

In The Matter Of:

*Karl McElfish II v.
Meridia Medical Group*

*Garth Essig, M.D.
August 2, 2005*

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[1] IN THE COURT OF COMMON PLEAS
[2] CUYAHOGA COUNTY, OHIO
[3] Karl McElfish II,)
[4] Individually and as)
[5] Administrator of the)
[6] Estate of Sherry)
[7] McElfish,)
[8] Plaintiff,)
[9] vs.) Case No. CV 04-537289
[10] Meridia Medical Group,)
[11] L.L.C., et al.,)
[12] Defendants.)
[13]
[14] Deposition of Garth Essig, M.D., a
[15] witness herein, called by the Plaintiff for
[16] examination under the statute, taken before me,
[17] Valerie J. Grubaugh, Registered Professional
[18] Reporter, Certified Realtime Reporter and Notary
[19] Public in and for the State of Ohio, pursuant to
[20] notice and stipulations of counsel hereinafter set
[21] forth, at the offices of the Deponent, The Ohio
[22] State University, 545 Means Hall, 1654 Upham
[23] Drive, Columbus, Ohio, on Tuesday, August 2, 2005,
[24] beginning at 3:30 o'clock p.m. and concluding on
[25] the same day.

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STIPULATIONS

[1]
[2]
[3] It is stipulated by and among counsel for
[4] the respective parties herein that the deposition
[5] of Garth Essig, M.D., a witness herein, called by
[6] the Plaintiff for examination under the statute,
[7] may be taken at this time and reduced to writing
[8] in stenotype by the Notary, whose notes may
[9] thereafter be transcribed out of the presence of
[10] the witness; that proof of the official character
[11] and qualification of the Notary is waived; that
[12] the witness may sign the transcript of his
[13] deposition before a Notary other than the Notary
[14] taking his deposition; said deposition to have the
[15] same force and effect as though the witness had
[16] signed the transcript of his deposition before the
[17] Notary taking it.
[18]
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[13]	EXHIBITS	MARKED
[14]	None	
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[1] GARTH ESSIG, M.D.
[2] of lawful age, being by me first duly placed under
[3] oath, as prescribed by law, was examined and
[4] testified as follows:
[5] **EXAMINATION**
[6] **BY MR. BECKER:**
[7] **Q:** Doctor, if you could just move a hair
[8] closer to the speaker phone, I would appreciate
[9] it.
[10] State your name, please.
[11] **A:** My full name is Garth, middle name
[12] Frederick, last name Essig, E-s-s-i-g.
[13] **Q:** And what is your current position at Ohio
[14] State?
[15] **A:** I am an Associate Professor of Obstetrics
[16] and Gynecology, and I'm the — the OSU Student
[17] Medical Student Clerkship Director for Obstetrics
[18] and Gynecology.
[19] **Q:** In addition to that, do you have a
[20] private practice?
[21] **A:** Yes.
[22] **Q:** And would you describe your current
[23] private practice?
[24] **A:** It's a general OB/GYN practice that is
[25] with both obstetrics and gynecology. And I cover

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[1] the resident practice on a periodic — we have a
[2] regular rotation, so we cover — tonight I'll be
[3] on for — all the GYN that comes through the
[4] emergency room will be my patients tonight.
[5] **Q:** I know you know the ground rules, but
[6] just for the record, as you know, this is a
[7] question and answer session under oath. It's
[8] important that you understand the question that I
[9] pose.
[10] If at any time the question that I ask is
[11] inartfully phrased or doesn't make sense, I would
[12] ask you to stop me and tell me so, and I'd be
[13] please to attempt to rephrase or restate the
[14] question. Fair enough?
[15] **A:** Okay. Fair enough.
[16] **Q:** However, Doctor, unless you indicate
[17] otherwise to me, I'm going to assume that you
[18] fully understood the question that has been posed,
[19] and you were giving me your best and most complete
[20] answer today. Fair enough?
[21] **A:** Good.
[22] **Q:** Do you have your complete file with you
[23] today?
[24] **A:** Yes.
[25] **Q:** Okay. Would you tell me and identify for

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[1] the record everything that has been sent to you
[2] that's within your file?
[3] **A:** Okay. Actually when we moved, I left
[4] some of the things in the other room, but I have
[5] the complete medical record for Ms. McElfish.
[6] Not necessarily in order here, I have
[7] depositions of Dr. Stockwell, I have depositions
[8] of Bic — let me just use the last name —
[9] Dr. Redline, Pamela Kelly, William Rayburn, and
[10] William Floyd.
[11] And I have other — some of the other
[12] depositions of the woman — the nurse practitioner
[13] was Hughes, I think is her name. Just trying to
[14] go by memory.
[15] I have all the reports that the various
[16] experts have rendered. I think that's about — I
[17] think that's about it.
[18] **Q:** Okay. Do you have the midwife's
[19] depositions as well?
[20] **A:** I do.
[21] **Q:** As a result, Doctor, of your review, did
[22] you generate any notes?
[23] **A:** No, I didn't. I generated the report
[24] that I sent to Reminger & Reminger in Cleveland.
[25] **Q:** But no notes? No handwritten notes?

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[1] A: No.

[2] Q: And are all the opinions that you're
[3] going to render in this case spelled out in that
[4] report?

[5] A: I believe so. It's a pretty small
[6] report. And I was really asked specifically to
[7] comment on the care of the midwives, and
[8] Dr. Karasik.

[9] Q: You were asked to comment on the care of
[10] the midwives and Karasik, and not Dr. Bailin?

[11] A: Correct.

[12] Q: And were you asked to focus your analysis
[13] or evaluation based on the events that occurred
[14] during labor and delivery?

[15] A: And the prenatal care.

[16] Q: In the last paragraph of your report
[17] dated November 15th, 2004, it says that it's your
[18] opinion that the labor and delivery team met the
[19] standard of care, correct?

[20] A: Yes.

[21] Q: I don't see any reference in this report
[22] relative to prenatal care. So are you now going
[23] to be rendering an opinion that the prenatal care
[24] met the standard of care as well?

[25] A: Yes, sir, I will.

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[1] Q: And that's the prenatal care by the
[2] midwives as well as Dr. Karasik?

[3] A: Yes.

[4] Q: Or "Karasik".

[5] MS. DI SILVIO: Actually, Mike, the whole
[6] second paragraph and third paragraph of his report
[7] address the prenatal care, so I'm not clear on
[8] your question, but that being said, I'll let the
[9] Doctor answer.

[10] MR. BECKER: Right. And I guess I didn't
[11] see a conclusion about standard of care as to the
[12] prenatal period.

[13] MS. DI SILVIO: I think the words
[14] "appropriate" are used repeatedly in those second
[15] and third paragraphs, but I will let the Doctor
[16] answer whatever question you put to him.

[17] MR. BECKER: Okay.

[18] THE WITNESS: Yes, I felt that the
[19] prenatal care that was rendered by the nurse
[20] midwives and Dr. Karasik was appropriate, and met
[21] the standard of care.

