete and at a minus 3 station. This was a large baby with no prior vaginal deliveries, the vertex was still unengaged. The nurse should be aware that that is not a normal progress of labor. She states in her deposition that she was hoping that the baby would labor down and the head would begin to descend, but that's not the way labor goes when it's going normally. That should be absolutely brought to the attention of the physician at that time so she failed to -- I don't think there's any dispute that she failed to notify the physician of that happening at 4:15.
The last area was failure to contact Dr. Tizzano when he did not arrive in a timely manner. She told the patient that she was expecting Dr. Tizzano to come in to talk with her about her change of heart about a VBAC and to evaluate her and she also testified in her deposition that that was her expectation, that Dr. Tizzano would come in in a short period of time, I

don't know that she really quantitated that amount of time, and when he failed to appear in that short period of time she should have recontacted him to have him come in and address those issues.
Q. At the risk of having Howard yell at me, let me interrupt you there for a minute. Are you looking at page 7 right now?
A. Yes.
Q. Under your number 3 on that page, that third line down that begins "certainly," what does that say?
A. "15 to 20 minutes."
Q. "Is adequate"?
A. "Is adequate," yes.
Q. Does that mean is adequate for the physician to arrive following that phone call?
A. Yes.
Q. So what you're saying is if he doesn't arrive in that time frame, the obligation is on tlie nurse to telephone him again?
A. Yes. She apparently was expecting him to come in rather promptly, which would have been appropriate and within the standard, and when he did not show up within that time frame I think she should have contacted him again to find out why he was not there and when he would be there.



Q. Are those all your criticisms of Nurse Moats?
A. Yes.
Q. You were going to begin to tell us your other criticisms of other hospital nurses. Go ahead.
A. Nurse Gwin failed to institute fetal resuscitation. She did not start oxygen until 8:06 when that should have been started at 7:58. She didn't change position of the baby until 8:06 and then changed it again at 8:10. These were both delayed responses to try to resuscitate this baby.
Q. Is that your only criticism of Nurse Gwin?
A. I suppose she falls under the same criticism, they had turned care from Nurse Moats to Nurse Gwin and I believe Nurse Moats testified that she told Nurse Gwin that Dr. Tizzano was supposed to be coming in and Gwin did not call Dr. Tizzano when she took over the care, so I guess she kind of dovetails onto Nurse Moats' failure to get him in there in a timely fashion.
Q. Any other criticisms of her other than those two?
A. No.
Q. Any other criticisms of any hospital employee?



A. No.
Q. I'd like to go through these with you, beginning with Nurse Moats at midnight. I believe you just said, I want to make sure it's clear on the record, if we assume that her testimony in her deposition transcript is accurate, would you agree that at midnight or thereabouts when she initially contacted Dr. Tizzano that Nurse Moats complied with the standard of care?
A. Yes.
Q. I'd kind of like to use that now to dovetail into your next two criticisms. First the failure to communicate with Dr. Tizzano at the time of the epidural. Did you see in her deposition where she indicated that she informed Dr. Tizzano during that first telephone conference at or about midnight that the patient was now desirous of an epidural?
A. I guess I don't recall the word "now" in her deposition, I recall that she said that she had spoken with Dr. Tizzano and got an okay for an epidural. I don't know that it was necessarily that she wanted it now.
Q. I'm sorry, it's midnight on the East Coast, I didn't mean to imply that the patient wanted it at that time, but do you recall in Nurse Moats' transcript



where she indicated that she informed Dr. Tizzano that the patient was desirous of an epidural for this delivery?
A. Yes.
Q. But you're saying even if we accept that as being true, there's an additional obligation upon Nurse Moats to telephone Dr. Tizzano at or about the time the labor is coming in such that the epidural would be done?
A. If she provided that information to Dr. Tizzano at midnight and if Tizzano fell below the standard of care and said she can have an epidural any time, don't bother calling me, then she would not be below the standard of care if she received a blanket order to let her have an epidural at any time. If, however, Dr. Tizzano was not informed about that or if he was not informed about the epidural or if he said if she's going to get an epidural call me so that I know what's going on, then she would be below the standard of care.
Q. Did you see tlie intrapartum standing orders?
A. I think they're in here.
Q. Let's save some trouble here, let me show you. Number 19.
A. Okay.

