IN THE COURT OF COMMON PLEAS

OF SUMMIT COUNTY, OHIO

MACKENZIE L. TARLE, a minor, etc., et al.,

Plaintiffs,

vs. Case No.

AKRON GENERAL MEDICAL CENTER, et al., CV 2001 05 2137

Defendants.

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Deposition of EDWARD FERRIS, M.D., called for examination under the statute, taken before me, Denise M. Munguia, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Hanna, Campbell & Powell, 3737 Embassy Parkway, Akron, Ohio, on Wednesday, January 9, 2002, at 10:23 o'clock a.m.

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APPEARANCES:

On behalf of the Plaintiffs:

Finelli & Margolis, by

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On behalf of the Defendant

Akron General Medical Center:

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RICHARD R. STRONG, ESQ.

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APPEARANCES, Continued:

On behalf of the Defendant
Edward Ferris, M.D.:

Hanna, Campbell & Powell, by
JEFFREY E. SCHOBERT, ESQ.
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EDWARD FERRIS, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF EDWARD FERRIS, M.D.

BY MR. FINELLI:

Q. Good morning, Doctor.

A. Hi.

Q. My name is Dan Finelli, the gentleman sitting to my left is Ron Margolis, my partner, and together we represent the Tarles in an action which have claimed you as a defendant. 10:23:19

Have you ever had your deposition taken before? 10:23:30

A. Yes.

Q. When was that?

MR. SCHOBERT: Note a continuing objection. 10:23:34

A. Once when, once when I was a resident in a case that got dismissed and once recently in a case that was a house case patient at the hospital that I was the attending on for the day. 10:23:56

Q. Is it fair to say it was like a clinic patient? 10:23:58

A. Clinic patient, yes. Yes.

Q. The one when you were a resident, were you named as a defendant? 10:24:05

A. I was, but then I was subsequently dropped.

Q. And the one where you were the attending physician, what was the disposition of that case? 10:24:2

A. The house case?

Q. Yeah, were you named as a defendant in that case?

A. I was. There's been no disposition yet. 10:24:2

Q. That's ongoing?

A. Correct.

Q. Can you tell me what the alleged facts are in that case?

A. It was a infant house case patient that delivered vaginally and then after that had some problems, was transferred to Children's Hospital. 10:24:3

Q. The infant? The infant had problems? 10:24:5

A. Right. 10:24:53

Q. Do you know who the plaintiff attorney is in that case?

A. Perantinides, I think his name is.

Q. Perantinides? 10:25:05

A. Yes.

Q. Mr. Perantinides?

A. Yes.

Q. Who was representing, who is your local -- who is your counsel? 10:25:12

A. (Indicating.)

Q. Mr. Schobert?

A. Yes.

Q. That's filed in Akron?

A. I believe so, yes. 10:25:17

Q. Other than those two that we just talked about, are there any other claims against you which name you as a defendant for substandard medical care, alleging substandard medical care? 10:25:29

A. Not that I'm aware of, no.

Q. Just a few ground rules, and you probably know them already. Your answers need to be verbal responses so the court reporter can take down those responses. At any time if 10:25:38

you don't understand my question or I need to clarify it, please stop me, I'll repeat it or rephrase it so that when you answer it, you're answering it understanding the question entirely. 10:25:41 10:25:51

A. Okay.

Q. Fair enough?

A. Yes.

Q. Okay. I have just been handed your CV. Let me go through that quickly. 10:25:5

You completed your residency in 1997?

A. Right.

Q. At Akron City Hospital?

A. Correct. 10:26:0

Q. And OB-GYN residency is a four-year residency?

A. Correct.

Q. And just tell me what you did after your residency, following your residency completion. 10:26:1

A. I joined the Summit OB/GYN Associates here in town.

Q. And you have been with them?

A. I have been with them ever since. 10:26:2

Q. Are you a partner of that group -- 10:26:31
A. Yes.
Q. -- or an associate?
A. Partner.
Q. And when did you become partner? 10:26:35
A. The year after I joined.
Q. That would have been July of 98?
A. Yes.
Q. How many obstetrician gynecologists are in the group, how many physicians? 10:26:49
A. Currently four.
Q. How about in 1998?
A. 1998 there was also four.
Q. And what hospital privileges do you have? 10:27:04
A. Akron City Hospital, Akron General Hospital.
Q. And do you also do gynecology work?
A. Yes.
Q. Divide for me your professional time between obstetrics and gynecology. 10:27:13
A. As far as a percentage you mean?
Q. Yes, how much is OB, how much is GYN?
A. It's hard to say. Maybe 60/40 OB 10:27:24

and GYN, something like that. 10:27:29

Q. How much GYN surgery do you do?

A. Do you want number of cases?

Q. Twenty percent of your GYN is surgery? How much of GYN is surgery? 10:27:43

A. I don't know, that's a difficult question to answer. I don't know if I have that number off the top of my head. I do a fair amount of surgery. I do surgery every week, put it that way. 10:27:56

Q. Fair enough. Tell me about your rotation, as far as your on-call schedule between the physicians in Summit OB/GYN Associates.

A. We split call equally. 10:28:07

Q. How often are you on call? Every fourth night?

A. Every fourth weekend and usually at least one weeknight a week.

Q. So one week during the month, then every fourth weekend? 10:28:26

A. One weekend a month, every fourth weekend, and then it would probably average out to be one weeknight a week Monday through Thursday. 10:28:34

Q. So that every night 24/7 there's one of you from Summit OB/GYN on call? 10:28:34

A. Correct.

Q. And you take on-call from home?

A. Right. 10:28:45

Q. Is that the schedule of on-call as it pertained to 1998 as well?

A. Yes.

Q. How far do you live from Akron General Hospital? 10:29:00

A. Akron General.

MR. SCHOBERT: You mean in terms of miles, time to drive or --

A. You mean miles?

Q. Time to drive. 10:29:08

A. On a good day, probably get there about, within about twenty minutes.

Q. Approximately how many miles?

A. I guess at that time it would be probably 12 to 14 miles, I would guess. I really don't know for sure. 10:29:22

Q. You live in Hudson at the present time?

A. Currently I do, yes.

Q. Were you living there in 1998? 10:29:30

A. No. 10:29:32

Q. Where were you living?

A. Cuyahoga Falls.

Q. Cuyahoga Falls. Okay.

Incidentally, during your residency, from 93 to 10:29:36
97, was Dr. Drake a resident in the OB-GYN program?

A. When I was a resident? No.

Q. Was Dr. McKelvey?

A. We may have overlapped slightly, 10:29:50
but I don't recall when she actually started, to be honest with you.

Q. Okay. The OB-GYN residency, does that include an internship year or is that straight four years OB-GYN? 10:30:06

A. The internship is part of the four years.

Q. So your first year you are doing kind of a transitional year?

A. You spend about six months within 10:30:16
the OB department and six months outside, approximately.

Q. So that if you are in your second year of residency, if you just started your second year of residency, basically you have 10:30:29

only had six months of OB-GYN residency or training? 10:30:31

A. Right. That would be fair to say. It depends on the program. Now, I'm talking about my residency. I don't know if all programs are like that. 10:30:43

Q. Your residency was Akron City Hospital. Did you rotate that residency through Akron General as well? Or do they have their own separate residency? 10:30:57

A. They have their own separate residency.

MR. SCHOBERT: Ron, I have an extra one.

MR. MARGOLIS: Thanks. 10:31:09

Q. Are you board certified?

A. Yes.

Q. When did you take the boards?

A. November of 99, I think it was.

Q. And that was oral boards? 10:31:20

A. Correct.

Q. Are there written boards as well?

A. Yes.

Q. And you passed that as well?

A. Correct. 10:31:25

Q. And then you did a fellowship? Or is that a fellowship as part of the academy? 10:31:26

A. I'm not sure what you're referring to.

Q. You have here under certificates fellowship FACOG 8-1? 10:31:36

A. Oh, that, just once you pass your oral boards --

Q. You can apply for fellowship?

A. -- you apply for a fellowship within the college. It's not, you know, nationally, it's not like an extra training, it's you become a fellow of the American College of OB-GYN. 10:31:45

Q. Have you done any publications in the field of OB-GYN? 10:31:58

A. No.

Q. Your boards are oral and written boards. Did you pass those the first time?

A. Yes. 10:32:19

Q. Summit Health Systems, or no, excuse me, Summit OB/GYN Associates in 1998, do you know who their medical carrier was, as far as malpractice insurance?

A. I would be guessing. 10:32:38

MR. SCHOBERT: I can supply you that information. 10:32:40

MR. MARGOLIS: Can we go off the record a minute?

MR. SCHOBERT: Yes. 10:32:46

(Discussion had off the record.)

Q. Doc, you know, I just have to go through this ine of questioning routinely. Have you ever been convicted of a state or federal offense? 10:33:51

A. No.

Q. Has your hospital privileges ever been diminished, revoked or suspended?

A. No.

Q. Your state medical license ever been revoked, suspended or diminished? 10:33:56

A. No.

Q. How many offices does Summit OB/GYN Associates have?

A. Currently we have three. In 98 I'm not sure if that was true. We had at least two at that time. 10:34:18

Q. In 98 Summit OB/GYN Associates would have been working out of Akron City and Akron General? 10:34:29

A. Correct.

Q. What materials have you brought with you today for purposes of the deposition?

A. Just a copy of the record, medical records. 10:34:41

Q. You have the records from Akron General Hospital?

A. Right.

Q. And your office records as well?

A. Right. 10:34:47

Q. Those records also contain the fetal monitor strips?

A. Yes.

Q. Have you reviewed anything for purposes of the deposition today? 10:34:53

A. No.

Q. Have you, other than your attorney, have you discussed this case with anyone else? Other than your attorney. Since it's been filed. 10:35:07

A. Yes.

Q. Who have you discussed it with?

A. Well, this case was filed and then refiled, so after the original file, I remember talking to Dr. Drake about it. 10:35:19

Q. And what was the contents of that conversation? 10:35:23

A. We just discussed the events of that night and I guess we basically came to the conclusion we were surprised by the outcome based on the way the events had unfolded. 10:35:42

Q. And when you say outcome, meaning the outcome of the trial?

A. Right.

Q. Why were you surprised? 10:35:51

A. Because we both felt that the fetal heart rate tracings looked very reassuring up until the very end of the -- just before she had the C section.

Q. Anyone else you discussed it with? 10:36:09

A. Not that I recall.

Q. Who initiated the conversation, you or Dr. Drake?

A. I don't recall that.

Q. Do you know where the conversation was held? 10:36:23

A. At the hospital.

Q. Were you in person or did you do it over the phone?

A. In person. 10:36:31

Q. Do you know exactly what point in time you had this discussion? 10:36:32

A. Be more specific.

Q. What year, what month?

A. It's been a while, so I don't recall exactly. 10:36:42

Q. Okay. Fair enough.

Have you reviewed any literature or publications or articles pertaining to the issues in this case since the case has been filed? 10:36:58

A. No.

Q. If you were going to refer to any type of OB-GYN text relative to issues in this case, what type of text would you refer to? 10:37:15

MR. SCHOBERT: Objection. Go ahead, you can answer.

A. I'm not sure I know what you mean.

Q. If you wanted to review a OB-GYN text or publications pertaining to issues in this case, or you wanted to direct a resident to issues that pertained to this case to a text, to a publications, what would you refer to? 10:37:28

A. I'm not sure that there would be 10:37:42

one source that I would go to. 10:37:44

Q. Okay. Let me take the dive this way: What text do you refer to professionally as far as your work in OB-GYN?

A. It really would depend on what I needed to look up. 10:37:54

Q. How about labor and delivery issues?

A. I don't know that, I honestly don't think there is one text that I would refer to for labor and delivery issues. Most of what we do later on in delivery is based on experience and training and not something that you would necessarily take out of a textbook. 10:38:03

Q. If you wanted -- if a resident came and asked you, you know, I want to research or look up something regarding stations during the period of labor, is there any one particular text or any text you would refer him to? 10:38:15

MR. SCHOBERT: Objection. Go ahead. 10:38:43

A. I don't think there's one particular text, but there are several good obstetrical textbooks. Gaby has a good textbook, Williams has a good textbook, and 10:38:49

then there are others, so I don't know that I would tell him to go look at one specific textbook, I think they all have their good and bad points. 10:39:00

Q. Do you know if the admission of Mrs. Tarle on October 3rd, 98 was subject to a peer review by Akron General Hospital? 10:39:09

A. Not that I know of.

Q. Did you review any depositions that have already been taken in this case? 10:39:29

A. I have not.

Q. Do you recall treating Mrs. Tarle, Michele Tarle --

A. Yes.

Q. -- in 1998? 10:39:38

A. Yes.

Q. Do you have independent recollection?

A. I think you'd have to be more specific on exactly what you want me to recall. 10:39:45

Q. Okay.

MR. MARGOLIS: Can you speak up just a little bit, please?

THE WITNESS: I'm sorry.

MR. SCHOBERT: It's very loud in 10:39:53

here. 10:39:54

MR. MARGOLIS: He's soft spoken and I'm hard of hearing.

MR. SCHOBERT: It's this system constantly moving the air. You can go ahead. 10:39:59

Q. I want to know if you have any recollection of Mrs. Tarle during her prenatal and labor and delivery, whether it's from reviewing the records or do you have independent recollection without reviewing the 10:40:10 records? Do you remember treating her?

A. Prenatally, I don't recall. I think I met her once, and I don't recall that visit at all. Once she was in labor, I have some recollections, vague recollections. If 10:40:22 you want specifics, I guess you would have to be more specific on what you want me to recall.