[22] BY MR. BECKER:

[23] Q: All right. Let me first talk about the
[24] midwives. Do you regularly deal with midwives?

[25] A: You know, I haven't because — we have a

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[1] few here, we had a midwife school for a while, and
[2] I was not — I didn't work with them simply
[3] because it was going to cost me more money on my
[4] malpractice insurance, and we already had faculty
[5] that were dedicated to doing that. So I really
[6] have not had that much contact with nurse
[7] midwives.

[8] Q: So since you don't directly work with
[9] them, the first question I have is how are you
[10] familiar with standard of care if you don't
[11] regularly work with them?

[12] A: That's a good question. But I think that
[13] as — as — their care of the patient, as I
[14] rendered — as you saw the report — or as I saw
[15] the prenatal care flowing, I thought that that was
[16] appropriate for whomever did it, whether it was a
[17] physician or a nurse midwife, or resident care.

[18] Q: All right. Are you saying that you
[19] applied the — what you considered obstetrical
[20] standard of care to the midwife?

[21] A: Yes.

[22] Q: All right. And you're not commenting on
[23] whether Dr. Bailin met the standard of care?

[24] A: No, I wasn't asked to.

[25] Q: Okay. And what is your understanding as

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[1] to when a midwife — if you have one, as to when a
[2] midwife should refer a patient directly to an
[3] obstetrician for case management?

[4] A: Well, I think any time that there's a
[5] change in the vital signs or any change in the
[6] chemistry — or the labs such as — I'm trying to
[7] say vital signs that — that are concerning, and I
[8] think most midwives work knowing what their role
[9] is, and if anything, I think they are anxious to
[10] communicate with their physician counterparts.

[11] And again, I don't have a huge experience
[12] to comment on that, but I think that — I think
[13] they are very careful about not doing things that
[14] they can't do. I think they are very aware of
[15] their limitations in the care of the patient.

[16] Q: You're assuming in this case that the
[17] midwives are very careful in their limitations?

[18] A: Yes.

[19] Q: What is your understanding as to what
[20] role Dr. Karasik had in this case?

[21] A: Well, there's really only one time that I
[22] saw his name mentioned in the chart, and that was
[23] the brief hospital stay of August 21st, 2000. I'm
[24] sorry, I got the wrong one. It was the brief stay
[25] of the 5th of September, 2000.

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[1] Q: And what was his responsibility?

[2] A: He was consulted before the patient was
[3] sent to the hospital for further evaluation.

[4] Q: And what is your understanding as to what
[5] Dr. Karasik was told?

[6] A: The —

[7] MS. DI SILVIO: Give him a minute, Mike,
[8] to get to his record.

[9] BY MR. BECKER:

[10] Q: If you need time to look at records, let
[11] me know.

[12] A: Yeah, okay. I'm just trying to get to
[13] the prenatal records here. Since we grabbed
[14] everything and ran over here, it was — yeah, on
[15] the 5th of September — I'm trying to read exactly
[16] where — Okay. Got it here.

[17] She was — The nurse midwife consulted
[18] because of swelling; blood pressure was elevated.
[19] She was — had swelling in her hands and was sent
[20] to be evaluated.

[21] And I can't — I think she had a
[22] nonstress test during that time, or just before,
[23] and Dr. Karasik was advised.

[24] Her cervix was closed. I can barely read
[25] the notation, but — so I think that it was just

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[1] The urinalysis that she had done then
[2] was — I'm trying to look at the other things.
[3] Uric acid was normal. Her enzymes were normal.
[4] So all of that was done.

[5] So I think there was — I mean, you
[6] wouldn't do that unless you thought there was a
[7] concern about toxemia pregnancy.

[8] I'm trying to find the urinalysis here.
[9] Here it is. But anyhow, there was no protein in
[10] the urine data, either.

[11] So I think that even though you were
[12] concerned about that from the office, it appears
[13] that the clean voided urinalysis that was done
[14] didn't find any protein in it, so it's a pretty
[15] hard argument to make for a diagnosis of toxemia
[16] without there being some proteinuria present.

[17] Q: When you say "a clean void urinalysis",
[18] what do you mean and what conclusions can you draw
[19] from that?

[20] A: They simply — this patient had a body
[21] mass index of 42, which is — which is in the
[22] range of morbid obesity. And even for a normal
[23] person to get a urine specimen with a cup is quite
[24] a gymnastic event.

[25] And so they usually cleanse the labia

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[1] the continuing concern about the patient's edema,
[2] and I think that this nonstress test had been
[3] previously set up, ultrasound and nonstress test
[4] had been previously set up for that time.

[5] Q: Do you know whether or not Sherry
[6] McElfish had been preliminarily diagnosed by
[7] anyone prior thereto with toxemia?

[8] A: I don't recall that there is anything in
[9] the chart that indicates that. I know they had
[10] some concerns about her blood pressure elevation.

[11] Q: If someone — If one of the midwives had
[12] diagnosed toxemia prior to that day, should that
[13] information have been relayed to Dr. Karasik?

[14] A: Yes, absolutely.

[15] Q: If Dr. — Hypothetically, Doctor, if
[16] Dr. Karasik had been told this patient had been
[17] previously diagnosed with toxemia, what should
[18] Dr. Karasik have done?

[19] A: I think sort of what was done here in
[20] terms of the labs that were done when she arrived
[21] there.

[22] They did — For example, they did a
[23] complete blood count that included a normal
[24] platelet count and her hemoglobin/hematocrit were
[25] within normal limits.

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[1] with a sponge and then collect the specimen. The
[2] patient can still do that herself, but they are
[3] just more careful in collecting the specimen.

[4] And I don't know, they probably don't use
[5] the dip stick, which introduces another possible
[6] error, and I think they use a more direct method.
[7] I could be wrong.

[8] At least in our hospital when they do the
[9] urinalysis, they use a chemical method for
[10] determining the proteinuria. It's the same method
[11] they use for doing 24-hour urines when they are
[12] finding the actual amount of protein in the urine
[13] over the specimen time.

[14] Q: Well, are you equating a 24-hour with a
[15] urinalysis?

[16] A: No. I'm saying it's the same chemical
[17] method that they do, rather than a dip stick. In
[18] the clinic we always use just the dip stick just
[19] because it's convenient and it's relatively
[20] predictive, particularly in values that are over
[21] two-plus.

[22] Q: You're saying the urinalysis is
[23] relatively predictive?

[24] A: No, the — If you're doing dip sticks in
[25] the clinic, that the dip stick is predictive, but

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[1] it's just so much easier to do than having to do
[2] the chemistry. It's cheaper and just more timing.
[3] You get the answer right away, you don't have to
[4] wait for somebody to do the whole urinalysis.

[5] Q: All right. But let's go back to the fact
[6] that you said there was a clean void urinalysis.

[7] My question is: What is the significance
[8] of that as to whether or not there is truly — she
[9] was ever spilling protein.

[10] A: Okay. If there is any — any mucous
[11] discharge present, mucous being a protein, you
[12] know, might throw off the dip stick a little bit,
[13] and that might be one of the reasons there was
[14] some variations from time to time in the dip stick
[15] reporting.

