In The Matter Of:

Karl McElfish II v.
Meridia Medical Group

Garth Essig, M.D.
August 2, 2005

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Original File 080205DE.TXT, 58 Pages
Min-U-Script® File ID: 1295249771

Word Index included with this Min-U-Script®

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

Karl McElfish II,)
Individually and as)
Administrator of the)
Estate of Sherry)
McElfish,)
Plaintiff,)
vs.) Case No. CV 04-537289
Meridia Medical Group,)
L.L.C., et al.,)
Defendants.)

Deposition of Garth Essig, M.D., a witness herein, called by the Plaintiff for examination under the statute, taken before me, Valerie J. Grubaugh, Registered Professional Reporter, Certified Realtime Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel hereinafter set forth, at the offices of the Deponent, The Ohio State University, 545 Means Hall, 1654 Upham Drive, Columbus, Ohio, on Tuesday, August 2, 2005, beginning at 3:30 o'clock p.m. and concluding on the same day.

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STIPULATIONS

It is stipulated by and among counsel for the respective parties herein that the deposition of Garth Essig, M.D., a witness herein, called by the Plaintiff for examination under the statute, may be taken at this time and reduced to writing in stenotype by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualification of the Notary is waived; that the witness may sign the transcript of his deposition before a Notary other than the Notary taking his deposition; said deposition to have the same force and effect as though the witness had signed the transcript of his deposition before the Notary taking it.

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EXHIBITS MARKED
None

GARTH ESSIG, M.D.
of lawful age, being by me first duly placed under oath, as prescribed by law, was examined and testified as follows:

EXAMINATION BY MR. BECKER:

Q: Doctor, if you could just move a hair closer to the speaker phone, I would appreciate it.

State your name, please.

A: My full name is Garth, middle name Frederick, last name Essig, E-s-s-i-g.

Q: And what is your current position at Ohio State?

A: I am an Associate Professor of Obstetrics and Gynecology, and I'm the — the OSU Student Medical Student Clerkship Director for Obstetrics and Gynecology.

Q: In addition to that, do you have a private practice?

A: Yes.

Q: And would you describe your current private practice?

A: It's a general OB/GYN practice that is with both obstetrics and gynecology. And I cover the resident practice on a periodic — we have a regular rotation, so we cover — tonight I'll be on for — all the GYN that comes through the emergency room will be my patients tonight.

Q: I know you know the ground rules, but just for the record, as you know, this is a question and answer session under oath. It's important that you understand the question that I pose.

If at any time the question that I ask is inartfully phrased or doesn't make sense, I would ask you to stop me and tell me so, and I'd be please to attempt to rephrase or restate the question. Fair enough?

A: Okay. Fair enough.

Q: However, Doctor, unless you indicate otherwise to me, I'm going to assume that you fully understood the question that has been posed, and you were giving me your best and most complete answer today. Fair enough?

A: Good.

Q: Do you have your complete file with you today?

A: Yes.

Q: Okay. Would you tell me and identify for the record everything that has been sent to you that's within your file?

A: Okay. Actually when we moved, I left some of the things in the other room, but I have the complete medical record for Ms. McElfish.

Not necessarily in order here, I have depositions of Dr. Stockwell, I have depositions of Bic — let me just use the last name — Dr. Redline, Pamela Kelly, William Rayburn, and William Floyd.

And I have other — some of the other depositions of the woman — the nurse practitioner was Hughes, I think is her name. Just trying to go by memory.

I have all the reports that the various experts have rendered. I think that's about — I think that's about it.

Q: Okay. Do you have the midwife's depositions as well?

A: I do.

Q: As a result, Doctor, of your review, did you generate any notes?

A: No, I didn't. I generated the report that I sent to Reminger & Reminger in Cleveland.

Q: But no notes? No handwritten notes?

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A: No.
Q: And are all the opinions that you're going to render in this case spelled out in that report?
A: I believe so. It's a pretty small report. And I was really asked specifically to comment on the care of the midwives, and Dr. Karasik.
Q: You were asked to comment on the care of the midwives and Karasik, and not Dr. Bailin?
A: Correct.
Q: And were you asked to focus your analysis or evaluation based on the events that occurred during labor and delivery?
A: And the prenatal care.
Q: In the last paragraph of your report dated November 15th, 2004, it says that it's your opinion that the labor and delivery team met the standard of care, correct?
A: Yes.
Q: I don't see any reference in this report relative to prenatal care. So are you now going to be rendering an opinion that the prenatal care met the standard of care as well?
A: Yes, sir, I will.