Q. I don't have a copy, can you read for the record what 19 says.
A. It says "epidural per anesthesia when labor established, PRN," meaning at the discretion of the nurse, "physician must be aware of epidural request." Again I'll come back to if Dr. Tizzano gave his blanket approval at 12:00 for an epidural, then I believe he's below the standard of care again because pain is a particular issue with VBAC and rupture. If he did not give a blanket approval, then he should have been notified at the time the patient says okay, I give up, I need an epidural.
Q. I want to make sure I understand what you're saying. I want you to assume for a moment, again -- obviously there's a factual dispute on this telephone call at midnight --
A. Yes.
Q. -- but I want you to assume for a moment that what Nurse Moats is saying in her deposition transcript is accurate; okay?
A. Yes.
Q. Would you agree with me that if she is accurate in what she is saying, that she compiled with the terms of order number 19 on the intrapartum standing orders?



A. Yes.
Q. If she did that, did she then comply with the standard of care even though she did not telephone him at or about 3:00 or 3:15 a.m. when the epidural was administered by anesthesia?
A. If he gave her a consent at midnight that epidural was fine with him, then she would comply with the standard of care.
Q. All right. Now, the next point in time of significance in your criticisms of her is 4:15 a.m., I believe; is that correct?
**A. Yes.**
Q. Back to this phone call at midnight in reference to that 4:15 a.m. phone call. Understanding this patient's status, whose obligation is it at midnight to discuss whether or not and when the patient becomes completely dilated? What I mean by that is this: Is it Dr. Tizzano's obligation to tell her to call him when this patient is dilated?
A. I think it's a shared obligation. This is a team effort and each should know what the issues are. I think the nurse should have an independent knowledge that she should call when the patient becomes complete. She's got a VBAC patient that has never delivered vaginally, she's got a big baby who has an abnormal



labor curve and that is something that should be reported to the physician. The physician also has an obligation if he was aware of the situation at midnight to realize that he's going out a little bit fairly far on a limb in allowing a labor of a woman with a floating head that has never delivered vaginally before so that he should be very aware of the parameters that since he's not really within a normal labor for a VBAC, a VBAC labor should be pretty normal, you just don't want to go off doing something that's not very normal as far as progress of labor and doing something that's really not within the standard kinds of parameters, so a VBAC should be conducted when things go very normally. When they start going other than normally, you have got to reassess things frequently and realize that you may not want to be continuing that. So she has an obligation to know that in somebody that's complete and at minus 3 or minus 4, I think she thought it was minus 3 at that time, that that is basically a failure of descent of any kind in this patient who's now completely dilated. And certainly the physician needed to make her aware, look, I need to know if this baby is still floating, I would like to be made aware at these particular times.
Q. I guess I'm confused because I specifically



wrote down, and my notes could be wrong, but I specifically wrote down earlier when Mr. Jackson was questioning you about this that the obligation is upon the physician.
A. I believe that's all he asked me about, did Dr. Tizzano have an obligation to specifically tell the nurse and I said yes. The nurse also has an obligation to know that this is not a normal labor pattern and that this is a VBAC patient, this is a patient with a big baby and the physician should know at 4:15 that this is not a normal labor curve.
Q. Well, if she's not made aware, how is she supposed to know?
A. She should have that knowledge independently. This is just like failure to progress. In her first pregnancy I believe she did not progress beyond seven centimeters. A nurse will know and should know that when you don't progress in dilatation that that is a dystocia, that is a failure to progress, and the physician needs to be notified about that. In this case she did not descend in station appropriately and that is a failure to progress and the physician needs to know about that. So that is standard nursing obstetrical knowledge that should be known by obstetrical nurses and the fact that the physician