[16] Still an accurate test and still a reason
[17] to do it, but the contaminants from the vaginal
[18] discharge are sometimes confounding.

[19] Q: I guess I'm not making myself clear. Are
[20] you saying there was not an indication to do a
[21] 24-hour urine?

[22] A: Right.

[23] Q: Why not?

[24] A: Because her urine then was negative, and
[25] you wouldn't do a 24-hour urine if you had a

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[1] within six hours, you would do it; or if you had
[2] it the next day, you know, I think most people
[3] would do it then, because your chance of having a
[4] significant yield is much better.

[5] And at that point you need to know
[6] exactly what your patient is doing. So just on a
[7] one-specimen time, I don't think you'd do it.

[8] Q: So what you're saying is if you have a,
[9] quote, clean void urinalysis, meaning no protein,
[10] that that kind of relieves one of the
[11] responsibilities to do a 24-hour urine because a
[12] clean void urinalysis means a finding of protein
[13] is unlikely?

[14] A: Right. You have less chance for
[15] contamination of the specimen. The contamination,
[16] you know, is one of those things that might
[17] increase the amount of protein in the urinalysis.

[18] Q: Do you do 24-hour urines on your clients,
[19] people that have preeclampsia and you're not sure
[20] whether they have preeclampsia or develop
[21] preeclampsia, do you ever put them in the hospital
[22] more than three or four hours and do a 24-hour
[23] urine?

[24] A: Well, that would be way too expensive
[25] just to get the urine specimen collected. We

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[1] negative protein in the urinalysis.

[2] I mean, you could do it, but your
[3] possibility of there being anything significant
[4] levels in it are pretty small.

[5] Q: Okay. Well, explain to me that
[6] conclusion.

[7] A: Well, if you have — if you're secreting,
[8] say, 500 milligrams, and if you just divide that
[9] over the usual 24-hour voiding period, it would
[10] give you at least a one-plus urine.

[11] And so anything less than that, you
[12] probably — I mean, you could do it, but the yield
[13] on it is so small. And it's such a pain in the
[14] neck to do a 24-hour urinalysis, or urine
[15] collection, that we usually don't ask the patients
[16] to do it.

[17] The usual way you do that is if they are
[18] consistently spilling two-plus, or over two-plus,
[19] then you give them the container and you collect a
[20] 24-hour urine specimen.

[21] Q: So you're saying the standard of care is
[22] if there's a two-plus protein in the urine, at
[23] some point, then you got to do a 24-hour urine?

[24] A: Well, if you have — if you have one
[25] two-plus and then you have a second two-plus

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[1] would give them — We have these containers that
[2] we send people home with, have preservative in it,
[3] and then they bring it back the next day. We have
[4] a place we can do that, you know, seven days a
[5] week, in the lab —

[6] Q: Excuse me. Under what circumstances do
[7] you collect a 24-hour urine?

[8] A: If we're — If we're getting a specimen
[9] that's over two-plus, so if it's three to
[10] four-plus out.

[11] And if we're getting persistence in
[12] two-plus, if we see the patient in the morning we
[13] might have them come back in the afternoon, just
[14] get another specimen.

[15] And if it's also two-plus, we would
[16] definitely do the 24-hour urine on that person.
[17] If the patient had other — other things that
[18] would make us alarmed — I mean, if we really were
[19] making the diagnosis of toxemia based on the other
[20] parts of this, which is, you know, hypertension,
[21] edema, the headaches, flashing lights, you know,
[22] things that are symptomatic, that patient we would
[23] probably put in and to begin more continuously
[24] monitoring the baby, because one of the problems
[25] with this toxemia is it's a — it's a — it's a

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[1] vasoconstrictive event, and you want to make sure
[2] that the baby isn't being compromised by this,
[3] because that's the first thing — I mean, that's
[4] one of the most sensitive things that happens in a
[5] toxemic patient; the babies become growth
[6] restricted because the placental bed is restricted
[7] by the vasoconstriction.

[8] So that patient would probably not wait
[9] to get the 24-hour urine before we put the patient
[10] in the hospital to at least do a long-time, what
[11] we call a nonstress test, and do the labs that
[12] were done here.

[13] Q: So you're saying if a patient is
[14] symptomatic, and has headaches, the seeing stars,
[15] those are patients you put in the hospital and
[16] monitor them?

[17] A: We would at least monitor them for a
[18] while. And if the labs were normal and if they
[19] weren't spilling any protein, that's not a patient
[20] you ignore, but that's a patient you probably see
[21] again in the next two or three days, four days
[22] maybe at the most.

[23] Q: You put them in the hospital for hours,
[24] or is it 24 hours?

[25] A: We wouldn't put them in for 24 hours

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[1] come to that conclusion at about this point that
[2] she has some pressure elevations, but she
[3] hasn't — I mean, every attempt whenever she goes
[4] to the hospital clinic — or to the hospital,
[5] rather, she doesn't spill any protein and her
[6] laboratory — what we call the PIH test,
[7] laboratory tests are normal.

[8] Q: You know, I didn't hear the very end of
[9] that sentence. Could you repeat your last
[10] sentence?

[11] A: Sure.

[12] I said that when she was sent into the
[13] hospital for observation, that the — the PIH, the
[14] pregnancy induced hypertension labs — it's just
[15] what we call them — or toxemia labs if you want
[16] to call them that, were normal, and at no time
[17] when she was seen in the — and a formal
[18] urinalysis was done, there was no proteinuria.

[19] So I think from that, you would conclude
[20] that there must be some form of chronic
[21] hypertension or gestational hypertension without
[22] the other associated problem.

[23] Q: Now, when preeclampsia is superimposed on
[24] a chronic hypertensive mom, does it generally
[25] appear to be — is the onset more subtle than

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[1] unless we had a bigger concern. Once the labs
[2] come back, in our experience, and they are
[3] negative, you know, we have a lot more room.

[4] And if the baby has a normal nonstress
[5] test or a biophysical profile, then that's
[6] predictive of a good outcome and the disease would
[7] not be — I mean, you don't want to ignore it, but
[8] you have some time now that you can let this baby
[9] stay in utero and grow and hopefully to a place
[10] where you can do an induction, or if they continue
[11] to do that.

[12] Q: Did you conclude that this mom was a
[13] chronic hypertensive?

[14] A: You know, in somebody with the — that's
[15] morbidly obese, and especially someone who is kind
[16] of short, if you don't use the proper blood
[17] pressure cuff you get blood pressures all over the
[18] place.

[19] And the problem is, the blood pressure
[20] cuff is so wide that it fills the space between
[21] their armpit and their elbow. I don't know if
[22] that was true of this person, but she was pretty
[23] small in stature, and I think that you do have a
[24] problem in getting the blood pressures.

[25] But I think that, you know, you have to

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[1] overt?

[2] A: Not necessarily. Preeclampsia is such
[3] a — it's such a treacherous thing. Sometimes it
[4] comes up slowly, and sometimes it comes up in a
[5] matter of days.