Q. Let's talk about prenatal. Did she have her total prenatal care with Summit OB/GYN Associates? 10:40:39

A. Yes.

Q. And you just mentioned you had only seen her one time during the prenatal care?

A. Correct.

Q. So that if a patient comes to you 10:40:44

that's pregnant, they go through prenatal care with your associate group, they're seeing various doctors? 10:40:46

A. Right.

Q. They're not assigned to one particular physician? 10:40:57

A. Right.

Q. So that anytime she came for prenatal care, she had seen whoever was rotating working the office at that particular time? 10:41:04

A. Basically we ask them to meet us all at least once, and then after that, you know, it really just depends on what day's convenient for them, who is in the office that particular day or, you know, some patients do have certain affinity for one person or another and they will see them for most of their prenatal care. 10:41:20

Q. And then if during their prenatal care they need to be hospitalized, who would be the attending physician from your group that cares for them? The physician that has coverage that day? 10:41:32

A. Correct. 10:41:43

Q. So is your hospital inpatients covered -- coverage -- strike that. 10:41:45

When you have in-hospital patients as a group, does the attending change daily based on the coverage? 10:41:58

A. I'm sorry, say that again.

Q. Let me make it -- if you have inpatient patients, hospital patients, OB-GYN patients, on a Monday they would see, let's say you, Dr. Ferris, because you are covering, you have coverage Monday, on Tuesday who would they see? Would that be Dr. Ferris again for the hospital coverage or is it whoever is on call for Tuesday? 10:42:13

A. It would depend on who was on call for Tuesday. 10:42:26

Q. So your on-call rotation not only covers the after hours, it also covers your hospital rotation?

A. During the day? Is that what you are asking me? 10:42:42

Q. Yes.

A. Yes.

Q. So basically are you on call every fourth day? Excluding weekends? 10:42:44

A. At that time, at that time it may not have been a full 24-hour period we were on call. We may cover part, you know, I might be in the office during the day and Dr. Terpylak could be covering the hospital and then at 6 o'clock we will switch. So it may not be a full 24-hour period of time. Is that what you are asking? 10:42:48 10:42:59

Q. Yes.

A. Yes. 10:43:08

Q. So on August 3rd, 98, when Mrs. Tarle was admitted to Akron General Hospital, would you have been covering the hospital as far as inpatients that day?

A. During the daytime hours, that I don't remember. Obviously I was on that night, but I don't recall if I was the physician during the daytime hours. 10:43:23

Q. Could you tell from the records in front of you which physician in your group would have been covering Mrs. Tarle during the day of August 3rd, 1998? 10:43:36

A. The only thing I see in the records was it may have been Dr. Terpylak was the initial physician. Now, at what point we 10:43:54

switched during that day, I don't know. Because -- 10:43:56

Q. Can you reference me where you see Dr. Terpylak as the initial physician?

MR. MARGOLIS: If it's there, he can go through those. 10:44:09

Q. Maybe this is --

MR. SCHOBERT: He's got it.

Q. Oh, you have it?

A. Initial H & P form. 10:44:14

Q. Just so we're on the same page, you're looking at the multidisciplinary assessment database?

MR. MARGOLIS: No.

MR. SCHOBERT: No, he's looking at something called medical record of patient for delivery, section 2 of 2. 10:44:22

A. It's her history and physical.

MR. SCHOBERT: It's her history and physical. 10:44:33

MR. FINELLI: Does it have it in here?

MR. MARGOLIS: I don't see it.

Q. I'm just used to looking at medical records. Here. Okay. I have the physical 10:44:47

exam. 10:44:57

A. Under remarks, page 2 of 2.

Q. Under remarks. Which starts off 24-year-old --

A. Right, and then it says -- 10:45:10

Q. -- GIPO?

A. Then it says plan, says per Dr. Terpylak patient to receive Pitocin and Epidurac at 4 centimeters dilation and fluid hydration. 10:45:21

Q. And that's signed by -- do you know who signed that? Is that Dr. Sanders?

A. Looks like Sanders, yes.

Q. Sanders? So Terpylak, Dr. Terpylak was one of your partners? 10:45:29

A. Right.

Q. So based on this information, you would glean, then, that Dr. Terpylak was at least on call when she was initially admitted on August 3rd, 98? 10:45:38

A. That's what I would assume, yes.

Q. You would not have -- let me ask you, do you have any records as far as call schedules that you keep that would date back to 1998? 10:45:54

A. That I'm not sure about. I can look. 10:45:55

Q. So Dr. Terpylak, based on this record, would have been on call during her initial admission. When would you have taken over the care of Mrs. Tarle on August 3rd, 98? 10:46:06

A. I don't know that off the top of my head. I would assume it was either probably at noon or at 6 o'clock. Those were generally the times when we would switch call. 10:46:24

Q. Would you be able to tell from looking at the doctor's progress notes? Because I know there were some calls made to you. I don't know if you can tell what time they started or -- the earliest I see is 2030. 10:46:41

MR. SCHOBERT: Yes, that's what I have down.

MR. FINELLI: I'm sorry?

MR. SCHOBERT: Yes, I was looking through my notes, but give me a moment to check. 10:47:38

Q. 2030 on August 3rd would have been 8:30, correct? Is that?

MR. MARGOLIS: Yes.

Q. Okay. If you were called at 8:30 10:47:56

p.m. on August 3rd, 98, you would have at least initiated your coverage at 6 p.m.? 10:48:01

A. Most likely.

Q. Because your call goes from either 12 noon or 6 p.m.? 10:48:08

A. Yeah, that's, those are the times where we traditionally would switch over. Now, on that particular day, I, you know, I don't remember for sure if there was some other extenuating circumstances that we would switch at an alternative time. 10:48:22

Q. So you either on that day switched at noon or 6 p.m.?

A. Most likely, yes.

Q. And there's nothing in the records that we can look at to determine whether or not you took over at noon on August 3rd or at 6 p.m. on August 3rd, correct? 10:48:40

A. Not that I saw.

Q. If you would have taken over at noon on August 3rd, your coverage would have went until when, into August 4th? Noon of August 4th? 10:48:57

A. Usually we would switch over the following morning, about 7 a.m. 10:49:14

Q. And we know Mrs. Tarle delivered by cesarean section sometime after 5 a.m. on August 4th, correct? 10:49:18

A. Right. Right.

Q. Of 98. So that if you were on coverage at noon on August 3rd, you would have still been on coverage for Mrs. Tarle when she had delivered on August 4th? 10:49:30

A. Yes.

Q. And if you would have been on coverage at 6 p.m. on August 3rd, you would have still been on coverage when she delivered on August 4th? 10:49:46

A. Yes.

Q. Are there any other doctors in your group, other than, excluding the prenatal care, that you can tell me if they were involved in the care of Mrs. Tarle during her hospital admission on August 3rd, 98? Besides you and Dr. -- 10:49:48 10:50:03

MR. SCHOBERT: Specific to August 3rd and 4th during her hours? Because I think there were later progress notes where her --

A. Postpartum.

MR. SCHOBERT: Postpartum. 10:50:14

A. Postpartum I think Dr. Mitchell saw her once and I think Dr. Monte might have seen her once. 10:50:15

Q. Let me narrow my question, then. Any other doctors besides you and Dr. Terpylak -- I am pronouncing that correct, right? 10:50:24

A. Terpylak.

Q. Involved in the care of Mrs. Tarle from the time of her admission on August 3rd, 98 until the time she delivered on August 4th, 98, from your group? 10:50:33

A. Not that I'm aware of.

Q. Looking over her prenatal records, you mentioned you had seen her one time. Were there any abnormalities during her prenatal care that was recorded or documented or diagnosed? 10:50:46

MR. SCHOBERT: I'm going to object. Go ahead.

Q. Do you understand my question? 10:51:00

A. I guess you would have to tell me what you mean by abnormalities.

Q. Well, did she have a pretty normal prenatal course?

A. From what I could see from the 10:51:10

chart, yes. 10:51:11

Q. She had no evidence of gestational diabetes?

A. I'd have to refer back. I don't recall. 10:51:18

Q. If you can look through her prenatal records.

A. Her glucola was normal.

MR. MARGOLIS: I didn't hear.

THE WITNESS: Her GCT at 28 weeks was normal. That's how we screen for diabetes. 10:51:44

Q. So she had no evidence of diabetes. Did she have hypertension?

A. Looks like she had a couple of borderline blood pressures. 10:52:23

Q. Anything warranting medication?

A. No.

Q. Any evidence of preeclampsia?

A. I would say no.

Q. Was she cultured at all during her prenatal care? 10:52:37

A. She had a GPS culture. And that was negative.

Q. That was negative. Any lab values that were abnormal that were significant or 10:52:49

caused concern for you and your group? 10:52:52

A. Doesn't appear so.

Q. Any ultrasounds done during her prenatal care?

A. Yes. 10:53:07

Q. Any abnormalities in the ultrasounds?

A. I'm looking. Doesn't appear, so her ultrasounds are normal.

Q. This was her first pregnancy, 10:54:03 correct?

A. I believe so.

Q. She would be considered a primip?

A. Right.

Q. And what does that refer to? What 10:54:12 does that mean?

A. Prime just means it's her, it would be her first delivery.

Q. Based on your review of the records, would it be fair to say that she had a 10:54:22 normal prenatal course?

A. I would say her prenatal course was relatively normal, with the exception of a couple of borderline blood pressures, yes.

Q. In general, during the course of 10:54:39

prenatal care, is it, in general, normal to see a patient with a couple borderline elevations of blood pressure? 10:54:41

A. That's not unusual.

Q. Any patient noncompliance during her prenatal care? 10:54:55

A. Not that I'm aware of.

Q. She would not have been considered a high risk patient at that point during her prenatal care, then? 10:55:22

A. No.

Q. Fair to say that during her prenatal care she had a healthy fetus?

MR. SCHOBERT: Objection.

MR. STRONG: I'll join that objection. 10:55:34

Q. And let me add, as best as you could determine?

A. I would say that her prenatal care was normal, but whether the baby was healthy or not, I don't know how, I don't know that I can comment on that. 10:55:49

Q. Can you comment on that question based upon the information you had as far as your clinical exams, evaluations, ultrasounds 10:56:01

and laboratory values? 10:56:04

A. Again, I only saw her one time, so from my own personal prenatal, she seemed to be doing fine at that point in her pregnancy, but again -- 10:56:18

Q. Okay. Let me ask you this, then: Based upon your review of the prenatal records, was there any cause for concern as far as fetal compromise?

A. I don't think we were concerned about fetal compromise, but that doesn't preclude that the baby couldn't have had some prenatal condition that we were unaware of. 10:56:43

Q. How would you determine, based on a prenatal record like this, as to whether or not there may be some fetal compromise? 10:57:00

A. Sometimes you can't. Sometimes a woman can be a completely normal prenatal course and still have a baby that has some problem that's unrecognized. 10:57:14

Q. And in those instances, the majority of the etiology is congenital?

A. I guess it would depend on what the problem was.

Q. How were her fetal heart tones 10:57:31

during the prenatal care? 10:57:31

A. From what I can tell, they were fine.

Q. Did she require any stress testing during her prenatal care? 10:57:38

A. Not that I'm aware of.

Q. What would be the indication to stress a patient during her prenatal care?

A. There are dozens of reasons to do prenatal testing. 10:57:49

Q. Can you give me a few? The majority of the reasons?

A. Any patient with diabetes requiring insulin, patients postdate, INGR, oligohydramnios, documented preeclampsia, 10:58:14 chronic hypertension.

Q. Would you ever stress, do a stress test if you are concerned about fetal distress or fetal compromise?

A. Yes. 10:58:31

Q. And as you mentioned, in this case she didn't undergo any fetal stress testing during her prenatal care?

A. Not that I'm aware of.

Q. When do you do any amniocentesis 10:58:40

during prenatal care? 10:58:44

A. That also depends on the clinical situation.

Q. What clinical situations would lend itself to a patient having amniocentesis? 10:58:54

A. In the first trimester we'll do it oftentimes for genetics, if there's a reason to.

Q. And what would the reason be?

A. There was an abnormality on ultrasound, if the mother was over age 35, was appropriately counseled and consented for her amniocentesis, if there's a abnormal triscreen. 10:59:10

Q. Abnormal?

A. Triscreen. 10:59:27

Q. And what is that?

A. Triscreen is a screening test we do in the second trimester to give us an indication of whether or not the baby is at risk for a chromosomal problem or birth defect. 10:59:37

Q. Anything else? Indication for amniocentesis?

A. Fetal lung maturity late in the pregnancy would be another reason to do an amnio. 10:59:54

Q. So those concerns would lend support for you, as a physician, to perform an amniocentesis, those things you just mentioned? 10:59:54

A. Correct.

Q. Did Mrs. Tarle have amniocentesis during her prenatal care? 11:00:03

A. No, not that I'm aware of.

Q. Fair to say, then, you, as physicians taking care of her during her prenatal care, didn't have any concern for those things you just mentioned as far as indications for amniocentesis, as far as Mrs. Tarle was concerned? 11:00:14

A. I would say it's fair to say.

Q. Doctor, I want you to -- well, let's start with the history and physical when she first came in on August 3rd. Can you tell me the time she was admitted on August 3rd? Not to confuse you, I think it's around 9 a.m. in the morning, and correct me if I'm wrong. 11:00:27 11:00:52

If you look at the nurses notes, I think that multidisciplinary assessment, it has time 09, I believe. Do you have that?