needs to know that is the action that the nurse needs to take.
Q. Is it your intention to testify at trial that had she made him aware at 4:15 a.m. or thereabouts that Mrs. Robbins was completely dilated that that would have changed the outcome in this case?
A. If the physician had done the proper management that was within the standard of care, yes, but the physician even at 6:00 and even at 7:44 did not do the proper management and fell below the standard of care so the nurse must comply with her standard and at least provide the information to the physician in a timely manner. I would not hold her to be below the standard if she had done that. Even if the physician had not done the proper thing, I would not be criticizing the nurse for her behavior in this case at this particular time given that scenario.
Q. I understand that, but would you agree with me that it would be mere speculation by you that this nurse acting any differently at 4:15 a.m. would have changed this baby's outcome?
MR. MISHKIND: Objection, that assumes that Dr. Tizzano would not have acted at that point and that calls for speculation.
MR. ROSSI: I'm not assuming anything, I'm



just asking him if it's pure speculation by him.
MR. MISHKIND: Note my objection, but he can answer the question.
A. Based on what Dr. Tizzano did in this case I don't believe he would have done a C-section at 4:15 if he had come in and evaluated the patient. That does not mean that the nurse is not below the standard of care. Does it alter the outcome, no, the outcome would be the same,
Q. BY MR. ROSSI: Moving on to 6:00 a.m. now. Did I hear you correctly earlier that if we assume that the information -- well, let me stop the question there, I don't want to assume anything.
Based on the information contained in Dr. Tizzano's note what he was told at 6:00 a.m., do you agree that the nurse complied with the standard of care and the information that was imparted upon him, just based solely on his note?
A. The information that he has in his note is sufficient to comply with the standard of care, that he had to come to the hospital in an expedite manner to evaluate Mrs. Robbins. He should have been told that she had already been in the second stage of labor for an hour and 45 minutes, but he would have found that out himself when he got to the hospital or he should



have found it out himself when he got to the hospital. Should she have told him that she was in the second stage of labor for an hour and 45 minutes, yes, but this information would be enough to have him come to the hospital to meet the standard of care.
Q. And touching upon the caveat you added there at the end, even if she had specifically told him when this patient became completely dilated at or about 4:15 a.m., it still would have been incumbent upon him to come within 15 to 20 minutes?
A. Yes. Whether she told him that or not, yes.
Q. In other words, it would not have changed anything?
A. No.
Q. Once he's made aware of this information at 6:00 a.m., as a Board-certified obstetrician isn't it really his decision then, his judgment, as to when he needs to come to the hospital?
MR. MISHKIND: Objection. Go ahead.
A. Certainly that's the majority of it. The nurse also has a role in getting the physician appropriately in the hospital in a timely manner. In this particular case the patient has essentially revoked her permission to do a VBAC, that creates essentially I'm not going to say emergency but very



close to that where the physician must respond and evaluate the situation and make a decision about what he's going to do with the management. So most of that is on the physician, but the nurse is an advocate for her patient and -- her two patients, the baby and the mother, and so again this is a team effort. Yes, most of it is the physician's responsibility to come in in a timely manner, but the nurse also has an independent knowledge base and judgment to protect her two patients and her expectation was that he would come in in a short manner, that it would not take as long as it did. She was surprised that it took so long for him to come in and yet she did nothing about it.
Q. And that criticism that you have applies to both nurses?
A. The other nurse was aware of the expectation and really she is -- now time has passed and so we're beyond two hours in the second stage and the physician is not there to evaluate the patient let alone to talk about the VBAC issue so it gets even worse the longer this goes without some resolution.
Q. So I understand your testimony, after he arrives at 7:44 a.m. is it your opinion that it would have been reasonable to call for a crash C-section at 8:00 a.m.?