[6] And that's one of those things always a
[7] little bit neurotic about it, because it's just
[8] kind of treacherous.

[9] So you need to see the patients more
[10] often and you need to do nonstress testing every
[11] two or three days just because you don't have —
[12] Normally if you do a nonstress test and it's
[13] normal, we would say that you would have a week of
[14] predictable good outcome.

[15] When you have elevated blood pressure,
[16] you need to do it at least twice a week just to
[17] make sure that you're not — that the patient's
[18] increased blood pressure isn't translating into
[19] diminished blood flow through the placenta and you
[20] end up with a baby that's growth restricted.

[21] (Pause.)

[22] (Mr. Becker was disconnected.)

[23] MS. BECKER: Ms. Court Reporter, do you
[24] have my last question?

[25] (Question read back as requested.)

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BY MR. BECKER:

[1] Q: And, Doctor, if you could just give your
[2] answer again, then I'll just flow from there.

[3] MS. DI SILVIO: Objection. Asked and
[4] answered again.

[5] THE WITNESS: Not necessarily, because
[6] the — the progress of preeclampsia in a patient
[7] is so unpredictable, and I wouldn't say that in my
[8] experience I've seen it be any less occult than if
[9] it had just occurred de novo.

[10] BY MR. BECKER:

[11] Q: Well, if someone is a chronic
[12] hypertensive, should they be monitored more
[13] closely for preeclampsia than a woman that's not a
[14] chronic hypertensive?

[15] A: Exactly. And I think that you're doing
[16] that when you're doing the nonstress testing more
[17] frequently, or the biophysical called the BPP, and
[18] the drawing of the PIH labs would be — would be
[19] looking for that. And rechecking the urine when
[20] the patient comes in for — to make sure there's
[21] no increase in proteinuria.

[22] Q: And you said that at some point these
[23] women require blood pressures taken at least twice
[24] a week?
[25]

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[1] was quite ill.

[2] Q: Okay. And she had HELLP Syndrome likely
[3] at that point?

[4] A: I think that she certainly had the
[5] elevated liver enzymes. But on admission her
[6] platelets weren't below the level that we would be
[7] concerned, and she didn't have any other evidence
[8] of hemolysis.

[9] By that I mean her bilirubin was normal,
[10] but her enzymes were really sky high at that
[11] point.

[12] Q: So how would you classify her on
[13] admission?

[14] A: On the basis of that, you know, you think
[15] it's coming. I mean, this is — you hear the
[16] thunder.

[17] Q: You think HELLP is coming?

[18] A: Yeah, something bad is coming. So that's
[19] why you do these things.

[20] And she was also — I mean, the first
[21] things quoted in the chart that she was saying is,
[22] "I can't breathe".

[23] At that point, you know, I would be
[24] concerned that she may be having some symptoms of
[25] congestive heart failure. And if you just look at

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[1] A: Yes.

[2] Q: Okay. And when is that indicated?

[3] A: Well, you know, I don't think anybody
[4] really could tell you, but I think if they are
[5] thinking — if you're seeing any elevated
[6] pressures, you probably ought to start doing that.

[7] And at first when you're far from term,
[8] you're probably not going to do anything, you
[9] know, as far as the baby is concerned, because you
[10] don't want to get a preterm birth out of it.

[11] But if the pressure is very high, then,
[12] you know, you just need to see that patient more
[13] frequently.

[14] And I'd be hard put to tell you an exact
[15] date, but I would think that certainly by — by 32
[16] weeks you would want to follow that patient a
[17] little more closely, because at this point you can
[18] have some impact on the baby in case the baby's
[19] growth stops.

[20] Q: Do you agree that Sherry McElfish
[21] developed one of the most severe forms of
[22] preeclampsia by September 16th?

[23] A: By September 16th?

[24] Q: Yes.

[25] A: Yes, when she came to the hospital she

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[1] this kind of coming out, you know, one ten-minute
[2] peel at a time, the baby is going to be
[3] compromised by that decreased cardiac output, if
[4] that's what's happening to her.

[5] I mean, that's the part that doesn't make
[6] any sense, was she was having all these other
[7] things, she had huge blood pressure, and she
[8] had — you know, in spite of the fact that she was
[9] feeling hot, she was clammy, and you worry that
[10] this is somebody who is headed for shock for some
[11] reason, because that's classic symptoms of
[12] somebody who is in shock.

[13] They complain of air hunger, can't
[14] breathe, their skin gets kind of clammy as they
[15] begin to shut down, and she obviously was having a
[16] lot of vasoconstrictive problems, which is what
[17] you see in the end stage of, you know, for the
[18] more severe forms of preeclampsia.

[19] Q: It should have been clear to the care
[20] givers at the time of admission that this mom is
[21] about to go into shock?

[22] A: Well, you know, you worry about it. And
[23] you worry — but, you know, usually mothers
[24] survive.

[25] And our first concern is the pregnancy,

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[1] and because, you know, we all have found that if
[2] we deliver the patient, then we cure the disease,
[3] too.

[4] So we save two people, then, by getting
[5] the delivery accomplished. And as you watch this
[6] baby start to have some big decelerations there,
[7] and you know if you see one big one, that there's
[8] another one coming, and I think the — I think the
[9] timing was appropriate.

[10] They could have done it maybe a little
[11] sooner, but you just hate to jump on somebody
[12] you've never seen before. And I think they were
[13] proper in making sure they had blood available and
[14] things like that before they did this operation.

[15] And this is a bigger operation on a
[16] patient who is — has a body mass index of 42,
[17] because there's complications from doing that,
[18] getting her airway started, and it was pretty
[19] obvious they were going to have to give her
[20] general anesthesia, which introduces another risk
[21] for the anesthesia folks.

[22] Q: Why was it important to have blood
[23] immediately available?

[24] A: In case you got into — In case she
[25] decompensated and developed DIC. And that's the

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[1] available, especially somebody you don't know
[2] well.

[3] Q: Right. But when is administration of
[4] blood indicated?

[5] MS. DI SILVIO: Objection. If you know
[6] that.

[7] BY MR. BECKER:

[8] Q: Do you defer that to a consultant?

[9] A: Well, you know, I would think that — I
[10] mean, I would not defer it because, you know, I
[11] have the same problems in operating on people.

[12] If you're anticipating a big blood loss
[13] and you have an IV line started, you know, you
[14] have this up there and you're ready to go, and if
[15] you get into the uterus and you find that she's
[16] got a placenta previa, because they didn't know
[17] she didn't have a placenta previa — I mean, if
[18] they knew what her records were they would know
[19] that she didn't, because she had so many
[20] ultrasounds.

[21] But you don't know whether that placenta
[22] is being — is kind of low lying there, and if you
[23] cut into it you're going to get a lot of blood
[24] loss, so you want to have that ready as you start
[25] this, because you don't have much time.

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[1] thing, you know, as they go on through HELLP, they
[2] begin to decrease their platelets. And if they —
[3] you know, then they just can't coagulate, so
[4] you're going to be potentially operating on
[5] somebody who is going to be anticoagulated.