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Q: And that's the prenatal care by the midwives as well as Dr. Karasik?
A: Yes.
Q: Or "Karasik".
MS. DI SILVIO: Actually, Mike, the whole second paragraph and third paragraph of his report address the prenatal care, so I'm not clear on your question, but that being said, I'll let the Doctor answer.
MR. BECKER: Right. And I guess I didn't see a conclusion about standard of care as to the prenatal period.
MS. DI SILVIO: I think the words "appropriate" are used repeatedly in those second and third paragraphs, but I will let the Doctor answer whatever question you put to him.
MR. BECKER: Okay.
THE WITNESS: Yes, I felt that the prenatal care that was rendered by the nurse midwives and Dr. Karasik was appropriate, and met the standard of care.

BY MR. BECKER:

Q: All right. Let me first talk about the midwives. Do you regularly deal with midwives?
A: You know, I haven't because — we have a few here, we had a midwife school for a while, and I was not — I didn't work with them simply because it was going to cost me more money on my malpractice insurance, and we already had faculty that were dedicated to doing that. So I really have not had that much contact with nurse midwives.

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Q: So since you don't directly work with them, the first question I have is how are you familiar with standard of care if you don't regularly work with them?
A: That's a good question. But I think that as — as — their care of the patient, as I rendered — as you saw the report — or as I saw the prenatal care flowing, I thought that that was appropriate for whomever did it, whether it was a physician or a nurse midwife, or resident care.
Q: All right. Are you saying that you applied the — what you considered obstetrical standard of care to the midwife?
A: Yes.
Q: All right. And you're not commenting on whether Dr. Bailin met the standard of care?
A: No, I wasn't asked to.
Q: Okay. And what is your understanding as to when a midwife — if you have one, as to when a midwife should refer a patient directly to an obstetrician for case management?
A: Well, I think any time that there's a change in the vital signs or any change in the chemistry — or the labs such as — I'm trying to say vital signs that — that are concerning, and I think most midwives work knowing what their role is, and if anything, I think they are anxious to communicate with their physician counterparts.
And again, I don't have a huge experience to comment on that, but I think that — I think they are very careful about not doing things that they can't do. I think they are very aware of their limitations in the care of the patient.
Q: You're assuming in this case that the midwives are very careful in their limitations?
A: Yes.
Q: What is your understanding as to what role Dr. Karasik had in this case?
A: Well, there's really only one time that I saw his name mentioned in the chart, and that was the brief hospital stay of August 21st, 2000. I'm sorry, I got the wrong one. It was the brief stay of the 5th of September, 2000.

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Q: And what was his responsibility?
A: He was consulted before the patient was sent to the hospital for further evaluation.
Q: And what is your understanding as to what Dr. Karasik was told?
A: The —
MS. DI SILVIO: Give him a minute, Mike, to get to his record.
BY MR. BECKER:
Q: If you need time to look at records, let me know.
A: Yeah, okay. I'm just trying to get to the prenatal records here. Since we grabbed everything and ran over here, it was — yeah, on the 5th of September — I'm trying to read exactly where — Okay. Got it here.
She was — The nurse midwife consulted because of swelling; blood pressure was elevated. She was — had swelling in her hands and was sent to be evaluated.
And I can't — I think she had a nonstress test during that time, or just before, and Dr. Karasik was advised.
Her cervix was closed. I can barely read the notation, but — so I think that it was just

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the continuing concern about the patient's edema, and I think that this nonstress test had been previously set up, ultrasound and nonstress test had been previously set up for that time.
Q: Do you know whether or not Sherry McElfish had been preliminarily diagnosed by anyone prior thereto with toxemia?
A: I don't recall that there is anything in the chart that indicates that. I know they had some concerns about her blood pressure elevation.
Q: If someone — If one of the midwives had diagnosed toxemia prior to that day, should that information have been relayed to Dr. Karasik?
A: Yes, absolutely.
Q: If Dr. — Hypothetically, Doctor, if Dr. Karasik had been told this patient had been previously diagnosed with toxemia, what should Dr. Karasik have done?
A: I think sort of what was done here in terms of the labs that were done when she arrived there.
They did — For example, they did a complete blood count that included a normal platelet count and her hemoglobin/hematocrit were within normal limits.