A. You mean once they did what they did?
Q. Yes.
A. I mean it was unreasonable to rupture the membranes, it was unreasonable to not stay right with the patient because he's now gone outside the standard of care, it was unreasonable not to have everybody available, then when we have the prolonged deceleration at 7:58 an emergency C-section, a crash C-section, whatever term you want to use, should be called, yes.
Q. I want to touch upon something you just said. You said it was unreasonable to have the staff or the team assembled?
A. No, I didn't say that. I'm sorry if I did, that's not what I meant.
Q. You're not critical of this hospital for not having people standing by to do crash C-sections?
A. No, but the physician should have called in the appropriate people prior to his ill-advised decision to rupture the membranes.
Q. Do you think a C-section should have been called at 7:44 a.m. or thereabouts when he arrived?
A. Let's go back. The C-section should have been called at 4:15, it then should have been called at 6:15 or 6:20, whenever he got in there, or should have gotten in there, at 7:44 a C-section should have been



called, yes, without rupturing her membranes.
Q. Let's take all the hypotheticals out of it. He arrives at 7:44 a.m.?
A. Yes.
Q. Are you saying that at that time when he arrived he should have called a C-section?
A. Yes, that's the only thing to be within the standard of care.
Q. If a C-section had been called at or about 7:44 a.m., is it your opinion this baby would have had a normal outcome?
A. Well, if we look at the timing of things the C-section was actually called at 8:12, incision was at 8:34, so that's a total of 22 minutes from decision to incision. If the decision was at 7:44 even assuming that he did not rupture the membranes and that the rupture occurred and became apparent at the time 7:58, if we take 22 minutes from 7:44, that would be 8:06 that the team would have arrived, been ready and incision would have been made. And very clearly this baby would have been normal at 8:06. Nothing -- the baby didn't even have time to start to develop significant problems and I believe that Dr. Tizzano has testified in his deposition that the baby -- he felt that the baby would be normal if delivered by 8:14 or



something in that range and I would agree with that.
Q. So even if baby had been delivered as late as 8:14 a.m., you believe baby would have been normal?
A. I believe that even later than that that the baby would have been normal to a degree of medical probability.
Q. Can you give us a time to a reasonable degree of medical probability as the latest time baby could have been delivered and still have been normal?
A. No, because even given the circumstances of this case the baby could have ended up being normal. Again, when we talked about the statistics and the Ph of 6.5 at the time of delivery, which we don't know what it was at the time of delivery, there's an 80 percent risk of neurologic handicap, still 20 percent of those babies end up being normal so there's just no way of being able to answer that. Even as long as it was in this case the baby could have ended up being normal. Statistically it was not likely the baby would be normal.
Q. This failure to institute oxygen by Nurse Gwin, I just don't understand how it works. If the obstetrician is there and the nurses are there acting under his mandate or dictate, if you will, help me understand how it works. Is that something the



nurse has to do on her own or does the obstetrician direct that?
A. No, it's basically a nursing function. There's certain things that the nurse has available to her to help increase the oxygen delivery to the baby; first is to add supplemental oxygen by face mask, second is to position the patient on one side or the other, knee-chest, Trendelenberg, any different position to try to move the cord if the cord is the problem with being squeezed. And increasing the IV fluids to increase the intravascular volume is the third thing that nurses can do and is really within their mandate and what they -- it's totally their scope of practice. Now, could the physician say give her oxygen, turn her on her side, open her IV up, call for a C-section stat, sure, the physician can also participate in those things, but they're generally nursing duties.
Q. Even if the physician is at the foot of the bed?
A. Yes.
Q. When do you believe the oxygen should have been administered, 7:59 a.m.?
A. Yes.
Q. So we're talking about -- and I believe it

was started at 8:06?
**A. Yes.**
Q. So we're talking about a seven-minute delay?
**A. Yes.**
Q. Are you prepared to state to a reasonable degree of medical probability that that delay in oxygen administration somehow played a part in this outcome?
**A. Since you phrased it that way, yes.**
Q. What is your opinion on that issue?
**A. I think it did play a part in it, it worsened the outcome.**
Q. Can you state to what degree?
**A. No.**
Q. How about the position changes, are you prepared to state to a reasonable degree of medical probability that the failure to position this patient differently during this period of time somehow played a part in this child's outcome?
**A. Again, phrased as such, yes.**
Q. And, again, can you state to what degree it played a part in the outcome?
**A. No.**
Q. We've been at this for roughly about three hours now. Have we covered all the opinions that you have in this case?