[6] Q: So when is blood — administration of
[7] blood indicated?

[8] A: Well, you wouldn't administer it at that
[9] point, but you just want to make sure that you've
[10] got blood set up.

[11] And I know in one of the depositions they
[12] made a big — there was a big discussion about
[13] whether she was type and crossed, or whether she
[14] was type and screened.

[15] This is a patient you want to have typed
[16] and crossed because you need to have that blood
[17] available, and that means that you can start the
[18] case before they have it up there, but you need to
[19] know when they are going to have it available
[20] before you start your incision.

[21] In other words, if you're going to have
[22] ten or 15 minutes, you probably have plenty of
[23] time. But if it's going to be another hour you
[24] might want to wait a little bit because you don't
[25] want to operate on somebody without blood

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[1] This baby is in trouble already, the
[2] mother is in trouble, and you hope that you can
[3] get out of this with two living patients.

[4] Q: Right. Let's go back to my question,
[5] though.

[6] When would blood — administration of
[7] blood be indicated for a mom with HELLP Syndrome?

[8] MS. DI SILVIO: Objection. You may
[9] answer if you can.

[10] THE WITNESS: If she's losing blood, you
[11] would give it on the basis of anemia, is the
[12] simple answer.

[13] BY MR. BECKER:

[14] Q: So as soon as you see the platelets are
[15] dropping, then you would administer blood?

[16] A: No. If her platelets dropped below, say,
[17] a hundred, you might want to give her platelets —
[18] you can give platelet transfusions, but you need
[19] to set that up for — that's a little bit harder
[20] to get up than just giving whole blood.

[21] So in the absence of platelet transfusion
[22] you would give whole blood, hoping there would be
[23] some live platelets in there that would help you
[24] out.

[25] But mostly you want to get the pregnancy

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[1] over with, stop the disease, and you know, usually
[2] delivering the baby and removing the placenta and
[3] getting the uterus closed, that's usually the end
[4] of the toxemia, but not always.

[5] **Q:** All right. Well, what happened to this
[6] mom by 2:30 a.m.?

[7] **A:** Let me get to my flow sheets here.

[8] She delivered at 1:18 and so they were —
[9] they were out of the operating room by about 2:18,
[10] I think. Let me see if I can find the anesthesia
[11] record here.

[12] You know, when they — I think the —
[13] that she did pretty well during the surgery
[14] because with positive pressure ventilation that
[15] anesthesia was giving, because she was on general,
[16] you know, probably held this problem off if she
[17] had some degree of failure.

[18] And so when they woke her up, the
[19] pressure was reduced and she probably would begin
[20] to — I mean, if she were going to have problems
[21] she would start to have problems in the
[22] postoperative time, just because the positive
[23] pressure ventilation was removed.

[24] And I'm trying to find — I'm talking
[25] while I'm trying to find the 2:00 time here.

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[1] **MS. DI SILVIO:** Is there anything in
[2] particular you want him to look at, Mike, to speed
[3] this along?

[4] **MR. BECKER:** Well, I'm interested in the
[5] blood pressure drop, hypotension, I think at 2:30.

[6] **MS. DI SILVIO:** Why don't you give him a
[7] second to get oriented with the record, Mike?

[8] **THE WITNESS:** I'm sorry, you asked, Mike,
[9] at what time?

BY MR. BECKER:

[10] **Q:** I think around 2:30 she became
[11] hypotensive?

[12] **A:** Yes.

[13] **Q:** Okay. And was a consultation indicated
[14] and warranted at that time?

[15] **MS. DI SILVIO:** Objection.

BY MR. BECKER:

[16] **Q:** Let me ask you this: Did you look at
[17] this case from at the postpartum event?

[18] **A:** Well, I couldn't stop reading it. I just
[19] kept reading because it was such a mystifying
[20] case.

[21] I would assume that anesthesia would
[22] still be — would still be helping at that point.
[23] I may be wrong, but if you needed more help, that

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[1] would be the time to see.

[2] But you'd be concerned that — that
[3] either you were beginning to have some problem
[4] with DIC, or there was some internal bleeding that
[5] you'd be worried about. So definitely at that
[6] point you'd check her labs.

[7] **Q:** And is that when you would be
[8] administering blood, or would you put a central
[9] line in first?

[10] **MS. DI SILVIO:** Objection. Beyond the
[11] scope.

[12] **MR. AUSTRIA:** Objection.

[13] **MS. SCHREMP:** Objection.

[14] **MS. DI SILVIO:** Objection. Beyond the
[15] scope of his opinions. You may answer if you can.

[16] **THE WITNESS:** Okay. I think that — that
[17] that would be a time, if you're going to put in a
[18] line to do that. You might have even done it
[19] during the procedure if you thought you were going
[20] to have —

[21] It's very nice to have the central venous
[22] pressure line because it helps to make sure that
[23] you're not overloading the patient if you're
[24] giving lots of fluids and so on.

[25] And it's been a real problem for patients

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[1] whose blood volume is already constricted, and
[2] then when they lose some blood, and then you're —
[3] the reason for their hypertension is taken away,
[4] then they frequently start to expand their —
[5] their extra vascular space — their vascular
[6] space, rather, and so they do try to drop down and
[7] you have to kind of catch up with that, so that
[8] would have been a helpful thing, I think, yes.

BY MR. BECKER:

[9] **Q:** Did you happen to read the discovery
[10] deposition of the anesthesiologist?

[11] **A:** No, I didn't see that, Mike.

[12] **Q:** I want you to assume it's true that she
[13] said she would have liked to have known
[14] preoperatively that this patient was suspected of
[15] having HELLP Syndrome. Do you appreciate that
[16] comment coming from the anesthesiologist?

[17] **MR. AUSTRIA:** Objection.

[18] **MS. SCHREMP:** Objection.

[19] **MS. DI SILVIO:** Objection.

[20] **THE WITNESS:** Yeah, that's kind of an odd
[21] comment to make, because I would have assumed that
[22] she would have looked at the chart and seen the
[23] labs if — they should have been available by that
[24] time that you'd be worrying about that.
[25]

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[1] You know, it's — I assume that she was
[2] also around the patient preoperatively. But yeah,
[3] I mean, I think that it's always important for the
[4] whole surgical team to be in touch with each other
[5] about what her concerns are.

[6] **BY MR. BECKER:**

[7] **Q:** I don't think she had an opportunity, to
[8] be fair to her, to review the chart prior to
[9] induction.

[10] **A:** Yeah, sometimes that happens, when
[11] everything happens at once.

[12] **Q:** Do you have an opinion whether or not the
[13] hospital nurses should have brought to her
[14] attention that this patient was suspected of
[15] having HELLP Syndrome?

[16] **MS. DI SILVIO:** Objection, beyond the
[17] scope of Dr. Essig's opinion. You may answer if
[18] you have an opinion.

[19] **THE WITNESS:** It's the same thing. I
[20] mean, the whole team has to really be on the
[21] patient's side here to make sure that we're all
[22] understanding what the patient's needs are.