MR. SCHOBERT: Yeah, I'm not disagreeing with you, I think that's what my 11:01:43

records reflect, so if you want him to verify that, that's fine. I'm not going to dispute. That appears to be -- 11:01:45

A. That sounds about right.

MR. SCHOBERT: I know that's the note when they put on the monitor and at 9 a.m. is what I have down in my notes. 11:01:55

Q. All right. Who did the history and physical? Was that Dr. Sanders?

A. Dr. Sanders, yes. 11:02:12

Q. Dr. Sanders?

A. Dr. Sanders.

Q. And we mentioned earlier she was a primip, this was her first pregnancy?

A. Correct. 11:02:29

Q. And at the time that she was admitted, she was two centimeters dilated?

A. It was a visual exam, so that's an estimate, but that's what it says here in the history and physical. 11:02:44

Q. So she didn't have a vaginal exam as part of her physical exam?

A. According to, according to this, it doesn't appear that way.

Q. Anything in the history and 11:02:57

physical exam that was not done that should have been included? 11:02:58

A. I don't see anything that strikes me as being excluded, no.

Q. And when you say visually she was two centimeters, that would have been done by speculum exam and visualization? 11:03:34

A. Correct.

Q. Is that routine, to do a speculum exam rather than a manual exam? 11:03:43

A. For membrane rupture it is, yes.

Q. So when she was admitted, her membranes had already ruptured?

A. Correct.

Q. Do we know how long her membranes were ruptured at that point? 11:03:55

A. It appears by history it was at 7:45 a.m.

Q. And you would not want to do a manual exam on admission because of the membranes rupturing, correct? 11:04:15

A. If she's not contracting, not in labor, oftentimes we will exclude, exclude a digital exam.

Q. Irrespective of whether the 11:04:31

membranes were ruptured or not? 11:04:40

A. Irrespective of whether the membranes were ruptured.

Q. And why would you exclude a digital? 11:04:40

A. Just to lower her risks for infection.

Q. By doing manual exams in somebody whose membranes are ruptured, the more manual exams you do, the increased risk of introducing 11:04:48 bacteria which can lead to infection?

A. That's the theory, yes.

Q. With a visual exam, you can't tell the effacement, correct? Or can you?

A. It's difficult to tell effacement 11:05:05 and dilation with a digital exam. It's an estimate.

Q. Can you tell station?

A. Not really.

Q. When is the first time we know -- 11:05:16 strike that.

When is the first time on her admission of August 3rd do we know what her dilation is, effacement and station?

THE WITNESS: What section are her 11:06:06

progress notes in? 11:06:08

MR. SCHOBERT: Here, there's an index in the front. Item 13.

A. You want to know when her first digital exam is, is that what you're asking me? 11:06:48

Q. Yes, I want to know when it was first determined what her station was. Because if you look at the Friedman curve, Doc, it looks like around 10 she's at station 4 with a dilation of 2. 11:07:02

A. Right.

Q. That's station of minus 4. Correct?

A. That's what it looks like from this curve, yes. 11:07:10

Q. And to document that, she would have needed to, in order to document that, she would have needed to have undergone a digital exam?

MR. SCHOBERT: I'm sorry, Dan, what was the station you were pointing her? 11:07:21

Q. At 10 o'clock on the Friedman curve she's on station minus 4, correct?

A. Yes, that's what the nurse documented, yes. 11:07:32

Q. With a circle, dilation of 2, correct? 11:07:33

A. Right.

Q. And my question is, in order to determine that station, a manual exam would have had to have been done? 11:07:40

A. I would say that's accurate. I don't see that it -- I don't see any other documentation of a manual exam.

Q. Okay. Who fills out the Friedman curve? Is it a physician or a nurse? 11:07:55

A. Nurse.

Q. The writing under the Friedman curve, is that done by a physician or a nurse or both? 11:08:09

A. At Akron General I think they do both, nurses and physician notes are intermixed.

Q. And that would continue with the continuing progress note on the next page? 11:08:19

A. That appears so.

Q. That would be filled out by nurses as well as physicians? Correct?

A. Correct.

Q. Okay. So we know at 10 o'clock she 11:08:33

was at 2 dilation, minus 4 station. You would agree that a minus 4 is very high? 11:08:37

MR. SCHOBERT: I'm going to object, but go ahead.

A. That's true, that's what her station was, and that's true, yes. 11:08:48

Q. And we know she was past her due date, correct?

A. She was about four or five days over her due date, yes. 11:08:59

Q. I think 40 plus 4 or 7, 4 days past her due date?

A. Yes.

Q. So we have a primip who is on admission minus station 4, past her due date by 4 days and at two centimeters dilation, correct? 11:09:10

MR. SCHOBERT: I'm going to, again, object on the basis of that conversation you had about verification of those findings, but go ahead. 11:09:21

Q. And I'm stating that based on the documentation of the Friedman's delivery curve.

A. Right.

Q. Primips usually present in labor at 11:09:37

a station of minus 4, or are their heads usually engaged, the babies' heads usually engaged for primips? 11:09:40

A. Either or.

Q. The majority of primips that you see that present themselves in labor, are the babies' heads usually engaged? 11:09:50

A. Sometimes they are, sometimes they are not. I don't know that I would classify as a majority or not, you know. 11:10:06

Q. In general, in your experience, in primips that present in labor, are the babies usually at zero station?

A. They usually present at zero station? 11:10:20

Q. Yes.

A. I would say no, that's not usual.

Q. How do they usually present as far as station?

A. They usually present at higher than the zero station. 11:10:26

Q. Minus 1?

A. Minus 1, minus 2, minus 3.

Q. Would it have been unusual for Mrs. Tarle as a primip to present in labor on August 11:10:38

3rd with a minus 4 station? 11:10:40

A. I wouldn't say it's unusual, no. She wasn't in labor either.

Q. Would you say when she presented as a primip with a past due date of minus 4 11:10:54 station, she would have been a patient that had a higher risk of undergoing a C section than a normal patient?

A. No.

Q. Why not? 11:11:07

A. It's not unusual for a primip to start out at a high station. She wasn't contracting, she wasn't in labor.

Q. How do you know she wasn't contracting or not in labor? 11:11:29

A. Well, just from what I have seen in the chart here. At 11:30 -- actually that's not it. I thought I saw somewhere they said that -- let me go back and see.

On the H & P it says no 11:12:03 contractions.

MR. MARGOLIS: Where are you reading?

MR. SCHOBERT: He said H & P.

A. H & P, it says no contractions. 11:12:10

MR. MARGOLIS: Okay. At what time? 11:12:12

THE WITNESS: This is her initial history and physical.

MR. FINELLI: Can we go off the record a second? 11:12:22

MR. SCHOBERT: Yes.

(Discussion had off the record.)

Q. Doctor, it looks like, correct me if I'm wrong, Pitocin is started around 10:45 a.m. on August 3rd? Or 10:30 a.m., somewhere in there? 11:15:37

MR. SCHOBERT: Yes.

Q. It started around 10:30, 10:45 a.m.?

A. Somewhere around that general range, yes. 11:16:08

Q. And Mrs. Tarle's presentation -- well, strike that.

Pitocin is oxytocin?

A. Correct. 11:16:17

Q. And the purpose of Pitocin in a setting of labor and delivery is what?

A. Stimulate contractions.

Q. And why do you want to stimulate contractions? 11:16:24

A. To effect --

MR. SCHOBERT: Keep your voice up a little bit. She's going to have trouble hearing you. You have your hand --

A. To stimulate contractions in order to allow labor to progress. 11:16:35

Q. Is that synonymous with induction?

A. You can use Pitocin to induce or augment labor.

Q. What is the induction of labor? Just the beginning of labor? 11:16:48

A. Yes, I mean you are trying to get someone to get into labor, yes.

Q. Is there any protocol for the use of Pitocin by Akron General Hospital? Any manual or protocol? 11:17:03

A. I'm not aware of any. I don't know.

Q. Pitocin would need to be started by a physician's order, correct? 11:17:17

A. Yes.

Q. Is there any degree of dilation or any degree of effacement or at any station in which starting Pitocin is contraindicated?

MR. SCHOBERT: I'm going to object 11:17:38

to the from of the question, go ahead. 11:17:39

A. You're talking about degree of dilation, station, or what was the other one?

Q. Yeah, let me clean that up. Is there any reason Pitocin would be 11:17:49 contraindicated based on the degree of dilation that the primip presents?

A. Not that I'm aware of.

Q. Is there any degree -- is there any contraindication to using Pitocin based on a 11:18:03 degree of effacement of a presentation of a primip?

A. Not that I'm aware of.

Q. Is there any contraindication to using Pitocin based on the station that a 11:18:14 primip presents in?

A. Not that I'm aware of.

Q. Is there any contraindication to using Pitocin in someone that has ruptured membranes? 11:18:32

A. I think if it's just a normal primigravida presentation, vertex presentation, with no evidence of fetal distress or anything like that, there's probably no contraindication to it. 11:18:58

Q. When a primip presents at station 4, are you able to determine whether it's a vertex presentation? 11:19:00

A. Yes.

Q. By how? 11:19:08

A. Either by examination, Leopold's or ultrasound.

Q. There was no ultrasound done here? To determine whether she had a vertex presentation? 11:19:29

A. That I'm not sure about. I don't recall specifically seeing somebody document that, I don't remember seeing it.

Q. And you mentioned Leopold's?

A. Leopold's. 11:19:38

Q. What's that?

A. Leopold's is an examination that you can do palpating the maternal abdomen to try to figure out the presentation of the baby.

Q. Okay. 11:19:51

A. Try to palpate the fetal head.

Q. Is there any documentation on her presentation whether or not Leopold's was done or any documentation that says she had a vertex presentation? 11:20:00

A. There is documentation of Leopold's on the H & P. And actually there is documentation by ultrasound here. 11:20:0

MR. SCHOBERT: Yes, I thought I saw that somewhere. 11:20:1

Q. That's on physical exam?

A. Yes.

Q. Vertex on ultrasound at 10 a.m. Okay. I see that.

We talked about the benefit of Pitocin as far as stimulating contractions, correct? 11:20:2

A. (Nodding affirmatively.)

Q. Any other benefits?

A. After delivery, it helps to minimize bleeding. 11:20:3

Q. How does it do that?

A. Just by stimulating, continuing to stimulate the uterus to contract and cramp down. 11:20:4

Q. So constrict the blood flow?

A. Correct.

Q. What are the risks of using Pitocin in primip?

A. The main risk would be 11:21:0

overstimulation of the uterus. 11:21:08

Q. And if you overstimulate the uterus, that can lead to fetal compromise and fetal distress?

A. Overstimulation can lead to tonic contraction which can affect blood flow to the fetus. 11:21:18

Q. And affecting the blood flow of the fetus could in effect put the fetus in compromise or distress? 11:21:31

A. If it was prolonged, that is true.

Q. And if you compromise the blood flow to the fetus, you can induce fetal hypoxemia?

A. That's true. 11:21:46

Q. And fetal hypoxemia is what?

A. That's just a lack of delivery of oxygen to the fetus.

Q. And what is fetal hypoxia?

A. That is the same thing, basically, lack of oxygen within the fetal tissues. 11:21:59

Q. Lack of oxygen in the fetal tissues, and one of the tissues could be the brain?

A. That's true. 11:22:12

Q. What is fetal asphyxia? 11:22:12

A. I'm not sure of a definition. I mean asphyxia seems like it would be an event outside of the uterus.

Q. If you have fetal hypoxemia, can that lead to fetal distress? 11:22:32

A. Yes.

Q. If you have fetal hypoxemia, that can lead to fetal hypoxia?

A. Yes. I mean I think hypoxia and hypoxemia are synonymous terms, in my mind. I don't really see a big difference between the two. 11:22:5

Q. Well, you mentioned fetal hypoxia is lack of oxygen in the tissues? 11:23:0

A. Well, within the fetal bloodstream, which is the same as hypoxemia.

Q. So hypoxemia would be lack of oxygen in the blood?

A. In the blood. 11:23:1

Q. Hypoxia would be lack of oxygen in the tissues?

A. In the -- no, I think hypoxia would mean essentially the same thing, it's within the blood. 11:23:2

Q. So we're in agreement that a lack of or a compromised blood flow to the fetus can lead to fetal hypoxemia? 11:23:23

A. Say that again.

Q. We agree that lack of or compromise of blood flow to the fetus can lead to fetal hypoxemia? 11:23:31

A. Sure it can.

Q. And lack of, compromise, or compromise of the blood flow to the fetus can lead to fetal hypoxia, which you state is synonymous with fetal hypoxemia? 11:23:42

A. Right.

Q. And fetal hypoxemia and/or fetal hypoxia can lead to fetal distress? 11:23:52

A. That's true.

Q. And you're saying that a risk of Pitocin is overstimulation of the uterus?

A. Correct. That's correct, yes.

Q. And overstimulation of the uterus can lead to compromised fetal blood flow? 11:24:06

A. That's correct.

MR. STRONG: Let's take a restroom break in a couple minutes.

MR. SCHOBERT: Yes. 11:24:21

Q. How do you determine whether or not Pitocin is causing overstimulation of the uterus? 11:24:21

A. It's a combination of watching the fetal heart rate tracing and seeing what the contraction pattern looks like. 11:24:31

Q. And what change in the contraction pattern would alert you to whether or not there is overstimulation of the uterus? The frequency or the intensity? 11:24:4

A. The frequency of the contractions.

Q. So if you have a baseline rate of contractions and they increase in frequency, that may alert you to perhaps overstimulation of the uterus if the patient is receiving Pitocin? 11:25:0

A. Right, yeah, I mean if you have contractions that are so frequent that it starts to cause fetal heart rate decelerations, that would be a situation where you are probably overstimulating the uterus. 11:25:1

Q. And that leads into my next question. What would you look for on fetal heart tracings that would cause you concern to think of overstimulation of the uterus by 11:25:2

Pitocin? 11:25:30

A. You would see a bradycardia.

Q. Bradycardia?

A. Right.

Q. Any other fetal heart tracings 11:25:37
other than bradycardia?

A. You're talking about a situation where there's overstimulation of the uterus?

Q. (Nodding affirmatively.)

A. You could see late decelerations. 11:25:49

Q. With overstimulation of the uterus --

A. Yes.

Q. -- with Pitocin?

Same question, could you see 11:25:57
variable decelerations?