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The urinalysis that she had done then was — I'm trying to look at the other things. Uric acid was normal. Her enzymes were normal. So all of that was done.
So I think there was — I mean, you wouldn't do that unless you thought there was a concern about toxemia pregnancy.
I'm trying to find the urinalysis here. Here it is. But anyhow, there was no protein in the urine data, either.
So I think that even though you were concerned about that from the office, it appears that the clean voided urinalysis that was done didn't find any protein in it, so it's a pretty hard argument to make for a diagnosis of toxemia without there being some proteinuria present.
Q: When you say "a clean void urinalysis", what do you mean and what conclusions can you draw from that?
A: They simply — this patient had a body mass index of 42, which is — which is in the range of morbid obesity. And even for a normal person to get a urine specimen with a cup is quite a gymnastic event.
And so they usually cleanse the labia

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with a sponge and then collect the specimen. The patient can still do that herself, but they are just more careful in collecting the specimen.
And I don't know, they probably don't use the dip stick, which introduces another possible error, and I think they use a more direct method. I could be wrong.
At least in our hospital when they do the urinalysis, they use a chemical method for determining the proteinuria. It's the same method they use for doing 24-hour urines when they are finding the actual amount of protein in the urine over the specimen time.
Q: Well, are you equating a 24-hour with a urinalysis?
A: No. I'm saying it's the same chemical method that they do, rather than a dip stick. In the clinic we always use just the dip stick just because it's convenient and it's relatively predictive, particularly in values that are over two-plus.
Q: You're saying the urinalysis is relatively predictive?
A: No, the — If you're doing dip sticks in the clinic, that the dip stick is predictive, but

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

Q: All right. But let's go back to the fact that you said there was a clean void urinalysis. My question is: What is the significance of that as to whether or not there is truly — she was ever spilling protein.

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

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

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

A: Right.

Q: Why not?

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

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negative protein in the urinalysis.

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

Q: Okay. Well, explain to me that conclusion.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q: Did you conclude that this mom was a chronic hypertensive?

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

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

But I think that, you know, you have to

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

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

A: Sure.

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

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

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

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overt?

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

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

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

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

(Pause.)

(Mr. Becker was disconnected.)

MS. BECKER: Ms. Court Reporter, do you have my last question?

(Question read back as requested.)

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BY MR. BECKER:
Q: And, Doctor, if you could just give your answer again, then I'll just flow from there.
MS. DI SILVIO: Objection. Asked and answered again.
THE WITNESS: Not necessarily, because the — the progress of preeclampsia in a patient is so unpredictable, and I wouldn't say that in my experience I've seen it be any less occult than if it had just occurred de novo.
BY MR. BECKER:
Q: Well, if someone is a chronic hypertensive, should they be monitored more closely for preeclampsia than a woman that's not a chronic hypertensive?
A: Exactly. And I think that you're doing that when you're doing the nonstress testing more frequently, or the biophysical called the BPP, and the drawing of the PIH labs would be — would be looking for that. And rechecking the urine when the patient comes in for — to make sure there's no increase in proteinuria.
Q: And you said that at some point these women require blood pressures taken at least twice a week?

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A: Yes.
Q: Okay. And when is that indicated?
A: Well, you know, I don't think anybody really could tell you, but I think if they are thinking — if you're seeing any elevated pressures, you probably ought to start doing that.
And at first when you're far from term, you're probably not going to do anything, you know, as far as the baby is concerned, because you don't want to get a preterm birth out of it.
But if the pressure is very high, then, you know, you just need to see that patient more frequently.
And I'd be hard put to tell you an exact date, but I would think that certainly by — by 32 weeks you would want to follow that patient a little more closely, because at this point you can have some impact on the baby in case the baby's growth stops.
Q: Do you agree that Sherry McElfish developed one of the most severe forms of preeclampsia by September 16th?
A: By September 16th?
Q: Yes.
A: Yes, when she came to the hospital she