[23] But I think from the anesthesia
[24] standpoint — and, again, I'm not an
[25] anesthesiologist — but you know, I would assume

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[1] on them, it's not a bad idea to give blood.

[2] Not — In fact, it's probably an indicated thing
[3] to do.

[4] **Q:** All right. Let's back up, Doctor,
[5] prenatally for a moment.

[6] As I understand your opinions here
[7] relative to Dr. Karasik, you feel because of the
[8] urinalysis during that September 5th brief
[9] hospital stay, that that relieves Dr. Karasik from
[10] doing a 24-hour urine or keeping the patient in
[11] the hospital for 24 hours or continued blood
[12] pressure monitoring?

[13] **A:** Right. Because you wouldn't have made a
[14] diagnosis of toxemia at that point with normal —
[15] normal labs and pressures that were reasonably low
[16] there in the hospital clinic.

[17] **Q:** Well, I mean, have you had — do you put
[18] patients in — I've asked you about 24-hour
[19] urines; you say you rather would do that on an
[20] outpatient basis.

[21] Do you put patients — moms in the
[22] hospital for at least a 24-hour period of time not
[23] only for monitoring the fetus, but for the mom's
[24] welfare for monitoring her blood pressure?

[25] **MS. DI SILVIO:** Objection. Asked and

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[1] that they see a patient who pressures are falling
[2] and their pulse — her pulse pressures — rather
[3] her pulse rate is not changing appreciably, but
[4] it's still a little bit high and you got to think
[5] that there may be some volume loss here someplace.

[6] And it doesn't really matter what the
[7] loss is, but you would begin thinking about
[8] replacing that. And knowing this patient's size,
[9] that may be the best way to monitor the patient,
[10] putting in a CV — a central venous pressure line.

[11] **BY MR. BECKER:**

[12] **Q:** Why would you be thinking — Should one
[13] be thinking that there was likely a volume loss at
[14] that point?

[15] **A:** Well, if the pressure is dropping and
[16] you're just giving the patient crystalloids — And
[17] usually in patients who have toxemia, their
[18] intravascular space is constricted so they look
[19] better than they are.

[20] And then when the constriction is gone,
[21] like during the anesthetic phase, they begin to
[22] open up their vessels and so all of a sudden
[23] there's a loss of total volume.

[24] But I think any time you see patients
[25] getting shocky, and especially if you've operated

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[1] answered. You may answer it again.

[2] **THE WITNESS:** Usually we would do that if
[3] the mother was having other symptoms associated
[4] with that, or if the labs are borderline so that
[5] we could repeat the labs, you know, about 12
[6] hours.

[7] And so that we can keep — Most of the
[8] time we're doing this because we see babies that
[9] are — that are growth restricted and, you know,
[10] we're having a hard time monitoring them perhaps;
[11] just as well in situations where the baby is
[12] better out than staying with the mom.

[13] But I think if your labs are normal on
[14] the first go round, you probably wouldn't keep the
[15] patient any longer than you had to.

[16] **BY MR. BECKER:**

[17] **Q:** All right. But you indicated that if the
[18] mom has other symptoms, then you would keep the
[19] mom in the hospital. What other symptoms would —
[20] **MS. DI SILVIO:** Well, objection. That's

[21] a mischaracterization of his testimony. I think
[22] what he just told you was if the labs are normal.

[23] **MR. BECKER:** Please don't testify for
[24] him.

[25] **MS. DI SILVIO:** I'm not, but I'm not

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[1] going to let you mischaracterize what he said for
[2] your case.
[3] **BY MR. BECKER:**
[4] **Q:** Here is my question again: I thought you
[5] had just indicated that relative to the topic of
[6] when you put moms in the hospital for more than a
[7] few hours, you indicated if they come in with
[8] other symptoms associated with preeclampsia. My
[9] question is: What other symptoms are you
[10] referring to?
[11] **MS. DI SILVIO:** Objection.
[12] Mischaracterization of testimony. What he said
[13] was if the labs were normal in the first go-round,
[14] you wouldn't keep them any longer than you have
[15] to. With that objection I'll let him answer.
[16] **THE WITNESS:** If you're asking what other
[17] symptoms might be present, I think if the patient
[18] has persistent headache, if they are having visual
[19] disturbance, you might watch this patient a little
[20] bit more closely.
[21] Or if the baby on the — the fetus
[22] evaluation was growth restricted, in other words,
[23] if the baby is falling off the growth curve,
[24] that's a patient you're having different
[25] indications for. Her toxemia is okay, but the

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[1] baby's not.
[2] So I think those are other reasons you
[3] would keep the mother in the hospital longer.
[4] **BY MR. BECKER:**
[5] **Q:** All right. So if the mom,
[6] hypothetically — Doctor, I want to make sure I
[7] have this straight — hypothetically, had
[8] persistent headaches and — or was seeing stars,
[9] and even though her labs might be normal or near
[10] normal, you would keep her in and watch her at
[11] least 24 hours?
[12] **MS. DI SILVIO:** Objection.
[13] **THE WITNESS:** Yeah, I'd probably watch
[14] her long enough so I was comfortable sending her
[15] home. Even though things are normal, there may be
[16] other things out there that you're kind of
[17] watching for.
[18] **BY MR. BECKER:**
[19] **Q:** All right. Do you have an opinion as to
[20] when — Let's work on some definitions here.
[21] And I have the term toxemia. Is toxemia
[22] the same thing as preeclampsia?
[23] **A:** Yes.
[24] **Q:** Okay. Do you have an opinion as to when
[25] Sherry first developed preeclampsia, if you have

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[1] an opinion?
[2] **A:** Yeah, I would — I think that — I think
[3] she was definitely hypertensive from time to time,
[4] and — but I think the unquestionable time that
[5] everything would agree on is when she was admitted
[6] to the hospital on that 16th, evening of the 16th.
[7] There's no question about that.
[8] Up to that point, I think you have a
[9] difficult time because usually toxemia is not
[10] intermittent, you either have it or you don't have
[11] it, and it's progressive.
[12] So I think that this is confusing because
[13] she did have pressure elevations and she, from
[14] time to time, did have some proteinuria, but none
[15] of that really rose to the level that I would
[16] think you'd make the diagnosis of preeclampsia.
[17] **Q:** Now, have you ever had — in your 30-year
[18] plus career, ever had a mom develop HELLP
[19] Syndrome?
[20] **A:** Yes.
[21] **Q:** Could you give me an idea how many times
[22] that's happened to you, your patients, or patients
[23] you were responsible for?
[24] **A:** You know, I would — it would be a guess,
[25] but I can think of, off the top of my head, maybe

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[1] four; maybe three or four.
[2] I've helped the residents with a lot more
[3] of those numbers, because it's one of those
[4] diseases that you don't see in your private
[5] practice very often. You certainly can, but my
[6] patients are usually in pretty good shape and they
[7] get, you know, consistent medical advice from me.
[8] So I mean, I think Zuspan and others have
[9] said that the best way to prevent this illness is
[10] to have really tight compliance with your patient
[11] population and so on.
[12] And this patient did comply; I didn't
[13] mean to imply that. But so I think that's why I
[14] don't see that much in my own practice. But it's
[15] been a surprise when I've seen it.
[16] You can see it coming — or I think it's
[17] coming and I've probably prepared for it a lot
[18] more than I've seen it, obviously, because you
[19] don't want it to get there. So it's a scary thing
[20] when it happens, and it just sometimes happens
[21] like a summer storm.
[22] **Q:** You said Justin and others —
[23] **A:** Zuspan.
[24] **Q:** Who?
[25] **A:** Fred Zuspan.