A. Lasting variable decelerations are more of a situation where the cord is getting compressed, so it wouldn't necessarily go along with overstimulation of the uterus. 11:26:14

Q. How about tachycardia?

MR. SCHOBERT: Just to finish your question, so it's clear on the record, tachycardia consistent with what, with overstimulation? 11:26:27

Q. Consistent with fetal heart tracings that may lead you to consider overstimulation in the uterus by Pitocin. 11:26:28

MR. SCHOBERT: I just want to --

MR. FINELLI: I said it kind of continuing with that question. 11:26:36

MR. SCHOBERT: I know, but sometimes it is taken out of context.

A. You may see a transient tachycardia, but then the heart rate would most likely drop. 11:26:42

Q. How about a change in the variability?

MR. SCHOBERT: Again, same --

Q. Pertaining to that question of overstimulation. 11:26:54

MR. SCHOBERT: Same question, as to the same question?

MR. FINELLI: I'm sorry.

A. Overstimulation, yeah, the variability could increase. 11:27:00

Q. And that is a tracing that may alert you to the fact that the uterus is overstimulated by Pitocin?

A. But keep in mind you have to have 11:27:15

both, you have to have a contraction pattern that looks overstimulated in conjunction with fetal heart tracings, yes. 11:27:16

Q. Just so I'm clear, then, any fetal tracing abnormality that we talked about that would support -- 11:27:27

A. You --

MR. SCHOBERT: Wait, let him finish his question.

Q. Any fetal heart tracing that we just mentioned that would lend to support of overstimulation of the uterus by Pitocin would have to be in conjunction with a change in the frequency of the uterine contractions? 11:27:38

MR. SCHOBERT: Objection. 11:27:52

A. I'm not sure I understand what you're saying.

Q. Okay. We talked about how the uterine contractions would change if you're considering the uterus being overstimulated by Pitocin and we talked about how the fetal heart tracings would change. But in order for you to assess whether the uterus is overstimulated by Pitocin, you would have to see both the fetal heart tracings and the uterine contraction 11:28:01 11:28:13

change in conjunction with each other? 11:28:15

A. Right, I think the main thing is the contraction pattern for overstimulation.

Q. Is there a risk of using Pitocin as you continue on a time line? Beyond, beyond 11:28:30 what hour of use of Pitocin does the risk increase?

MR. SCHOBERT: Object. Go ahead.

A. I don't know of a definition that would say that you have to stop after a certain 11:28:46 number of hours, or that there's a risk after a certain number of hours.

Q. So if you are using Pitocin for four hours, the risk is the same as if you were using Pitocin for 12 or 13 hours? 11:28:57

MR. SCHOBERT: Objection.

A. The risk is as it applies to what? Overstimulation?

Q. Or compromise to the fetus.

MR. STRONG: I'm going to object to 11:29:16 that.

A. I'm not sure I understand exactly what you're -- Pitocin by itself does not cause compromise to the fetus. Is that what you mean? 11:29:27

Q. No, let me ask it this way. 11:29:28

MR. SCHOBERT: Yeah, just tell him to rephrase the question. He'll get the question to you that you can understand.

Q. Is there a finite period of time in 11:29:34 which the use of Pitocin has then become contraindicated?

A. Not that I'm aware of.

MR. SCHOBERT: Did you say you needed a bathroom break? 11:29:49

MR. STRONG: Yeah, I'll admit to that.

MR. FINELLI: Do you want to take a break?

MR. SCHOBERT: Well, he wants to, 11:29:54 and I believe they have delivered the original charts, so I'll take a few minutes to go over it, make sure none of my correspondence is in there, and then you can have that, and we asked them to see if there are any billing records or 11:30:03 any scheduling information. I apologize I didn't have it, but they found it and they delivered it for us.

MR. FINELLI: Yeah, I just want to ask one more question. 11:30:13

MR. SCHOBERT: Fine. 11:30:14

Q. Is there any protocol in your office with regard to the use of Pitocin during labor and delivery?

A. No. 11:30:20

Q. And you do not rely on any protocols by Akron General Hospital in your care of your patients in labor and delivery as it pertains to Pitocin protocols?

A. I have never seen a Pitocin protocol at Akron General. 11:30:28

MR. FINELLI: Okay. Fair enough. We'll take a break.

(Recess taken.)

Q. Doctor, just a few cleanup questions. In the beginning we talked about a case where you were deposed as a resident that was dismissed, correct? 11:36:55

A. (Nodding affirmatively.)

Q. Do you know if any money was paid out on your behalf on that case? 11:37:07

MR. SCHOBERT: Note a continuing objection. Go ahead, Doctor.

A. When you say on my behalf, you mean there was a -- 11:37:20

Q. Based on any alleged facts of your substandard care. 11:37:21

A. No.

Q. You're not aware of money being paid out? 11:37:28

A. I don't know if there was a settlement or what happened on the case.

Q. The history and physical exam that we had talked about earlier, that was done by Dr. Sanders, correct? 11:37:42

A. History and physical was done by Dr. Sanders, right.

Q. Was Dr. Sanders at that time a OB-GYN resident?

A. No. 11:37:54

Q. What type of resident was he? If a resident or a medical student, what was he?

A. He was a resident at the hospital. I'm not sure what department he came from. He was a rotating resident. 11:38:07

Q. I believe he was a family practitioner. Do you have any knowledge to the contrary?

A. No, I don't.

Q. And you, as a group treating Mrs. 11:38:23

Tarle, would have relied on the history and physical examination, correct? Information gleaned from the history and physical? 11:38:25

A. I don't think we would have relied on it at all, to be honest with you. 11:38:33

Q. Then what's the purpose of the history and physical being performed by Dr. Sanders?

A. It's, I think it's required by the hospital for every patient admitted, they have a history and physical. 11:38:46

Q. And you're saying you and your group would not rely on the findings of the history and physical examination as it pertains to your care provided to Mrs. Tarle? 11:38:59

A. Not necessarily, no.

Q. When was the first time a physician from your group would have evaluated Mrs. Tarle on her admission of August 3rd, 98?

A. I'm not sure. I don't know. 11:39:17

MR. MARGOLIS: Feel free on any of these questions to look at the records.

A. Can you repeat your last question?

MR. SCHOBERT: He wants to know the first time you can tell from the records of 11:39:32

anybody from your group, Terpylak or anybody else from your group evaluating her after she came to the hospital. 11:39:34

Q. Anyone from your group, yes.

A. You mean, you know, physically walked in and saw her? Is that what you mean? 11:39:44

Q. Yes, one of your physicians, either you or someone from your group actually evaluating Mrs. Tarle, your patient, when she was admitted on August 3rd, 98. And when I say your, I'm meaning your group. 11:39:56

A. My recollection from the chart is the first time is when I came in for the C section. Now, I don't know if Dr. Terpylak could have been there earlier in the day and I don't recall if I was there earlier in the day, but from the chart, that's what I can tell. 11:40:14

Q. Okay. So fair to say up until the time that she goes for an emergency C section, there is no documentation of any evaluation or physical exam by either you or any physician from your group? 11:40:27

A. Right, from what I can tell from the chart, that's true.

Q. And normally, as a physician, when 11:40:41

you evaluate a patient, you would document that? 11:40:43

A. Normally, yes.

Q. When you do a vaginal exam or a clinical exam on a patient, you would document that in the chart? 11:40:49

A. Right.

Q. Because there's other physicians that rely on that documentation as it pertains to the continuing care of that patient, correct? 11:40:56

A. Correct.

Q. And she was admitted around 9 o'clock on August 3rd, 98, correct?

A. Correct. 11:41:06

Q. And you arrived on August 4th, 98 at some point in time when Mrs. Tarle was already undergoing emergency C section?

A. She was already delivered by the time we got there. 11:41:25

Q. Do you know what time, from the records, you had arrived at the hospital?

A. No.

Q. You can't tell from the records at what point in time? But you can say that when 11:41:33

you arrived at the hospital she had already delivered? 11:41:36

A. Correct.

Q. Who performed the surgery? Was it Dr. McKelvey? 11:41:45

A. I think it was Dr. McKelvey, Dr. Drake and Dr. Cook.

Q. Fair to say, then, that between the time she was admitted on August 3rd, 98 up until the time she went for emergency C section, after 5 a.m. on August 4th, 98, you and/or the physicians in your group relied on the physicians taking care of her during that hospitalization as far as the care and management that was provided her? 11:42:00 11:42:19

A. I would say that's fair to say.

Q. Fair to say that the physicians that were taking care of her from her admission of August 3rd, 98 through the time, up through the time she delivered on August 4th, 98 were resident physicians? 11:42:30

A. Yes.

Q. There were no other attendings outside of your group that were involved in the care of her up through the time that she -- 11:42:39

A. Dr. Cook was involved. 11:42:42

Q. Dr. Cook was involved as far as the emergency C section was --

A. Correct.

Q. He had no involvement prior to the surgery itself, correct? 11:42:50

A. Not that I'm aware of.

Q. Do you have any criticisms of Dr. Cook relative to his care pertaining to Mrs. Tarle August 4th, 98? 11:43:02

A. I'm not sure I know exactly how involved he was, so I would have to say no, I don't really have any criticisms of him.

MR. MARGOLIS: I'm sorry.

A. I don't really have any criticisms of him, but I don't know how involved he was during the surgery, so -- 11:43:33

Q. Okay. Fair enough.

Have you ever had any discussions with Dr. Cook? 11:43:42

A. No.

MR. SCHOBERT: About this case you mean?

Q. About this case, about Mrs. Tarle?

A. No. 11:43:46

Q. If you know, has any of your partners had any discussions with Dr. Cook as it pertains to the care of Mrs. Tarle? 11:43:46

A. Not that I'm aware.

Q. I think I asked you that, have you discussed this case at all with your partners? You mentioned Dr. Drake. 11:43:57

A. Yeah. We talked, I mean I guess I talked to them about it in the few days right after it happened, but that would have been the only time. You know. 11:44:12

Q. After the time that the delivery happened or --

A. Yeah, that day, the day or two or three right after the delivery. I think I may have talked to them about it. 11:44:23

Q. Tell me the guidelines, if any, as it pertains to the management and care of a patient that your group practices when a patient of yours is admitted with ruptured membranes as a primip that gets admitted to the labor and delivery floor. 11:44:43

MR. SCHOBERT: I'm sorry, could you repeat, could you repeat that question?

(Record read.) 11:45:00

MR. SCHOBERT: Thank you. 11:45:10

A. I don't think we have any standard guidelines as a group.

Q. In general, what is your course of management and care to a patient of yours who 11:45:21 is a primip with ruptured membranes who gets admitted to the labor and delivery floor?

A. Really just depends on the clinical situation.

Q. And what about her clinical 11:45:34 situation changes your answer?

MR. SCHOBERT: I'm going to object. Go ahead.

A. You're -- I'm not sure I understand exactly what you're asking me. 11:45:47

Q. I mean is there a standard, is there any standard of care that you adhere to, you or your group, as it pertains to the management and care of your patients that are admitted to labor and delivery? 11:46:02

MR. SCHOBERT: Objection.

A. That's a very broad question. I mean it really depends on the patient and what their clinical situation is, how far along they are, I mean there's all kinds of stuff that 11:46:16

goes into how we manage them. I can't say that I would manage any one patient exactly as I manage any other patient. It really just -- 11:46:18

Q. Okay. How about a patient that presents herself as Mrs. Tarle did? What's your standard of care of management and practice? 11:46:28

MR. SCHOBERT: Object. Go ahead.

A. We have, you know, a hypothetical patient in her situation, primigravid, just over her due date, comes in with ruptured membranes, the standard would be, or I think the general way I would manage her is to eventually start Pitocin and then manage her symptomatically after that. It just depends how things go after that as to what decisions you make with regards to her care. 11:46:55 11:47:15

Q. At any point in time would you not want to evaluate her and examine her prior to delivery? 11:47:29

MR. SCHOBERT: I think you mean that in a personal sense. You're talking about him or a member of his group?

Q. You or your group, when I refer to you, I am referring to you or a member of your 11:47:40

group. 11:47:44

MR. SCHOBERT: Okay, generally. Just so he's clear on the question.

A. If the need arised, yes, I would do that. 11:47:50

Q. And what particular need would need to arise for you to want to examine the patient prior to delivery? And we're talking a hypothetical with the same fact pattern scenario and clinical presentation as Mrs. Tarle. 11:48:04

MR. SCHOBERT: Object, but go ahead.

A. I would say that if any one of us were at the hospital while she was in labor, we would have stopped by, at least talked to her and possibly examined her, depending on when her last exam was and what was happening at the time. Outside of that, if we were not physically present at the hospital, then we would present in any point in time where we felt that she was either getting close to delivery or there were problems arising and there was a need for us to be there. 11:48:22 11:48:36

Q. So if the patient, such as Mrs. 11:48:59

Tarle, was getting close to delivery or if there were problems that had arisen that you felt you needed to be there, then you, and you were not in the hospital, and again, I say you, meaning you or your partners, then you would come in from the outside and evaluate this patient? 11:49:02 11:49:14

A. That's fair to say.

Q. Absent those two conditions, then, you rely totally on the information that's relayed to you by the residents taking care of her, correct? 11:49:24

A. I think it would be the standard for this OB-GYN community to do that.

Q. It would be the standard for the OB-GYN community, what, in the Akron area? 11:49:40

A. Yes. We have two large -- or moderate-sized residency programs and I went through one of those residency programs, so I know how the system works, and most, if not all, of the attendings in the area rely on the resident's evaluation and care of the patient while they are laboring. 11:49:58

Q. So just so I am clear, you're stating that the standard of care in the Akron 11:50:15

area is for you, as an attending physician, to rely on the information relayed to you, information that comes from the residents, as it pertains to your care and management of the patient that presents in labor and delivery, absent any problems arising or getting close to delivery? 11:50:17 11:50:34

A. Well, I don't know about that last part of the statement, but in general, yes. I mean we do rely on the resident's evaluation and interpretation of what's going on, yes. 11:50:48

Q. And in this particular case, you relied on the care and management provided to Mrs. Tarle by Dr. McKelvey, Dr. Drake and Dr. Sanders? As physicians? 11:51:13

MR. MARGOLIS: Sanders.

