

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, CV 2001 05 2137

et al.,

Defendants.

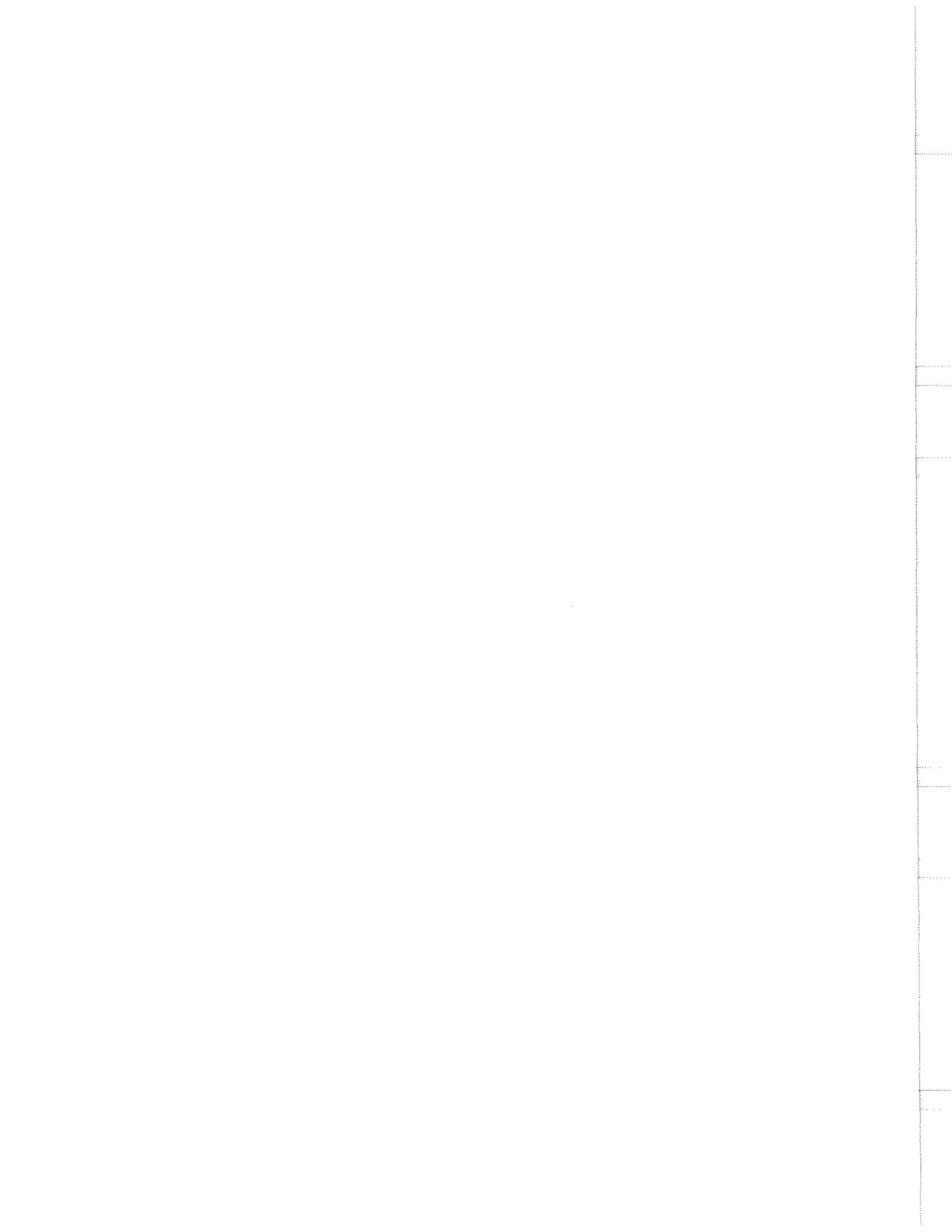
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Deposition of EDWARD FERRIS, M.D.,
called for examination under the statute, taken
before me, Denise M. Munguia, a Registered Merit
Reporter and Notary Public in and for the State
of Ohio, pursuant to notice and stipulations of
counsel, at the offices 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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11 ----

1 EDWARD FERRIS, M.D., of lawful age,
2 called for examination, as provided by the Ohio
3 Rules of Civil Procedure, being by me first
4 duly sworn, as hereinafter certified, deposed
5 and said as follows:

6 EXAMINATION OF EDWARD FERRIS, M.D.

7 BY MR. FINELLI:

8 Q. Good morning, Doctor.

9 A. Hi.

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

10:23:19

15 Have you ever had your deposition
16 taken before?

10:23:30

17 A. Yes.

18 Q. When was that?

19 MR. SCHOBERT: Note a continuing
20 objection.

10:23:34

21 A. Once when, once when I was a
22 resident in a case that got dismissed and once
23 recently in a case that was a house case
24 patient at the hospital that I was the
25 attending on for the day.

10:23:56

1 Q. Is it fair to say it was like a
2 clinic patient?

10:23:58

3 A. Clinic patient, yes. Yes.

4 Q. The one when you were a resident,
5 were you named as a defendant?

10:24:05

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

8 Q. And the one where you were the
9 attending physician, what was the disposition
10 of that case?

10:24:27

11 A. The house case?

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

14 A. I was. There's been no disposition
15 yet.

10:24:29

16 Q. That's ongoing?

17 A. Correct.

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

20 A. It was a infant house case patient
21 that delivered vaginally and then after that
22 had some problems, was transferred to
23 Children's Hospital.