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was quite ill.
Q: Okay. And she had HELLP Syndrome likely at that point?
A: I think that she certainly had the elevated liver enzymes. But on admission her platelets weren't below the level that we would be concerned, and she didn't have any other evidence of hemolysis.
By that I mean her bilirubin was normal, but her enzymes were really sky high at that point.
Q: So how would you classify her on admission?
A: On the basis of that, you know, you think it's coming. I mean, this is — you hear the thunder.
Q: You think HELLP is coming?
A: Yeah, something bad is coming. So that's why you do these things.
And she was also — I mean, the first things quoted in the chart that she was saying is, "I can't breathe".
At that point, you know, I would be concerned that she may be having some symptoms of congestive heart failure. And if you just look at

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this kind of coming out, you know, one ten-minute peel at a time, the baby is going to be compromised by that decreased cardiac output, if that's what's happening to her.
I mean, that's the part that doesn't make any sense, was she was having all these other things, she had huge blood pressure, and she had — you know, in spite of the fact that she was feeling hot, she was clammy, and you worry that this is somebody who is headed for shock for some reason, because that's classic symptoms of somebody who is in shock.
They complain of air hunger, can't breathe, their skin gets kind of clammy as they begin to shut down, and she obviously was having a lot of vasoconstrictive problems, which is what you see in the end stage of, you know, for the more severe forms of preeclampsia.
Q: It should have been clear to the care givers at the time of admission that this mom is about to go into shock?
A: Well, you know, you worry about it. And you worry — but, you know, usually mothers survive.
And our first concern is the pregnancy,

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and because, you know, we all have found that if we deliver the patient, then we cure the disease, too.

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

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

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

Q: Why was it important to have blood immediately available?

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

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

Q: So when is blood — administration of blood indicated?

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

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

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

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

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available, especially somebody you don't know well.

Q: Right. But when is administration of blood indicated?

MS. DI SILVIO: Objection. If you know that.

BY MR. BECKER:

Q: Do you defer that to a consultant?

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

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

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

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

Q: Right. Let's go back to my question, though.

When would blood — administration of blood be indicated for a mom with HELLP Syndrome?

MS. DI SILVIO: Objection. You may answer if you can.

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

BY MR. BECKER:

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

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

So in the absence of platelet transfusion you would give whole blood, hoping there would be some live platelets in there that would help you out.

But mostly you want to get the pregnancy

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

Q: All right. Well, what happened to this mom by 2:30 a.m.?

A: Let me get to my flow sheets here. She delivered at 1:18 and so they were — they were out of the operating room by about 2:18, I think. Let me see if I can find the anesthesia record here.

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

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

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

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MS. DI SILVIO: Is there anything in particular you want him to look at, Mike, to speed this along?

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

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

THE WITNESS: I'm sorry, you asked, Mike, at what time?

BY MR. BECKER:

Q: I think around 2:30 she became hypotensive?

A: Yes.

Q: Okay. And was a consultation indicated and warranted at that time?

MS. DI SILVIO: Objection.

BY MR. BECKER:

Q: Let me ask you this: Did you look at this case from at the postpartum event?

A: Well, I couldn't stop reading it. I just kept reading because it was such a mystifying case.

I would assume that anesthesia would still be — would still be helping at that point. I may be wrong, but if you needed more help, that would be the time to see.

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

Q: And is that when you would be administering blood, or would you put a central line in first?

MS. DI SILVIO: Objection. Beyond the scope.

MR. AUSTRIA: Objection.

MS. SCHREMP: Objection.

MS. DI SILVIO: Objection. Beyond the scope of his opinions. You may answer if you can.

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

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

And it's been a real problem for patients

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

BY MR. BECKER:

Q: Did you happen to read the discovery deposition of the anesthesiologist?

A: No, I didn't see that, Mike.

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

MR. AUSTRIA: Objection.

MS. SCHREMP: Objection.

MS. DI SILVIO: Objection.

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

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

BY MR. BECKER:

Q: I don't think she had an opportunity, to be fair to her, to review the chart prior to induction.

A: Yeah, sometimes that happens, when everything happens at once.

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

MS. DI SILVIO: Objection, beyond the scope of Dr. Essig's opinion. You may answer if you have an opinion.

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

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

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

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

BY MR. BECKER:

Q: Why would you be thinking — Should one be thinking that there was likely a volume loss at that point?

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

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

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

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on them, it's not a bad idea to give blood. Not — In fact, it's probably an indicated thing to do.