Q. And Sanders? Is it Sanders?

MR. MARGOLIS: S A U N D E R S.

A. I guess I would qualify that by saying that I think Dr. Drake and Dr. McKelvey, I would certainly have no problem relying on their care. I don't know Dr. Sanders very well and I don't recall having any real interaction with him during this whole process. 11:51:30

Q. Fair to say, though, that in this 11:51:47

case, Mrs. Tarle's labor and delivery and her admission, you relied on the care and management of Mrs. Tarle as it was provided by the residents, Dr. McKelvey and Dr. Drake and Dr. Sanders? 11:51:47 11:52:00

MR. SCHOBERT: Objection.

A. In the respect that they were updating me with regards to problems, yes.

Q. And you relied on that information?

A. Right. 11:52:10

Q. As far as your care and management to Mrs. Tarle?

A. Right.

Q. Do you know where you were on the evening of August 3rd, 98? Were you home? 11:52:27

A. I was home.

Q. Do you know what year residents Dr. McKelvey and Dr. Drake were on August 3rd, 1998?

A. I don't know that for sure off the top of my head. I know Dr. McKelvey was senior to Dr. Drake, but whether she was a third or fourth year or he was a second or third year, I'm not positive of that. 11:52:48

Q. Could Dr. McKelvey have been a 11:52:59

second-year resident? 11:53:01

A. Could she have been? I don't think she was.

Q. And the residency year begins July 1 of that year, correct, of any particular 11:53:12 year?

A. Yes, in most cases, yes.

Q. Are there any cases where it doesn't?

A. There are some residents that start 11:53:23 midyear for some reason.

Q. So if Dr. McKelvey was a third-year resident on August 98, she would have only been a third-year resident for perhaps, by math, approximately one month's time? 11:53:39

A. That would be, that would be accurate, yes.

Q. Were there any problems that arose in the care of Mrs. Tarle that would have required you, as part of your habit of 11:53:54 practicing, to come in and evaluate Mrs. Tarle?

A. I'm sorry, say that again.

Q. Were there any problems that arose on behalf of Mrs. Tarle during her August 3rd, 98 admission which would have caused you to, as 11:54:10

part of your practice of seeing patients, to come in and evaluate Mrs. Tarle? 11:54:14

A. Not, not until they took her for C section. Not that I was made aware of prior to that. 11:54:27

Q. And I think they took her to C section at 4:59 a.m. on August 4th, 98, correct?

A. Correct.

Q. And you're stating, then, that there were no, as far as you were concerned, problems that arose in Mrs. Tarle's labor and delivery care through 4:59 a.m. that caused concern for you to come in and evaluate Mrs. Tarle? 11:54:34 11:54:49

A. Right, that's correct, I was not made aware of or given any indication anybody was in any way uncomfortable with the way things were going.

Q. And how would you have been made aware of any potential problems that might have arisen in Mrs. Tarle's care? 11:55:06

A. Phone calls.

Q. Did you receive phone calls during her admission? 11:55:17

A. Yes.

Q. Did you receive phone calls from Dr. McKelvey? 11:55:17

A. Yes.

Q. Did you receive phone calls from Dr. Drake? 11:55:22

A. Yes.

Q. Did you receive phone calls from Dr. Sanders?

A. Not that I recall. 11:55:28

Q. Reviewing the records, is there any information that would have been conveyed to you during her admission that would now cause you to, cause concern for you to have wanted to come in and evaluate Mrs. Tarle? 11:56:00

MR. SCHOBERT: Objection.

A. I'm sorry, repeat that. Repeat that.

Q. In your review of the chart, is there any information that was not told to you, okay, by conversation with the residents, that if it was told to you would have made you want to come in and evaluate Mrs. Tarle? 11:56:15

MR. SCHOBERT: Prior to when he actually -- 11:56:30

MR. FINELLI: Prior to the delivery. 11:56:31

MR. SCHOBERT: Prior to when he actually came in?

MR. FINELLI: Right. 11:56:34

MR. SCHOBERT: I'll object, but go ahead.

MR. STRONG: Objection.

A. I honestly can't say that I know or I can remember for sure what information was specifically relayed to me or not. This is three and a half years ago. 11:56:40

Q. But upon your review of the chart now, is there any information in the chart, either the documentation or the fetal monitor strips that, had that information been conveyed to you, would have made you want to come in and see Mrs. Tarle prior to delivery? 11:56:50

MR. STRONG: Objection.

MR. SCHOBERT: Objection. Go ahead. 11:57:02

A. I really don't have a problem with the care that was given. I mean I think everything that they did, after reviewing the strips and seeing how her labor pattern went, 11:57:13

would not have caused me any concern, even if I had been there myself, I don't think I would have done anything drastically different than what they did. 11:57:16

Q. So you had no criticism of the care that Dr. McKelvey provided Mrs. Tarle? 11:57:25

A. No.

Q. You have no criticism of the care that Dr. Drake provided Mrs. Tarle?

A. No. 11:57:33

Q. You have no criticism of the care that Dr. Sanders provided Mrs. Tarle?

A. No.

Q. You have no criticism -- do you have any criticisms of the care that the nurses provided Mrs. Tarle during that August 3rd? 11:57:39

A. The only criticism that I would give the nurses after reviewing the chart was that there was a period of time where they were not increasing the Pitocin and that seemed to delay her ability to dilate. 11:58:01

Q. So were there orders, then, by the physicians to increase the Pitocin and they were not followed through by the nurses? Is that what you're saying? 11:58:12

A. Well, I don't recall seeing a specific order until around midnight or so to actually start increasing it again, but I think the standard would be that when someone is not progressing through labor, that they would be increasing the Pitocin to try to effect better quality contractions. 11:58:15 11:58:34

Q. And to increase, for a nurse to increase the Pitocin, would that have to come from a doctor's order or can she just increase the Pitocin on her own? 11:58:47

A. No, it's kind of a standard order to do that.

Q. There was a standard order, Pitocin order? 11:58:57

A. Yes.

Q. As part of the physician's orders or as part of a protocol?

A. I think it's part of the physician's orders. 11:59:02

Q. Can you direct that, direct me to that?

Is it under the admit to labor and delivery order, that's a typed order, Doc?

MR. SCHOBERT: Section -- 11:59:32

A. What section are you in? 11:59:33

MR. SCHOBERT: He doesn't have the same section that you have.

Q. This isn't in the same order as yours. 11:59:38

MR. SCHOBERT: You know what, what are they under? Yeah, ours don't -- the nurse doesn't have a specific, organize this thing in a specific order number. I have seen it. Easier said than done. 11:59:54

MR. FINELLI: I thought you do this all by yourself.

MR. SCHOBERT: Here it is.

A. Here it is.

Q. The standard typed physician order, it looks like, for labor and delivery. Under Pitocin number 9, I think, correct? 11:59:59

A. Correct.

Q. Where it says Pitocin for augmentation, can you translate that for me? 12:00:08

A. Pitocin 10 units at a thousand cc's, they didn't write what sort of, what sort of a, what sort of IV fluid they put it in, but usually they will have an IV fluid there, and at 2 units per minute, increase by 2 units per 12:00:28

minute every 15 or 20 minutes until contractions are every two, three minutes. 12:00:31

Q. So based on this order, the nurse should make sure that contractions are occurring at a frequency of every two to three minutes? 12:00:41

MR. STRONG: Objection.

A. Just based on this order, yes, but I will tell you that beyond this is a kind of a standard. Standard way of titrating Pitocin would be if someone is not progressing, you would increase it, you would continue to increase the Pitocin as long as you weren't overstimulating the uterus. 12:00:54

Q. Okay. At what point in time was Mrs. Tarle not progressing by which you feel that the Pitocin should have been increased? 12:01:12

A. Let me look at the labor again. She had this period of time between 7 o'clock and midnight where she kind of fell off the labor curve. 12:01:43

Q. And during that period of time you feel that the Pitocin should have been increased?

A. It would have helped her to 12:01:58

progress a little bit quicker, yeah. Because once it did start getting increased at around midnight is when she started to progress again. 12:02:00

Q. Are there any conversations that you had with the residents where you indicated that the Pitocin should be increased? 12:02:17

MR. SCHOBERT: You're asking him whether he recalls that or whether he's seen --

MR. FINELLI: Or whether there's any documentation. 12:02:27

MR. SCHOBERT: All right.

A. I don't recall that.

Q. You were called by the residents during that period of time, from 7 o'clock p.m. to midnight on August 3rd, correct? 12:02:38

A. That's correct.

Q. And you were aware, based on the documentation, of the status of Mrs. Tarle during that period of time?

A. I'm sorry, say that again. 12:02:48

Q. And during that period of time, from 7 o'clock to midnight on August 3rd, based on the phone calls, you were informed of the status of Mrs. Tarle during that period of time? 12:02:57

A. Correct. 12:02:57

Q. At any point in time did you recommend increasing the Pitocin to stimulate the contractions?

A. I don't specifically recall that today, but I guess what would be a standard within the conversation would be to ask about the Pitocin. I don't really -- you know, I can't comment beyond that. 12:03:07

Q. But based upon what you see now, you feel that the Pitocin should have been increased? 12:03:25

A. Retrospectively, I think, I think it would have helped.

Q. And at that point in time, had you had this knowledge that you see now documented in front of you, you would again increase, you would have again recommended the Pitocin be increased? 12:03:38

A. I would have, yes, I would have had it increased only to allow her labor to progress. I don't know if it would have made any difference as far as the final outcome, you know, just to get her back in labor. 12:03:53

Q. Would there have been some 12:04:12

information that you would have asked the residents about as to whether or not she is progressing during that period of time as far as her labor? 12:04:13

A. Normally, yes, if someone is falling off the labor curve, that would be something we would talk about. 12:04:24

Q. And if that's something you would have talked about, would you have recommended increasing the Pitocin? 12:04:30

A. Usually.

Q. Do we know if during that period of time the Pitocin was increased?

A. I don't think it was.

MR. SCHOBERT: Why don't you take a look? 12:04:44

A. I will take a look and just make sure.

Q. What are you looking at, Doctor?

A. Obstetric accountability record. 12:05:09

Q. Obstetric accountability record. Where it starts at 1930?

A. Right. So from -- it stayed pretty much at the same level until around 12:15, 12:30, which is when she started to get back on 12:05:29

the labor curve. 12:05:31

Q. 12:15, 12, 12:15 a.m.?

A. A.m.

Q. Okay. On August 4th?

A. August 4th. 12:05:41

Q. And what happens at 12:15 a.m. with the Pitocin? It's increased?

MR. SCHOBERT: Are you looking there?

MR. FINELLI: Yes. 12:05:56

A. Right, it's increased at that time.

Q. Let's talk about the time period between 7 and 12, 7 p.m. and 12 on August 3rd. You would agree that during that period of time she remained at 7 centimeters dilated? 12:06:12

A. I think she remained anywhere from, from what I could tell from some of the notes here, anywhere from 6 to 7.

Q. Based on the Friedman curve that you have in front of you, between 7 and 12 that evening is there any documentation of any change -- 12:06:31

A. Not looking at the Friedman curve, no.

Q. -- in the dilation? 12:06:43

MR. SCHOBERT: Let him finish his question and then you answer it. Why don't you do it again just so -- 12:06:44

Q. Based on the documentation with respect to the Friedman curve, was there any change in her dilation from 7 to 12? 12:06:52

A. No.

Q. Was there any change in her station from 7 to 12?

A. Yes. 12:07:01

Q. What was the change?

A. Looks like she went from a minus 1 to zero, well, almost zero station. I guess it would be zero station. It's hard to tell exactly where they are plotting, but -- 12:07:16

Q. In a primip, what is the expected rate of cervical dilation on an hourly basis?

A. You can expect anywhere from one to two centimeters an hour.

Q. And based on Mrs. Tarle's labor between 7 p.m. and midnight on August 3rd, given the fact that she was a primip, her membranes had ruptured and she had already been on Pitocin for approximately eight to ten hours, would you agree that that was an arrest 12:07:35 12:07:56

of labor? 12:08:00

A. No.

MR. STRONG: Objection.

Q. I'm sorry?

A. No. 12:08:03

Q. Why not?

A. She didn't have an arrest of labor, she eventually got to complete dilation. You can't have an arrest that suddenly unarrests.

Q. I'm asking between the period of 7 and -- 12:08:12

A. I think she fell off the labor curve, but I don't think she arrested the labor.

Q. If you were treating her at around 11 p.m. or 11:30 p.m. and had noticed no change in her labor from 7 p.m., would you have considered that an arrest of labor at 11:30 p.m. that evening? 12:08:20

MR. SCHOBERT: Objection. Go ahead. 12:08:37

MR. STRONG: Objection.

A. I don't think we considered that arrest of labor. Yeah, I mean if we had, we would have probably sectioned her at that 12:08:46

point. 12:08:47

Q. If you would have considered an arrest of labor at 11:30 p.m., you would have sectioned her?

A. Correct. 12:08:53

Q. Would you have -- why would you have sectioned her?

A. If --

MR. SCHOBERT: Objection. Go ahead. 12:08:59

A. If we make a diagnosis that she is arresting her labor, then the only other way she's going to deliver is by C section.