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[1] Q: Fred Zuspan?
[2] A: Yeah. He was my former chief. So that
[3] was something he argued about all the time.
[4] Q: Did any of those women die?
[5] A: No, fortunately.
[6] Q: Was it necessary for any of those women
[7] to be administered blood products, if you recall?
[8] A: No, I never had to on my own private
[9] patients.
[10] On the resident side, because they
[11] frequently can't get in here to the clinic — I
[12] mean, to the hospital, they don't have rides or
[13] they don't have — they just come too late, plenty
[14] of those patients we have had to give blood
[15] products to.
[16] Q: But none of them, to your knowledge, have
[17] died?
[18] A: None of them have died that I can think
[19] of. It's something you remember, I'll tell you.
[20] Q: You are aware that your colleague in
[21] Columbus, David Stockwell, has an opinion that
[22] differs slightly with yours?
[23] A: Yes.
[24] Q: Okay.
[25] A: Yeah, I've read his deposition.

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[1] Q: And how long have you known David
[2] Stockwell?
[3] A: I hate to tell you this, but I think he
[4] was one of my students at one time.
[5] Q: Long time?
[6] A: Long time.
[7] Q: Okay. Is he well respected in the
[8] community?
[9] A: David is very well — he's a very good
[10] person, too.
[11] Q: Have we covered all the opinions you're
[12] going to give at trial?
[13] A: I believe so, sir.
[14] Q: And as to any causation opinions as to
[15] the timing of the — had there been an earlier
[16] Cesarean section, do you have an opinion as to
[17] whether or not the outcome would have been
[18] different?
[19] A: I think if we had a crystal ball and
[20] you'd have known that earlier, you might have
[21] avoided that.
[22] But, you know, as you look at it, without
[23] looking too far ahead, just look at it as it reels
[24] off on the calendar, I don't think there's a
[25] single place in there would I have advised

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[1] delivery on this patient.
[2] MR. BECKER: One moment. Let me just go
[3] over my notes.
[4] (Pause.)
[5] BY MR. BECKER:
[6] Q: Doctor, is there anything you can refer
[7] me to, any authority, any textbooks or journal
[8] articles that stands for the proposition that if a
[9] urinalysis is — is clean, that one need not
[10] consider a 24-hour urine?
[11] A: I'm sticking my neck out a little bit,
[12] but I think that the — that the Technical
[13] Bulletin, and I wish I could tell you which one
[14] that — they revised it a couple years ago on
[15] management of — I believe it's called Management
[16] of Pregnancy Induced Hypertension. I think they
[17] address there the — when you should get a 24-hour
[18] urine.
[19] MR. BECKER: That's all the questions I
[20] have, Doctor.
[21] MS. DI SILVIO: Anyone else?
[22]
[23] EXAMINATION
[24] BY MS. SCHREMP:
[25] Q: Doctor, this is Pam Schremp and I

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[1] represent Dr. Lucy Stine. Do you plan to offer
[2] any criticisms of Dr. Stine at trial?
[3] A: No.
[4] Q: And I'm to assume that you then have no
[5] criticisms of Dr. Stine?
[6] A: That's correct.
[7] MS. SCHREMP: Thank you. That's all I
[8] have for you, Doctor.
[9]
[10] EXAMINATION
[11] BY MR. AUSTRIA:
[12] Q: Dr. Essig, my name is Bob Austria. I'm
[13] here on behalf of Dr. Bailin. Can you hear me?
[14] A: Yes, sir.
[15] Q: Okay. Good. Just a few questions.
[16] First of all, did you see any indication
[17] in Mrs. McElfish's prenatal record that required
[18] the transfer of this patient's care from the
[19] certified nurse midwife to an obstetrician?
[20] A: As I understand your question, no.
[21] Q: Okay. Do you see any indication in
[22] Mrs. McElfish's medical — prenatal medical
[23] records of where she required a 24-hour urine
[24] collection?
[25] A: I did not.

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[1] Q: Okay. Doctor, did you see any indication
[2] in Mrs. McElfish's prenatal period where she
[3] required a 24-hour hospitalization?
[4] A: I thought she had one, was it — It
[5] wasn't 24 hours, I misunderstood that. No, I
[6] mean, I think that the — the admission to the
[7] hospital was proper to get further careful
[8] analysis of what she was doing in the clinic.
[9] And I really actually — As I think about
[10] it, I don't know the time on the one. I know the
[11] one on the 5th was a short one. I thought the
[12] other one was a little bit longer. But no.
[13] Q: Okay. When you say "the other one", are
[14] you referring to the August 21st, 2000 inpatient
[15] admission?
[16] A: Yes.
[17] Q: Okay. Now, with respect to Dr. Bailin's
[18] delivery of the Joshua McElfish as of 1:18, I
[19] believe, on September 17th, do you find the
[20] delivery of that — of Joshua at that time
[21] appropriate?
[22] A: On the 18th?
[23] Q: Excuse me. I believe it's on the 17th.
[24] A: The 17th. Okay. Yes.
[25] Q: Do you find any contraindication in the

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[1] medical records regarding the actual delivery of
[2] Joshua McElfish, itself, with respect to Dr.
[3] Bailin's treatment?
[4] A: Do I see any contraindication?
[5] Q: Yes, with — contained within the medical
[6] records with respect to the actual delivery by Dr.
[7] Bailin at that time?
[8] A: No, I don't, as I understand what you're
[9] asking. Did Dr. Bailin — he came after the
[10] delivery, didn't he, or toward the end? Did he
[11] make it for the C-section? I can't remember.
[12] Q: Why don't you review the medical records
[13] at 1:18, Doctor.
[14] MS. DI SILVIO: Bob, what do you want him
[15] to look at?
[16] MR. AUSTRIA: Just to confirm that Dr.
[17] Bailin was present at the actual delivery.
[18] THE WITNESS: Yes, he was, I think,
[19] right.
[20] BY MR. AUSTRIA:
[21] Q: Okay. With respect to the — And the
[22] delivery at that time was the appropriate thing to
[23] do, is that correct, Doctor?
[24] A: Yes, very much so.
[25] Q: Okay. Can you tell me the patient's —