Q: All right. Let's back up, Doctor, prenatally for a moment.

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

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

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

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

MS. DI SILVIO: Objection. Asked and

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answered. You may answer it again.

THE WITNESS: Usually we would do that if the mother was having other symptoms associated with that, or if the labs are borderline so that we could repeat the labs, you know, about 12 hours.

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

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

BY MR. BECKER:

Q: All right. But you indicated that if the mom has other symptoms, then you would keep the mom in the hospital. What other symptoms would —

MS. DI SILVIO: Well, objection. That's a mischaracterization of his testimony. I think what he just told you was if the labs are normal.

MR. BECKER: Please don't testify for him.

MS. DI SILVIO: I'm not, but I'm not

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going to let you mischaracterize what he said for your case.

BY MR. BECKER:

Q: Here is my question again: I thought you had just indicated that relative to the topic of when you put moms in the hospital for more than a few hours, you indicated if they come in with other symptoms associated with preeclampsia. My question is: What other symptoms are you referring to?

MS. DI SILVIO: Objection. Mischaracterization of testimony. What he said was if the labs were normal in the first go-round, you wouldn't keep them any longer than you have to. With that objection I'll let him answer.

THE WITNESS: If you're asking what other symptoms might be present, I think if the patient has persistent headache, if they are having visual disturbance, you might watch this patient a little bit more closely.

Or if the baby on the — the fetus evaluation was growth restricted, in other words, if the baby is falling off the growth curve, that's a patient you're having different indications for. Her toxemia is okay, but the

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baby's not.

So I think those are other reasons you would keep the mother in the hospital longer.

BY MR. BECKER:

Q: All right. So if the mom, hypothetically — Doctor, I want to make sure I have this straight — hypothetically, had persistent headaches and — or was seeing stars, and even though her labs might be normal or near normal, you would keep her in and watch her at least 24 hours?

MS. DI SILVIO: Objection.

THE WITNESS: Yeah, I'd probably watch her long enough so I was comfortable sending her home. Even though things are normal, there may be other things out there that you're kind of watching for.

BY MR. BECKER:

Q: All right. Do you have an opinion as to when — Let's work on some definitions here.

And I have the term toxemia. Is toxemia the same thing as preeclampsia?

A: Yes.

Q: Okay. Do you have an opinion as to when Sherry first developed preeclampsia, if you have

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an opinion?

A: Yeah, I would — I think that — I think she was definitely hypertensive from time to time, and — but I think the unquestionable time that everything would agree on is when she was admitted to the hospital on that 16th, evening of the 16th. There's no question about that.

Up to that point, I think you have a difficult time because usually toxemia is not intermittent, you either have it or you don't have it, and it's progressive.

So I think that this is confusing because she did have pressure elevations and she, from time to time, did have some proteinuria, but none of that really rose to the level that I would think you'd make the diagnosis of preeclampsia.

Q: Now, have you ever had — in your 30-year plus career, ever had a mom develop HELLP Syndrome?

A: Yes.

Q: Could you give me an idea how many times that's happened to you, your patients, or patients you were responsible for?

A: You know, I would — it would be a guess, but I can think of, off the top of my head, maybe

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four; maybe three or four.

I've helped the residents with a lot more of those numbers, because it's one of those diseases that you don't see in your private practice very often. You certainly can, but my patients are usually in pretty good shape and they get, you know, consistent medical advice from me.

So I mean, I think Zuspan and others have said that the best way to prevent this illness is to have really tight compliance with your patient population and so on.

And this patient did comply; I didn't mean to imply that. But so I think that's why I don't see that much in my own practice. But it's been a surprise when I've seen it.

You can see it coming — or I think it's coming and I've probably prepared for it a lot more than I've seen it, obviously, because you don't want it to get there. So it's a scary thing when it happens, and it just sometimes happens like a summer storm.

Q: You said Justin and others —

A: Zuspan.

Q: Who?

A: Fred Zuspan.

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

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Q: And how long have you known David Stockwell?
A: I hate to tell you this, but I think he was one of my students at one time.
Q: Long time?
A: Long time.
Q: Okay. Is he well respected in the community?
A: David is very well — he's a very good person, too.
Q: Have we covered all the opinions you're going to give at trial?
A: I believe so, sir.
Q: And as to any causation opinions as to the timing of the — had there been an earlier Cesarean section, do you have an opinion as to whether or not the outcome would have been different?
A: I think if we had a crystal ball and you'd have known that earlier, you might have avoided that.
But, you know, as you look at it, without looking too far ahead, just look at it as it reels off on the calendar, I don't think there's a single place in there would I have advised

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delivery on this patient.
MR. BECKER: One moment. Let me just go over my notes.
(Pause.)