Q. She was in active phase at that point, correct? 12:09:11

A. She was active phase. She did not have adequate contractions.

Q. What is active phase?

A. Well, it's kind of an arbitrary definition, but it can be anywhere from four to five centimeters to completely dilated. 12:09:24

Q. So once they reach about four or five centimeters, they then go from latent phase into active phase?

A. Generally speaking, yes, that's 12:09:39

kind of how we define it, but -- 12:09:41

Q. So at 11:30 p.m., if you would have considered this an arrest of labor, you would have sectioned her, correct?

A. Right. 12:09:50

Q. At 11:30 p.m. would you have considered that this was a contracted -- a protracted labor?

A. You have to give me what your definition of protracted labor is. 12:10:07

Q. What's your definition?

A. If she were having adequate contractions throughout this time, I would have been much closer to or much more willing to probably C section her, but you've got to 12:10:21 realize that during that whole period of time, and the updates I was getting were all very reassuring, at no point did somebody call me and give me any indication that they felt like she needed to have a C section, and it seemed 12:10:41 reasonable at that time to be patient and allow her the ability to get back on the labor curve.

Q. And this is during the period of between 7 and midnight on August 3rd, 7 p.m.?

A. Right. 12:10:57

Q. And if I understand you correctly, during that period of time, if she would have had adequate contractions, then you would have been concerned as far as sectioning her? 12:11:03

A. Right, retrospectively, when I look at this chart, it did not appear that she had adequate contractions at that time. 12:11:13

MR. STRONG: Could you read back that last question? I didn't get that down.

MR. FINELLI: Take one minute. 12:11:25

(Record read.)

(Recess taken.)

Q. Doctor, I think you testified that if Mrs. Tarle was having good contractions during the period of 7 p.m. to 12 midnight, you would have wanted to section her? 12:15:11

MR. SCHOBERT: Objection.

MR. STRONG: Objection.

MR. SCHOBERT: I don't think that's his exact testimony, but go ahead, Doctor. 12:15:21

A. I was thinking about my answer.

MR. FINELLI: Do you want to go back and read that? Can we go back to that?

(Record read.)

Q. Let me clean this up. Doctor, I 12:18:28

thought I asked you if you thought she had arrested labor at 11:30 p.m. you would have wanted to section her, correct? 12:18:30

MR. SCHOBERT: Objection. I think it's been asked and answered. Go ahead. 12:18:37

MR. STRONG: Objection.

A. If we had, if we had, yeah, if we had labeled her as being in an arrested state, we would have sectioned her, yes.

Q. And why would you have wanted a section? 12:18:48

A. Because --

MR. SCHOBERT: Objection.

A. -- there would have been no other way to deliver. We already said that. I mean if she's arrested her labor, she can't deliver vaginally, then she has to be delivered by C section. 12:18:53

Q. And if you don't deliver her by C section at that time, what happens to the fetus? 12:19:03

MR. STRONG: Objection.

MR. SCHOBERT: Again, on the hypothetical, objection.

Q. At 11:30 p.m.? 12:19:08

MR. SCHOBERT: Assuming an arrest of labor? 12:19:09

Q. Assuming an arrest of labor, you don't section her, what happens to the fetus?

MR. SCHOBERT: All right. Objection. Go ahead. 12:19:14

MR. STRONG: Objection.

A. I don't know that there's anything that happens to the fetus. I suppose, I mean I don't know, I mean if there's no -- if the baby is doing fine, if you don't section immediately, probably nothing is going to happen to the baby. 12:19:21

Q. Would that be the standard of care, if you considered arrest of labor at 11:30, to have sectioned her? 12:19:45

MR. STRONG: Objection.

MR. SCHOBERT: Objection. Go ahead.

A. Would that be standard of care? 12:19:57

Q. If you thought at 11:30 that she had an arrest of labor and you said you wanted to section her, would that be the standard of care?

A. At that time, yes. 12:20:05

MR. SCHOBERT: Let him -- go ahead. Objection. 12:20:05

A. If at that point you considered her arrested, yeah, the standard of care would be to do C section. 12:20:11

Q. And the reason that you prospectively or retrospectively did not think she had an arrest of labor at 11:30 was that she was not having adequate contractions?

A. The reason was that the updates that I was getting from the residents, it seemed reasonable to give her some more time. So, first baby, they weren't giving me really any concerns about the way the baby was doing, the Pitocin had been turned off for a period of time, restarted, I don't recall specifically, you know, what we talked about with regards to her contractions, but it didn't seem like we needed to intervene at that point. 12:20:28 12:20:43

Q. Based on the documentation, it states that you were notified, correct, at several points in time? 12:21:10

A. Correct.

Q. What is the type of information that you would want to know when a resident 12:21:22

calls you in regards to someone that's in labor? 12:21:25

A. We generally talk about fetal heart tracing, mother's comfort level, contraction pattern, and any other concerns or problems that may have arised, to fevers, et cetera. 12:21:40

Q. And what was your knowledge of the contraction patterns that Mrs. Tarle was having between 7 p.m. and midnight on August 4?

A. I don't recall. I really don't recall, I don't recall specifically what our conversations were with regards to that. 12:21:55

Q. Based on the lack of progression between 7 and midnight relative to her dilation, would your care at midnight change based on the type of contractions she was having between that period of time? 12:22:13

MR. SCHOBERT: Objection.

MR. STRONG: Objection.

Q. You want me to rephrase that? 12:22:34

A. Yeah, would you?

Q. Okay. Based on the lack of progression of her cervical dilation between 7 p.m. and midnight on August 3rd, is the types of contractions or the contraction pattern that 12:22:49

she's having significant to you as far as the management and care of that patient at midnight? 12:22:51

A. The contraction pattern is part of the overall assessment of it, yes. 12:23:01

Q. And how would that play a role?

A. I don't know that that by itself would push me one way or the other. I mean you have to take everything into account, the fact that it's her first baby, what the fetal heart rate tracing looks like, and what's been going on leading up to that point. 12:23:12

The fact of the matter is this patient didn't arrest, I mean she went to complete dilation, and had it not been for the fetal heart rate tracing going bad, she may have been able to deliver vaginally, so I don't see how you can argue an arrest disorder in this particular patient. 12:23:24

Q. At 11:30 at night on August 3rd, if she was having good contractions between 7 p.m. and 11:30, based on her labor curve here, would there have been any change in your care or therapy? 12:23:36

MR. SCHOBERT: Objection. Asked 12:23:50

and answered. Go ahead. 12:23:51

A. Repeat it.

Q. Okay. You talked a little bit about the knowledge that you received from the physicians, the residents that were calling you. Absent anything documented here, how is it that you have recollection of what they told you as far as the fetal heart tracings or the reassuring patterns? 12:24:20

A. I just remember in general, just very generally that the conversations that we were having were very positive. They were simply calling me, updating me on the progress, letting me know that there were some variable decelerations, but overall they felt like the heart rate tracing looked fine, and as a result of everything they were telling me, we felt like it was reasonable to kind of allow things to progress. 12:24:32 12:24:50

Q. So based on your recollection, there was no concern in the phone conversations you had with the residents relative to her care from either Dr. McKelvey, Dr. Drake or Dr. Sanders? 12:25:06

A. Not until she -- 12:25:17

MR. STRONG: Objection. 12:25:18

A. -- went for a C section.

Q. If you look at the progress note, I think it's 2225, when it says called Dr. Ferris and discussed, and it has arrested status 12:25:36 crossed out?

A. Right.

Q. Was there ever concern expressed to you that this patient had arrested in her labor? 12:25:49

A. No, not that I recall.

Q. And if it was discussed with you, your response would have been what?

MR. STRONG: Objection.

MR. SCHOBERT: Objection. 12:26:01 Hypothetical. Go ahead.

A. If Dr. Drake or Dr. McKelvey had called me up and said that they felt that she wasn't going to make it and that she was going to need a C section, I would have came in to 12:26:11 assess it myself.

Q. Okay. Whose decision would it be in Mrs. Tarle's situation as to whether or not this patient goes for a C section? The residents' or yours? 12:26:23

A. It's my decision. 12:26:24

Q. Can the residents, if they -- can the residents make the decision to take Mrs. Tarle for a C section?

A. Only in emergency. 12:26:31

Q. And what would constitute an emergency?

A. A bad heart rate tracing. Or, you know, that would be probably it, bad heart rate tracing. 12:26:44

Q. And what would you consider a bad heart rate tracing?

A. Heart rate tracing that looked like there could be some fetal compromise or fetal distress, if there was just any pattern that 12:26:59 would be deemed very nonreassuring and didn't resolve to standard methods. It's a judgment call.

Q. And if that is a consideration by Dr. McKelvey or Dr. Drake, they can take that 12:27:16 patient for emergency C section?

A. Right, they would notify me in a normal situation, they would notify me, tell me what their concerns were, and if they really felt like there was distress on the fetus, I 12:27:31

would not tell them to not do it, I would say go ahead and deliver the baby and I'll be there as soon as I can. 12:27:33

Q. Would they still have to get your authority to proceed with an emergency C section? 12:27:42

A. Yeah, probably. I mean I can tell them, I guess, I can tell them not to do it, but I don't know why I would do that.

Q. But before they would proceed to the OR, they would call you to get your authority to say yes? 12:27:51

A. To tell me, yes.

Q. Even on an emergency basis?

A. Right. 12:27:59

Q. Whose responsibility would it be to take Mrs. Tarle to an emergency C section? Talking about care decisions, whose responsibility? Would it be your responsibility as to when she goes for an emergency C section? 12:28:21

MR. SCHOBERT: I'm going to object.

A. I'm not sure I know how to answer that question. I mean if I'm not physically at the hospital, then I have to rely on the 12:28:29

physicians that were there. And that's why they have a 24-hour attendant there, to step in in emergency situations like that. 12:28:32

Q. But you are the attending physician and were the attending physician for Mrs. Tarle on August 3rd, 98? 12:28:41

A. That's correct. That's correct.

Q. And as the attending physician, the management and care that Mrs. Tarle receives is ultimately your responsibility? 12:28:50

MR. SCHOBERT: Objection.

A. In an ideal world, that would be a very simple way of putting it, but I think in a real world, there are situations that arise where you have to rely on the people that are at the hospital to do the right things in your absence. And that's true of any doctor in any situation. 12:29:14

Q. And in the real world, if you were concerned and you were not at the hospital, you had every opportunity to go to the hospital and evaluate Mrs. Tarle for yourself? 12:29:20

MR. SCHOBERT: Wait, objection, I'm not sure, you're talking about generally or are you talking about specifically in this case? 12:29:32

MR. MARGOLIS: He said Mrs. Tarle. 12:29:35

MR. FINELLI: Mrs. Tarle.

MR. SCHOBERT: Well, read the question back so he hears it because it started off one way and ended a different way. 12:29:39

(Record read.)

MR. SCHOBERT: Okay. Object. Go ahead. You can answer.

A. That is a question?

Q. Uh-huh. 12:29:56

A. Is that a question? Can you please rephrase the question?

Q. In the real world, you're talking about the real world and then we're talking about responsibility and I'm saying in your 12:30:02 real world, that's your phrase, that if you had any concerns as far as the care or management of Mrs. Tarle, you had every opportunity for you, as the attending physician, to go to the hospital and evaluate Mrs. Tarle for yourself? 12:30:13

A. If there were concerns that arose prior to her going for a C section, yes, I would have gone in and evaluated her myself.

Q. Right, and as part of your responsibility, you had an opportunity to do 12:30:23

that? If the need arose, in your mind? 12:30:3

A. If there was a need, yes.

Q. All right. So that, in effect, as the attending physician, responsibility of Mrs. Tarle comes under you, as far as your care and 12:30:3 management during her labor and delivery?

MR. SCHOBERT: Objection.

Q. You're the attending, you're the one that's billing for the services, correct?

MR. SCHOBERT: Objection. Asked 12:30:4 and answered.

MR. MARGOLIS: It hasn't been answered, respectfully.

MR. SCHOBERT: We can be discreet about it, but I'm going to object and indicate 12:30:5 that I think it's been asked and answered. Go ahead, Doctor.

A. I think, I understand what you're asking me, but I think in emergencies the responsibility has to, it switches to the 12:31:0 people that are there. If I'm not physically there, it's hard for me to be responsible for what's happening.

Q. Let's break it down this way: Between the time she was admitted on August 3rd 12:31:

at 9 a.m. until 6 p.m. on August 3rd, was the care and management of Mrs. Tarle your responsibility? 12:31:37

A. To?

Q. 6 p.m., from the time she was admitted at 9 a.m. to 6 p.m. on August 3rd. 12:31:38

A. Care, based on the information I was receiving, it's my responsibility, yes.

Q. If you had not received any information, is Mrs. Tarle your responsibility, as the attending physician? 12:31:53

A. Talking about theoretically, if nobody calls me at home about the patient, is she my responsibility?

Q. Yes. 12:32:08

A. Of course she is. But if I'm not getting any calls, then I'm probably going to be there doing the work myself.

Q. And based on the information you received on Mrs. Tarle from 9 a.m. to 6 p.m., is she your responsibility? 12:32:17

MR. SCHOBERT: Did you say a.m.? I'm sorry.

MR. FINELLI: 6 p.m. 9 a.m. to 6 p.m. 12:32:28

MR. SCHOBERT: Objection. Asked and answered. Go ahead. 12:32:29

A. Yes.

Q. She is your responsibility?

A. I am responsible for what's happening based on the information that is being given to me. 12:32:32

Q. And based on the information you received on Mrs. Tarle from 6 p.m. to midnight on August 3rd, is the care and management of Mrs. Tarle your responsibility? 12:32:42

A. Sure. And as it is the next period of time. And then --

Q. Let's take it one at a time because we were confused earlier. So between 9 a.m. and 6 p.m. she would have been your responsibility? 12:32:5

MR. SCHOBERT: Objection. Go ahead.

A. Right. 12:33:05

MR. FINELLI: Did you pick that up?

THE NOTARY: Yes.