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[1] Can you go to the 2:10? Excuse me — the 0210
[2] labs that were taken on September 17th, Doctor?
[3] A: September 17th? I have that here.
[4] Q: I'm going to ask about the hematocrit and
[5] the hemoglobin levels.
[6] A: They are kind of all bunched up here.
[7] MS. DI SILVIO: From what time, Bob?
[8] MR. AUSTRIA: 0210, September 17th.
[9] THE WITNESS: There were several labs.
[10] You don't want the differential. Here I got it, I
[11] think. That's the white count and the platelet
[12] count and so on. That what you meant,
[13] Mr. Austria?
[14] BY MR. AUSTRIA:
[15] Q: Yes. The hemoglobin and hematocrit right
[16] there.
[17] A: Yes.
[18] Q: Are those a 0210? What level do you have
[19] for the hematocrit?
[20] A: Forty.
[21] Q: Forty.one?
[22] A: Yeah.
[23] Q: And what about the hemoglobin?
[24] A: The hemoglobin was 13.9.
[25] Q: Okay. Do you know the patient's blood

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[1] loss during her C-section?
[2] A: It's listed variously as 400 to a
[3] thousand.
[4] Q: Okay. At that time after the labs are
[5] taken at 2:10 and given the patient's blood loss,
[6] is it still your opinion that blood products were
[7] needed to be given to this patient at 0230?
[8] MS. DI SILVIO: Objection. I don't think
[9] he ever said that, Bob. You may answer, Doctor,
[10] if you can.
[11] THE WITNESS: You know, you can see that
[12] this patient is really concentrated, because
[13] usually if you multiply the figure — the
[14] hemoglobin times three, it should tell you the
[15] hematocrit. And she's — she's fairly
[16] concentrated there.
[17] And then — But the vital signs are
[18] beginning to change, and all I was really
[19] indicating was that when you start to see the
[20] blood pressure dropping and the pulse staying up,
[21] you know, you need to think that that might be
[22] something you're going to have to do. I didn't
[23] say that I would actually do it then.
[24] BY MR. AUSTRIA:
[25] Q: Okay.

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[1] A: Okay.
[2] Q: Did you see any evidence of blood loss
[3] from the medical record?
[4] MS. DI SILVIO: Other than what he just
[5] talked about during the surgery?
[6] MR. AUSTRIA: Yes.
[7] THE WITNESS: No.
[8] MR. AUSTRIA: That is all I have, Doctor.
[9] Thank you.
[10] THE WITNESS: All right.
[11] MS. DI SILVIO: Anyone else?
[12] MR. BECKER: Doctor, you said that the —
[13] MS. DI SILVIO: Hold on a second, Mike.
[14] Erin, do you have any questions?
[15] MS. HESS: Dr. Essig, I have just one
[16] question for you.

[17] EXAMINATION
[18] BY MS. HESS:

[20] Q: You don't have any criticisms of the
[21] nursing staff in this case, correct?
[22] A: No.
[23] MS. DI SILVIO: Is that correct?
[24] THE WITNESS: Yes, that's correct. Yes,
[25] no, I don't have any criticism.

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[1] 2:30, and if not earlier than 2:30, during the
[2] surgery would have been a good time to put a
[3] central line in, correct?
[4] A: If you're going to, and if you thought —
[5] if the operators thought that there was going to
[6] be a continued loss, or what I should say is
[7] there's going to be a high volume replacement,
[8] that's an excellent thing to do.
[9] We do it fairly frequently for severe
[10] toxemic patients because we know that we have a
[11] harder time monitoring them. And I don't know
[12] that that's necessarily the universal thing.
[13] It's kind of tricky putting it in because
[14] you can drop the lung, for example, and some
[15] people are not very comfortable doing that.
[16] Q: But it should have been foreseeable to
[17] the care giver that she would need — she could
[18] well need a high volume replacement?
[19] A: Again, I think people have to make that
[20] judgment on the spot.
[21] Q: And that judgment should have been made
[22] by 2:30, if not sooner?
[23] MS. DI SILVIO: Objection.
[24] THE WITNESS: I would think so, yeah.
[25] MR. BECKER: That's all I have.

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[1] MS. HESS: Thank you.
[2] MS. DI SILVIO: Okay, Mike.

[3] FURTHER EXAMINATION
[4] BY MR. BECKER:

[6] Q: Doctor, you mentioned that at 2:10 the
[7] H & H tells you that you're concentrated, is that
[8] what you said?
[9] A: Yes; or she came in at 15 and got a
[10] hematocrit of 44 at 019. And the next one is —
[11] she's a little bit down, but she's still
[12] maintaining that same kind of high concentration,
[13] which is typical of patients that have toxemia.
[14] Q: Okay. And what conclusions can you draw
[15] about the high concentration?
[16] A: Well, that when she finally opens up her
[17] vascular bed, that it's going to look like she's
[18] dropped a lot.
[19] And in fact, you know, that did start to
[20] happen, and I think that's probably why she was a
[21] little hypotensive there. And then that may have
[22] been confounded by the same time she was beginning
[23] her disseminated intravascular coagulation
[24] process.
[25] Q: I think you indicated earlier that at

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[1] MS. DI SILVIO: Anyone else?

[2] FURTHER EXAMINATION
[3] BY MR. AUSTRIA:

[5] Q: All right. Doctor, this is, again, Bob
[6] Austria. Can you hear me again?
[7] A: Yes, sir.
[8] Q: Okay. Thank you.
[9] If the records reflect that Dr. Bailin
[10] contacted a Dr. Loutman, who is a nephrologist, do
[11] you find that an appropriate medical consult to
[12] make at that point?
[13] A: Did you say "appropriate"?
[14] Q: Yes.
[15] A: Okay. Yes.
[16] Q: And second: Is it fair to say that some
[17] patients who have severe preeclampsia and develop
[18] HELLP Syndrome and subsequently DIC, but no matter
[19] what you can — no matter what you do for that
[20] patient, that some of those patients will die; is
[21] that correct?
[22] A: Well, yeah, I'd have to say yes.
[23] MR. AUSTRIA: That is all I have. Thank
[24] you.
[25] MS. DI SILVIO: All right. Thank you.

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[1] We'll read it. Mike, can we have more than seven
[2] days?

[3] MR. BECKER: Yes. Thank you.

[4] MS. DI SILVIO: May we have more than
[5] seven days for Dr. Essig to read and sign?

[6] (Discussion held off the record.)

[7] (Signature not waived.)

[8]

[9] (Thereupon, the deposition was concluded
[10] at 4:55 o'clock p.m. on Tuesday, August
[11] 2, 2005.)

[12]

[13]

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[1] AFFIDAVIT

[2]

[3]

[4]

[5] STATE OF _____,)

[6]) SS:

[7] COUNTY OF _____,)

[8]

[9] Garth Essig, M.D., having been duly
[10] placed under oath, deposes and says that:

[11] I have read the transcript of my
[12] deposition taken on Tuesday, August 2, 2005 and
[13] made all necessary changes and/or corrections as
[14] noted on the attached correction sheet, if any.

[15]

[16]

[17]

[18] Garth Essig, M.D.

[19] Placed under oath before me and
subscribed in my presence this _____ day of

[20] _____, 20____.

[21]

[22]

[23] Notary Public

[24] My Commission Expires:

[25]

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