BY MR. BECKER:

Q: Doctor, is there anything you can refer me to, any authority, any textbooks or journal articles that stands for the proposition that if a urinalysis is — is clean, that one need not consider a 24-hour urine?
A: I'm sticking my neck out a little bit, but I think that the — that the Technical Bulletin, and I wish I could tell you which one that — they revised it a couple years ago on management of — I believe it's called Management of Pregnancy Induced Hypertension. I think they address there the — when you should get a 24-hour urine.
MR. BECKER: That's all the questions I have, Doctor.
MS. DI SILVIO: Anyone else?

EXAMINATION
BY MS. SCHREMP:

Q: Doctor, this is Pam Schremp and I

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represent Dr. Lucy Stine. Do you plan to offer any criticisms of Dr. Stine at trial?
A: No.
Q: And I'm to assume that you then have no criticisms of Dr. Stine?
A: That's correct.
MS. SCHREMP: Thank you. That's all I have for you, Doctor.

EXAMINATION
BY MR. AUSTRIA:

Q: Dr. Essig, my name is Bob Austria. I'm here on behalf of Dr. Bailin. Can you hear me?
A: Yes, sir.
Q: Okay. Good. Just a few questions. First of all, did you see any indication in Mrs. McElfish's prenatal record that required the transfer of this patient's care from the certified nurse midwife to an obstetrician?
A: As I understand your question, no.
Q: Okay. Do you see any indication in Mrs. McElfish's medical — prenatal medical records of where she required a 24-hour urine collection?
A: I did not.

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

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

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

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

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A: Okay.
Q: Did you see any evidence of blood loss from the medical record?
MS. DI SILVIO: Other than what he just talked about during the surgery?
MR. AUSTRIA: Yes.
THE WITNESS: No.
MR. AUSTRIA: That is all I have, Doctor. Thank you.
THE WITNESS: All right.
MS. DI SILVIO: Anyone else?
MR. BECKER: Doctor, you said that the —
MS. DI SILVIO: Hold on a second, Mike. Erin, do you have any questions?
MS. HESS: Dr. Essig, I have just one question for you.

EXAMINATION
BY MS. HESS:

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

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MS. HESS: Thank you.
MS. DI SILVIO: Okay, Mike.

FURTHER EXAMINATION
BY MR. BECKER:

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

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

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MS. DI SILVIO: Anyone else?

FURTHER EXAMINATION
BY MR. AUSTRIA:

Q: All right. Doctor, this is, again, Bob Austria. Can you hear me again?
A: Yes, sir.
Q: Okay. Thank you. If the records reflect that Dr. Bailin contacted a Dr. Loutman, who is a nephrologist, do you find that an appropriate medical consult to make at that point?
A: Did you say "appropriate"?
Q: Yes.
A: Okay. Yes.
Q: And second: Is it fair to say that some patients who have severe preeclampsia and develop HELLP Syndrome and subsequently DIC, but no matter what you can — no matter what you do for that patient, that some of those patients will die; is that correct?
A: Well, yeah, I'd have to say yes.
MR. AUSTRIA: That is all I have. Thank you.
MS. DI SILVIO: All right. Thank you.

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We'll read it. Mike, can we have more than seven days?
MR. BECKER: Yes. Thank you.
MS. DI SILVIO: May we have more than seven days for Dr. Essig to read and sign?
(Discussion held off the record.)
(Signature not waived.)

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

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AFFIDAVIT

STATE OF _____,)
) SS:
COUNTY OF _____,)

Garth Essig, M.D., having been duly placed under oath, deposes and says that:
I have read the transcript of my deposition taken on Tuesday, August 2, 2005 and made all necessary changes and/or corrections as noted on the attached correction sheet, if any.

Garth Essig, M.D.
Placed under oath before me and subscribed in my presence this _____ day of _____, 20___.

Notary Public
My Commission Expires:

Lawyer's Notes

D

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Lawyer's Notes