MR. MISHKIND: Who's counting, but it's three-and-a-half hours.
MR. ROSSI: I was being generous and taking out the break time.
MR. JACKSON: And the arguments.
MR. MISHKIND: The comments by Mr. Jackson.
**A.** It's an hour **50** with the arguments now. Yes, I've given you all my opinions.
MR. ROSSI: Just let me look through my notes, but I think that I'm probably done.
Q. BY MR. ROSSI: There was something I've wanted to ask you, I've been looking at this the whole deposition.
**A.** It's a sucker trap for lawyers.
Q. Tell me about that. We're talking about a framed piece "congratulations, Dr. Elliott, retired June 20, 1998." It's got a shirt in the frame. What's that all about?
**A.** My shirt was retired.
Q. Is that a shirt you used to wear regularly or something?
**A.** Quite regularly, yes, and the residents that year decided that they felt it should be retired so they got it from my wife and put it under glass so I could no longer wear it.



Q. The reason I ask I notice also you've got a plaque over here from your group presented to you saying "in recognition of your 15 years of support and service" and that's also dated 1998. Was that just because coincidentally you had 15 years at that point?
**A. I've never noticed it's the same year. Our group kind of commemorates five-year anniversaries for all employees so I have a five and a ten-year also. And hopefully a 20-year.**
Q. As you sit here today you are not retired, are you?
**A. Oh, I wish, but, no, I'm not.**
MR. ROSSI: That's all I have, thank you.
**A. Thankyou.**

FURTHER EXAMINATION
BY MR. JACKSON:
Q. Just one question, Doctor. If you formulate any new opinions or change any opinions that you expressed today or alter them in any way, I assume you'll agree that we're entitled to know that and have an opportunity to talk to you. Do you agree with that?
**A. Certainly.**
MR. MISHKIND: Certainly if there are any based upon the deposition of Angel, Nancy Morgan and to



the extent the policies are submitted or obviously any of the testimony of your experts I will immediately notify you and give you more than sufficient time to reconvene the deposition.
Q. BY MR JACKSON Would you also agree with me, Doctor, that Mr. Mishkind should bear the expense of any additional time for that?
**A. I don't want to get into that.**
MR. MISHKIND: You won't dignify his last comment. Are you done?
MR. JACKSON: I am for now.
MR. MISHKIND: Signature will be reserved, the doctor will read the deposition.
(Exhibits 1 and 2 marked for identification.)
(9:28 p.m.)

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John P. Elliott, M.D.

STATE OF ARIZONA )
) ss.
COUNTY OF MARICOPA )

BE IT KNOWN that the foregoing deposition was taken before me, JENNIFER LLOYD, a Certified Court Reporter in the State of Arizona; that the witness before testifying was duly sworn by me to testify to the whole truth; that the questions propounded to tlie witness and the answers of the witness thereto were taken down by me in shorthand and thereafter reduced to print by computer-aided transcriptioii under my direction; that the deposition was submitted to the witness to read and sign; that the foregoing 128 pages are a true and correct transcript of all proceedings had upon the taking of said deposition, all done to the best of my skill and ability.

I FURTHER CERTIFY that I am in no way related to any of the parties hereto nor am I in any way interested in the outcome hereof.

DATED at Phoenix, Arizona, this 23th day of August, 2001.

Certified Court Reporter
Certificate No. 50165

Page 129

## -D-

## -Q-



## -R-

## -S-

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