A. I mean I think the same as we talked about before, sure, I mean decisions based on the information are my responsibility. 12:33:

It's always a decision to make for the C section. 12:33:16

Q. Because I was confused with your answers, I'm breaking it down in these steps. From 12 a.m. on August 4th, 98 through the time that she delivers on August 4th, 98, was Mrs. Tarle your responsibility, as far as her care and treatment? 12:33:28

MR. SCHOBERT: Objection. Go ahead. 12:33:38

A. The decision that was made for the C section was my responsibility. Based on the information I was getting. I mean the responsible thing to do, when they call and tell me the heart rate tracing is going down, is to do an emergency C section. 12:33:49

Q. So is your answer to your question --

A. Whether I'm there or not. Right. Right. I'm telling you my responsibility would be to tell them to start the C section and go. 12:33:57

Q. Was there ever a consideration of CPD in Mrs. Tarle?

A. Consideration for CPD?

Q. Yes. 12:34:35

A. I would say yes. 12:34:35

Q. At what point in time?

A. During that period of time where she was falling off the labor curve, we were considering it. 12:34:42

Q. Is that something you would have discussed with the residents, do you recall, CPD?

A. I mean CPD is along the same continuums of arrest of labor or arrest of dilation and labor, it's all basically the same thing. We have already told you that and I don't think that that was the case and the record would reflect that that's true, she didn't arrest, she got to complete dilation. 12:34:5 12:35:0

Q. What is CPD?

A. Cephalopelvic disproportion.

Q. And how does that impact on labor and delivery?

A. Well, I mean very generally it means that the head is not going to fit through the pelvis. 12:35:1

Q. Okay. How is that diagnosed?

A. It's a clinical diagnosis, clinical diagnosis. In my mind, CPD is a diagnosis 12:35:?

that's made when a woman reaches complete dilation and tries to push. I don't think you can make that diagnosis prior to that. 12:35:38

Q. You mentioned earlier that Mrs. Tarle had fallen off the labor curve. 12:35:50

A. Correct.

Q. Did you have any concerns or considerations when she fell off the labor curve?

A. In what sense? 12:35:59

Q. In any sense, medical sense.

MR. SCHOBERT: Objection. This has been asked and answered. Go ahead.

A. The only concerns, you know, like I said before, during that period of time, the updates I was getting were reassuring and we felt reasonable to allow her labor to progress. I mean did I feel like there was a problem with the fetus? Of course not. If I did, we would have done something. 12:36:12 12:36:28

Q. Was Mrs. Tarle ever made aware by you or your group that her care on August 3rd during labor and delivery was going to be provided by resident physicians?

A. I'm not aware. 12:36:44

MR. MARGOLIS: What did he say? 12:36:47

THE WITNESS: I'm not aware of that.

MR. FINELLI: I want to mark this as Plaintiffs' Exhibit 1. 12:37:

A. I will tell you that all patients have the opportunity to refuse having residents take care of them. All patients have that right.

- - - - -

(Thereupon, Ferris Deposition Exhibit 1 was marked for purposes of identification.)

- - - - -

MR. FINELLI: She can't -- 12:37:1

THE NOTARY: That's all right.

MR. SCHOBERT: You want to look at it? He's going to ask you about it. That's out of his chart.

MR. FINELLI: Was that the original? 12:37:34

MR. SCHOBERT: Yes.

MR. FINELLI: I'm sorry, I would have made a copy and marked it.

MR. MARGOLIS: It's all right. We 12:37:3

put it back in the chart. 12:37:39

MR. SCHOBERT: We'll put it back and if you want to make a --

MR. MARGOLIS: I'm just going to ask the court reporter to take the whole chart and copy it and then get it back to you. 12:37:45

MR. SCHOBERT: Why don't we talk about that.

Q. Doctor, you have been handed what's been marked as Plaintiffs' Exhibit 1. Can you identify that? 12:37:53

A. This is a document dated at the time.

Q. Summarize, what's the content of the document? 12:38:05

A. Just talks about our fees and our contact at the insurance companies and where they may possibly be getting other -- it's mostly a financial thing.

Q. Does it talk anything about the labor and delivery or her hospitalization for delivery? 12:38:25

A. No, but I don't think that's the intent of this. This is more just, this looks more geared towards payment and where your fees 12:38:34

will be coming from and insurance companies, and there is a, I think there is a consent form that they sign when they are admitted for labor and delivery that talks about the residents being involved. 12:38:39 12:38:53

Q. And in that consent form it talks about the residents providing care?

A. I think so.

Q. Is there a consent form in these --

MR. MARGOLIS: I think he's talking about the hospital records. 12:39:04

A. Yeah, the hospital.

Q. Is there a consent form in the hospital records?

A. I don't know. But I think -- 12:39:0

Q. Are you looking at the consent form?

A. This looks like the consent form right here, for the hospital.

Q. And I guess my question is is there anything in there that discusses resident care? 12:40:0

A. It talks about assistants, but I don't know if it talks -- this is a hospital form, so this is the first time I'm actually looking at this, too. 12:40:1

Q. Other than assistants, any mention of residents providing care? 12:41:14

A. I don't see anything.

Q. Was Mrs. Tarle ever informed by you, meaning you or your partners, that she was going to have resident care entirely from the time of her admission on August 3rd up through her delivery? 12:41:23

MR. SCHOBERT: Object. That's not what transpired. 12:41:34

A. I don't know.

Q. You mentioned that Mrs. Tarle had the opportunity to refuse resident care. Do you know if she had an expectation of either you or your partners coming in to provide care for her from the time she was admitted to the time she delivered by C section? 12:41:43

A. I don't have any idea what her expectations were.

Q. Because it's something you did not discuss with her, correct? 12:41:59

A. I don't recall discussing it with her.

Q. The Pitocin was discontinued at approximately 1945 on August 3rd, correct? 12:42:09

Q. And you're saying from based on fetal monitor strips 66340 through 66341, there was evidence of variable decelerations? 12:47:0

MR. STRONG: Objection. I think he said variable with a late component, twice. 12:47:4

A. With a late component. And lasted for about five minutes.

Q. And that would be indicative of cord compression?

A. Variable decelerations are generally thought to be caused by cord compression. 12:47:5

Q. And you agreed that cord compression can cause compromise to fetal blood flow? Talked about that earlier. 12:48:06

A. Cord compression can decrease fetal blood flow, sure.

Q. And can lead to fetal hypoxia?

A. If it's prolonged.

Q. Would this be considered prolonged? 12:48:19

A. Not at all.

Q. At what station was she at this point in time?

A. Minus 1.

Q. Would you expect a baby that's a 12:48:4

minus 1 station to have cord compression? 12:48:42

A. Baby can have cord compression at any station.

Q. Was this information communicated to you at the time? 12:48:53

A. I don't recall specifically.

Q. Or anytime thereafter?

MR. SCHOBERT: You mean turning Pit off, that is what you're asking, Dan?

MR. FINELLI: Right, and on the 12:49:06 fetal heart tracings and the resuscitative measures that were instituted.

MR. SCHOBERT: Do you have specific recall of that today?

A. I don't recall at 1830 if I was 12:49:13 notified about that or not.

Q. At any time do you recall if you were notified of this information?

MR. STRONG: Objection. Asked and answered. 12:49:24

MR. SCHOBERT: Go ahead.

A. No, I don't recall if I was notified about this. I do recall being notified that the Pitocin was off.

MR. SCHOBERT: You heard that. He 12:49:34

said he does recall being told the Pitocin was off at some point. 12:49:34

Q. Is this the type of information that you would expect to be told about by the residents, the change in fetal heart tracings, resuscitative measures? 12:49:45

A. Usually, if it's persistent. I mean if they have a patient like this who has four or five variables and then it resolves, they may not tell me about that. 12:49:56

MR. MARGOLIS: That's not responsive to what you asked.

MR. FINELLI: Can you read that back?

(Record read.) 12:50:09

Q. So based on your answer, due to the fact that this wasn't prolonged, this is information that may have not been conveyed to you?

A. Possible. 12:50:43

Q. If this information was conveyed to you, would it have impacted upon the decisions in your care?

A. Not at all.

Q. Looking -- have you had a chance to 12:51:00

review the fetal monitor strips? 12:51:02

A. Yes.

Q. Is there -- were you ever told during the course of her admission during labor and delivery there were any strips that were 12:51:13 nonreassuring?

A. No, not until the very end.

Q. When she went for emergency section?

A. Right. 12:51:26

Q. Up until the time she went for emergency C section, based upon your review of the fetal monitor strips, were there any tracings that you interpreted as nonreassuring?

A. No. 12:51:37

Q. What is a nonreassuring pattern?

A. A lot of that has to do with judgment and experience, but any persistent severe variable decelerations, persistent late decelerations with lack of variability would be 12:52:06 considered concerning, or a bradycardia like she had.

Q. And you're stating most of that is based upon experience as an OB-GYN physician?

A. Right. A lot of times you can see 12:52:21

a heart rate tracing, and even though it has some of that features, those features, you may not be as concerned about it as other times. Based on the variability and other factors. 12:52:24

Q. And in this case you were relying, as far as the interpretation of the fetal heart tracings, on the experience of OB-GYN residents? 12:52:40

A. Well, yes.

Q. At any point in time, other than 1830 on August 3rd, were there any, was there any other point in time where resuscitative measures were implemented on Mrs. Tarle, if you know? 12:52:55

A. Looks like at 8:25 she was put on her left side, had oxygen on. 12:53:39

Q. I'm sorry, what time?

A. 8:25.

Q. P.m.?

A. P.m. Go back all the way. 12:53:48

11:30, looks like they did the same thing.

MR. SCHOBERT: What time?

THE WITNESS: 11:30.

Q. 11:30 p.m.? 12:54:45

A. P.m. 12:54:48

Q. Were those two instances in time, as far as the resuscitative measures, conveyed to you by the residents?

A. I don't recall if I was 12:55:12
specifically told about that or not.

Q. In the habit of your practice in dealing with resident care, is that type of information that is normally conveyed to you or
that you request? 12:55:24

A. Again, it really all depends on the clinical situation. Sometimes, you know, we see fetal heart rate decelerations so often during the course of a labor that oftentimes
it's just done by the nurses without notifying 12:55:46
anybody. So I can't say whether we specifically talk about it every single time it happens. I would say that's probably not the case, but --

Q. But in this case it was brought to 12:56:07
the resident's attention?

MR. STRONG: What was that question? I didn't hear that.

MR. SCHOBERT: I believe the
question was -- 12:56:12

Q. In this case --

MR. SCHOBERT: -- I assume the nurses brought it to the resident's attention, that is the question? 12:56:13

MR. MARGOLIS: Yes, he said many times the nurses don't even let anybody know about the changes in the fetal heart rate. 12:56:17

MR. STRONG: I know, I just wanted to hear what the question was.

Q. But in this case it was brought to the resident's attention? 12:56:25

A. Doesn't say that.

MR. SCHOBERT: Well, again --

A. I don't know that that happened. It doesn't say that anybody told the resident about it. 12:56:36

Q. If you look at 2320 on the nursing observation, are you with me, Doc?

A. Yes.

Q. You see where Dr. Drake was notified? 12:56:56

A. Correct, he was notified of the variable decelerations. Ten minutes later is when she put the oxygen on, turned her. Doesn't say anything about notifying anybody at 12:57:06

Q. Is that your answer? Would you then agree with the question or disagree with the question? 12:58:08

A. You're saying preservation. I don't know that that's how I would word it. You're assuming this baby was healthy when we went in on this. 12:58:16

Q. I'm saying in general, during labor, one of the goals of --

MR. SCHOBERT: Objection. Go ahead. 12:58:27

A. The goal is to deliver the mother and infant safely and healthy.

Q. And if there is fetal distress, the remedy is certainly treating the underlying cause or prompt delivery of the fetus? 12:58:41

MR. SCHOBERT: Objection.

A. I'd say that's fair to say.

Q. Would you agree the goal of fetal heart monitoring is to detect fetal hypoxia at its earliest stage? 12:58:51

A. I don't think fetal monitoring detects fetal hypoxia. It detects abnormalities in the fetal heart tracing which could lead to a problem. 12:59:17

that point. 12:57:08

Q. You do agree that it says Dr. Drake notified?

A. Yes.

Q. As you sit here today, you can't tell us what Dr. Drake -- the information that was notified to him? 12:57:14

A. I can't say one way or the other.

Q. Would you agree the goal to be pursued constantly during labor is preservation of fetal well-being by early detection and relief of fetal distress? 12:57:28

MR. SCHOBERT: Objection. Go ahead.

A. Can you say that again? 12:57:40

Q. Okay. The goal to be pursued constantly during labor is preservation of fetal well-being by early detection and relief of fetal distress?

MR. SCHOBERT: Objection. Go ahead. 12:57:54

Q. It's one of the goals; is it not?

A. I think the goal is to deliver a healthy baby and a healthy mom, get the mom through okay, is the goal. 12:58:04

Q. Okay. So the goal of fetal heart monitoring is to detect abnormalities at the earliest possible time? 12:59:20

A. Right.

Q. How do you determine evidence of fetal distress during labor? Are there specific things you look for? 12:59:35

A. I think we talked about this once.

MR. SCHOBERT: Yes, objection.

A. Severe persistent variable decelerations, persistent late decelerations, fetal bradycardia, prolonged absence of fetal variability, would be some of the things you would look for. 12:59:46

Q. How about fetal scalp blood pH? 12:59:58

A. Fetal scalp blood pH is done at specific times based on the heart rate tracing.

Q. When is it indicated to do fetal scalp blood gauge determinations?

A. At any point in time that the physician taking care of the patient wants more information as to the well-being of the baby. Based on the heart rate tracing. 13:00:12

Q. And at what point in time would they want information, based on what type of 13:00:26

fetal heart tracing? 13:00:29

A. Well, it's like we talked about.

Q. I'm sorry?

A. Just like in those instances like that we talked about. If there's persistent 13:00:39 variations of the fetal heart rate tracings to cause them enough concern to see if the baby is tolerating labor okay or not.

Q. So in bradycardia, a fetal heart tracing in bradycardia, you would want to get a 13:00:53 fetal heart pH?

MR. SCHOBERT: Objection.

A. Depends on the situation. Not on every bradycardia would you do that.

Q. On which bradycardia would you want 13:01:02 to do that?

MR. SCHOBERT: Objection.

MR. FINELLI: If he doesn't want to give me a specific answer, then I'm going to play general with him. 13:01:09

MR. SCHOBERT: I think in general the question is --

A. There's no way to give a specific answer.

MR. SCHOBERT: They're very 13:01:14

general. I mean he's told you that sometimes you do it and sometimes you don't. If you give him a specific example, maybe then -- 13:01:15

Q. At any point during Mrs. Tarle's care would you have wanted to obtain a fetal scalp blood pH? 13:01:24

A. No, but I do recall discussing that with Dr. Drake at one point.

Q. When?

A. I don't recall exactly when the time was. But I do recall him telling me about the fetal heart rate tracing and I asked him specifically do you think we need to do a pH, and he said no, I think the pattern looks good. 13:01:35

Q. So it was you that brought up the option of obtaining a fetal scalp blood gauge? 13:01:49

A. Right.

Q. And it was Dr. Drake that said he didn't think it was necessary?

A. Right. 13:02:00

Q. And based on his observation and his experience, you decided not to get a fetal scalp blood gauge?

A. Right.

Q. You don't recall what time? 13:02:14

A. I don't recall what time. 13:02:16

Q. But at some -- he had some concern with the fetal heart tracing at that point in time?

A. No, he called to update me on her care and I asked him if he thought that it was -- that we should do one, and he said no, really it doesn't look like it's necessary right now. We'll keep an eye on it. 13:02:23

Q. What is amnio infusion? 13:02:38

A. It's infusion of saline into the uterus to try to hydrodistend it a little bit to resolve variable decelerations due to cord compression.

Q. Was there any indication in Mrs. Tarle's care to provide amnio infusion? 13:02:57

A. Her variable decelerations were never persistent, so probably not. And after midnight her pattern looked great, so I don't think there was any indication to do it. 13:03:17

Q. When do you, during labor and delivery, when do you institute tocolytic agents?

MR. STRONG: Total what?

MR. SCHOBERT: Tocolytic agents. 13:03:36

A. Tocolytic agents? 13:03:38

Q. Right.

A. To try to stop premature labor. And occasionally we'll give the tocolytic agent when we think we have a hypertonic uterus, 13:03:48 overstimulated uterus.

Q. So I guess other than premature, in someone that is due gestationalwise or even late, when would you give a tocolytic agent?

A. You'll have to say that again. 13:04:11 Rephrase it.

Q. You talked about someone in a premature status. Someone that is in labor and delivery that is due or that is actually late, when would you give a, what indication would 13:04:21 you have to give a tocolytic agent?

A. I would say only in a situation where you felt the uterus was hyperstimulated.

Q. And how does a tocolytic agent act?

A. It acts to relax the uterine 13:04:34 muscle.

Q. And improves fetal oxygenation?

A. Well, it will improve blood flow, and thereby possibly improve fetal oxygenation.

Q. Was there any indication during 13:04:48

Mrs. Tarle's care for her to receive tocolytic agents? 13:04:50

A. There was a reason to give a tocolytic agent when she went into bardycardia.

Q. I'm sorry? 13:04:59

A. It was reasonable to give a tocolytic agent when she went into the bradycardia at the end.

Q. Anytime before that?

A. Not that I could see. 13:05:19

MR. FINELLI: Let's take a one-minute break. I'm almost done.

(Recess taken.)

Q. Doctor, when you are reviewing, during a patient's labor and delivery, when you are reviewing the fetal heart tracings, you're doing that as you are taking in the whole clinical picture, are you not, you're just not reviewing the tracings -- 13:11:50

A. Right. 13:12:02

Q. -- in snippets, you're reviewing the tracings as it relates to the clinical picture as far as her station, her dilation, and what's taken place prior to her course of labor, correct? 13:12:13

A. Sure. 13:12:14

Q. Okay. Now, I think you mentioned earlier, when you arrived at the hospital, the baby was already delivered?

A. Correct. 13:12:24

Q. Were you there at all during the resuscitative period for the baby?

A. Briefly.

Q. Can you tell me your knowledge of what happened during the resuscitation of the 13:12:33 baby?

MR. SCHOBERT: You're asking his recollections versus his review of the chart?

Q. His knowledge, yeah. Your recollection. 13:12:44

A. I mean I haven't reviewed anything as far as the chart goes, but my recollection was that the baby's heart rate was fine.

Q. When?

A. When I walked into the 13:12:56 resuscitation room. They had made mention what the heart rate was, I don't know what it was, whether it was 140s or something, normal.

Q. Can you tell me at what point in time post delivery did you walk into the 13:13:07

resuscitation room? 13:13:11

A. I don't know that for sure. I'm not sure how much time had elapsed between the time the baby was born and the time I had walked in there. It was minutes. Whether it 13:13:20 was two minutes or ten minutes, I don't know.

Q. When you walked in, was the baby already tubed?

A. Yes.

Q. And tell me what else you recall. 13:13:33

A. I recall that they had, they were having some trouble ventilating the baby. And there was mention that they weren't getting a lot of chest rise. And so then I remember they removed the tube and tried to bag the baby, 13:13:55 still weren't getting a lot of chest rise, and the anesthesiologist intubated the baby and got it going better.

Q. Who was involved with the resuscitation care at that point? 13:14:08

A. McKelvey was there, there was one or two nurses there, there was someone from anesthesia there.

Q. Did you partake at all in the resuscitative efforts? 13:14:23

A. No. 13:14:24

Q. What was your role once you got to the hospital? What did you do?

A. Well, my main responsibility is to the mom, the baby was being taken care of, so I 13:14:35 just briefly checked on the baby and then I scrubbed into the case.

Q. At what point in time, when you scrubbed in on the case, where were they as far as the care of Mrs. Tarle in the OR? 13:14:56

A. Where were they?

Q. I mean were they closing, were they --

A. Oh, no. No. Really nothing more had been done other than the delivery. I mean 13:15:11 I scrubbed in and basically finished the C section from that point. They hadn't put any sutures in even in the uterus yet, I don't think.

Q. When you scrubbed in, who was in 13:15:24 the room as far as physicians taking care of her?

A. Dr. Cook and Dr. Drake were still with the mother.

Q. And what did you do when you went 13:15:35

in? 13:15:37

A. When I scrubbed into the case?

Q. Yes. Right.

A. I just finished the C section with Dr. Drake. Dr. Cook scrubbed out at that point. 13:15:42

Q. So Dr. Cook scrubbed out when you scrubbed in?

A. Right.

Q. And you completed the closure of the uterus? 13:15:52

A. Closure of the uterus and the rest of the case.

Q. Were there any complications to Mrs. Tarle at the point in time when you scrubbed in? 13:15:59

A. There was some concern about the bladder, but it turned out to be fine. There was no -- they thought there might have been an injury to the bladder, but there wasn't, so there was really no complication. 13:16:11

Q. Was the placenta already removed?

A. Yeah.

Q. Was there any evidence of abruptio placentae? 13:16:24

A. It was conveyed to me that they thought she had abrupted. Now, I don't recall there being any, I don't recall there being any visible evidence other than there wasn't a lot of blood left in the umbilical cord. 13:16:25 13:16:38

Q. And not a lot of blood left in the umbilical cord, is that pathognomonic for abruptio placentae?

A. Not at all.

Q. At any point in time up to her time that she went for surgery, did she have any vaginal bleeding or hemorrhaging? During her labor. 13:16:50

A. Oh, not that I was made aware of, no. 13:17:04

Q. When you determine that a patient needs to go to emergency C section and you're in the hospital, what is the checklist that you go through? Who are the people you notify? What do you do? 13:17:16

MR. MARGOLIS: In Akron General.

A. You would notify anesthesia, you would notify either the nursery or a neonatologist, depending on your -- depending on what the situation was. And of course you 13:17:32

would ask the labor and delivery personnel to get a room ready, stuff like that. 13:17:39

Q. So you would notify anesthesia, an anesthesiologist. Do you do that personally or do you have somebody do that? 13:17:49

A. Usually we just delegate a nurse to do that as we're getting ready for the C section.

Q. I see. So in general, generally it's the nurse's responsibility to notify anesthesia, or an anesthesiologist? 13:17:58

A. That's generally how it works.

Q. And you also mentioned you either notified nursery or a neonatologist?

A. Right. 13:18:10

Q. If a neonatologist is not in the hospital, you notify nursery?

A. Right. Yes.

Q. You notify nursery irrespective of whether a neonatologist is in the hospital or not? 13:18:21

A. Right. Yes.

Q. If a neonatologist is not in the hospital, do you notify a neonatologist?

A. It depends on the situation, 13:18:29

oftentimes we will, it really just depends on what your index of suspicion is as far as what the baby's going to -- how the baby is going to do. 13:18:32

Q. In Mrs. Tarle's case, was there an index of suspicion where a neonatologist should have been notified? 13:18:44

A. I think the neonatologist was notified because of the heart rate tracing, the degree of the bradycardia. 13:18:56

Q. Do you know if a neonatologist was in the hospital at the time that she went to emergency C section?

A. I don't know. I don't know that for sure. I don't think there was one in the hospital at the time. 13:19:06

Q. We know that Dr. McKelvey initiated the emergency C section, but eventually she scrubs out to assist in the resuscitative efforts of the baby? 13:19:32

A. Right.

Q. Is that normal for the surgeon to scrub out and assist in the resuscitative efforts?

A. It's not normal for the attending 13:19:38

surgeon to do that. It would be normal for an upper level resident to scrub out to do that. 13:19:40

Q. But in this case she was the primary surgeon on the case, correct?

A. Well, I would say Dr. Cook would have been the primary surgeon. He was the acting attending at the time. 13:19:53

Q. So is it your knowledge, are you saying that Dr. Cook was in the operating room at the beginning of the emergency C section? 13:20:04

A. I don't know about that. But once he was scrubbed in, I mean he would have stayed in with the mother.

Q. And it would not have been unusual for Dr. McKelvey to have scrubbed out and do resuscitative efforts? 13:20:18

A. Right.

Q. Do you have any criticisms of how any physicians or surgeons performed in the emergency room? And we talked about Dr. Cook, and you said you didn't have any criticisms of him. Anyone else? 13:20:28

A. Not really. I think they did it as quickly and as efficiently as they could, so no, I don't really have any criticisms about 13:20:47

the C section itself. 13:20:50

Q. Do you have any criticisms of anyone involved in the resuscitative efforts of the baby?

MR. SCHOBERT: Objection. 13:20:55

A. I wasn't there the whole time, so I have a hard time answering that question, like I said. The only thing that I saw that I guess would be at all concerning was that they were just having a little troubling ventilating 13:21:10 during that brief period of time that I was there, but, you know, what had happened prior to that or after that, it's hard for me to comment on the whole thing.

Q. We talked about the surgeon 13:21:30 scrubbing out. Is it normal or is it routine for the anesthesiologist to scrub out on the case to assist in the resuscitative measures?

A. There was probably an anesthetist in the room with the patient, with Michele, the 13:21:45 mother, so, you know, honestly, that's the first and only child I've ever had at Akron General where resuscitation was required of that degree, so I don't know if they usually have an anesthesiologist there to help or not. 13:22:04

Q. But if I heard you correctly, you are saying besides the anesthesiologist, there was also an anesthetist? 13:22:08

A. I think there was an anesthetist with, you know, still back with the C section. 13:22:17

Q. Right, in the OR room?

A. Right.

Q. Do you have an opinion as to what caused the neurological deficits in this baby?

A. I don't have an opinion on that. 13:22:30

MR. SCHOBERT: And he won't. If that will change, I will tell you, but I don't expect to ask him that question.

(Discussion had off the record.)

MR. FINELLI: I have no further questions. 13:23:05

MR. SCHOBERT: Rick?

MR. STRONG: I have no questions today.

MR. SCHOBERT: Doctor, you have the right to review the transcript, and I would advise you to exercise that right. 13:23:08

THE WITNESS: Yes, I will review it.

(Deposition concluded at 1:23 p.m.)

CERTIFICATE

The State of Ohio,)

SS:

County of Cuyahoga.)

I, Denise M. Munguia, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, EDWARD FERRIS, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 17th day of January, 2002.

Denise M. Munguia

Denise M. Munguia, Notary Public
within and for the State of Ohio

My commission expires May 23, 2005.

I N D E X

SIGNATURE OF WITNESS

The deposition of EDWARD FERRIS, MD taken in the matter, on the date, and at the time and place set out on the title page hereof.

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

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

AFFIDAVIT

The State of Ohio,)

) SS:

County of Cuyahoga)

Before me, a Notary Public in and for said County and State, personally appeared **EDWARD FERRIS, MD**, who acknowledged that he/she did read his/her transcript in the above-captioned matter, listed any necessary corrections on the accompanying errata sheet, and did sign the foregoing sworn statement and that the same is his/her free act and deed.

In the TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at this_____ day of_____ A.D 2001.

_____

Notary Public

_____

My Commission Expires:

DEPOSITION ERRATA SHEET

RE: **MACKENZIE L. TARLE, A MINOR, ETC., ET AL. VS. AKRON GENERAL MEDICAL CENTER, ET AL.**

RRS File No.: **5274**

Deponent: **EDWARD FERRIS, MD**

Deposition Date: **JANUARY 9, 2002**

To the Reporter:

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

_____