10:24:38

24 Q. The infant? The infant had
25 problems?

10:24:56

1 A. Right.

10:24:53

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

4 A. Perantinides, I think his name is.

5 Q. Perantinides?

10:25:05

6 A. Yes.

7 Q. Mr. Perantinides?

8 A. Yes.

9 Q. Who was representing, who is your
10 local -- who is your counsel?

10:25:12

11 A. (Indicating.)

12 Q. Mr. Schobert?

13 A. Yes.

14 Q. That's filed in Akron?

15 A. I believe so, yes.

10:25:17

16 Q. Other than those two that we just
17 talked about, are there any other claims
18 against you which name you as a defendant for
19 substandard medical care, alleging substandard
20 medical care?

10:25:29

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

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

10:25:38

1 you don't understand my question or I need to
2 clarify it, please stop me, I'll repeat it or
3 rephrase it so that when you answer it, you're
4 answering it understanding the question
5 entirely.

10:25:41

6 A. Okay.

7 Q. Fair enough?

8 A. Yes.

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

10:25:50

11 You completed your residency in
12 1997?

13 A. Right.

14 Q. At Akron City Hospital?

15 A. Correct.

10:26:00

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

18 A. Correct.

19 Q. And just tell me what you did after
20 your residency, following your residency
21 completion.

10:26:10

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

24 Q. And you have been with them?

25 A. I have been with them ever since.

10:26:20

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

1 and GYN, something like that.

10:27:29

2 Q. How much GYN surgery do you do?

3 A. Do you want number of cases?

4 Q. Twenty percent of your GYN is

5 surgery? How much of GYN is surgery?

10:27:43

6 A. I don't know, that's a difficult

7 question to answer. I don't know if I have

8 that number off the top of my head. I do a

9 fair amount of surgery. I do surgery every

10 week, put it that way.

10:27:56

11 Q. Fair enough. Tell me about your

12 rotation, as far as your on-call schedule

13 between the physicians in Summit OB/GYN

14 Associates.

15 A. We split call equally.

10:28:07

16 Q. How often are you on call? Every

17 fourth night?

18 A. Every fourth weekend and usually at

19 least one weeknight a week.

20 Q. So one week during the month, then

10:28:20

21 every fourth weekend?

22 A. One weekend a month, every fourth

23 weekend, and then it would probably average out

24 to be one weeknight a week Monday through

25 Thursday.

10:28:34

1 Q. So that every night 24/7 there's
2 one of you from Summit OB/GYN on call?

10:28:34

3 A. Correct.

4 Q. And you take on-call from home?

5 A. Right.

10:28:45

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

8 A. Yes.

9 Q. How far do you live from Akron
10 General Hospital?

10:29:00

11 A. Akron General.

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

14 A. You mean miles?

15 Q. Time to drive.

10:29:08

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

18 Q. Approximately how many miles?

19 A. I guess at that time it would be
20 probably 12 to 14 miles, I would guess. I
21 really don't know for sure.

10:29:22

22 Q. You live in Hudson at the present
23 time?

24 A. Currently I do, yes.

25 Q. Were you living there in 1998?

10:29:30

1 A. No. 10:29:32

2 Q. Where were you living?

3 A. Cuyahoga Falls.

4 Q. Cuyahoga Falls. Okay.

5 Incidentally, during your residency, from 93 to 10:29:36
6 97, was Dr. Drake a resident in the OB-GYN
7 program?

8 A. When I was a resident? No.

9 Q. Was Dr. McKelvey?

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

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

16 A. The internship is part of the four
17 years.

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

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

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

1 only had six months of OB-GYN residency or
2 training?

10:30:31

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

10:30:43

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

10:30:57

11 A. They have their own separate
12 residency.

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

15 MR. MARGOLIS: Thanks.

10:31:09

16 Q. Are you board certified?

17 A. Yes.

18 Q. When did you take the boards?

19 A. November of 99, I think it was.

20 Q. And that was oral boards?

10:31:20

21 A. Correct.

22 Q. Are there written boards as well?

23 A. Yes.

24 Q. And you passed that as well?

25 A. Correct.

10:31:25

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

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

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

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

9 Q. You can apply for fellowship?

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

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

17 A. No.

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

20 A. Yes. 10:32:19

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

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

1 MR. SCHOBERT: I can supply you
2 that information.

10:32:40

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

5 MR. SCHOBERT: Yes.

10:32:46

6 (Discussion had off the record.)

7 Q. Doc, you know, I just have to go
8 through this line of questioning routinely.
9 Have you ever been convicted of a state or
10 federal offense?

10:33:51

11 A. No.

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

14 A. No.

15 Q. Your state medical license ever
16 been revoked, suspended or diminished?

10:33:56

17 A. No.

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

20 A. Currently we have three. In 98 I'm
21 not sure if that was true. We had at least two
22 at that time.

10:34:18

23 Q. In 98 Summit OB/GYN Associates
24 would have been working out of Akron City and
25 Akron General?

10:34:29

1 A. Correct.

10:34:36

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

4 A. Just a copy of the record, medical
5 records.

10:34:41

6 Q. You have the records from Akron
7 General Hospital?

8 A. Right.

9 Q. And your office records as well?

10 A. Right.

10:34:47

11 Q. Those records also contain the
12 fetal monitor strips?

13 A. Yes.

14 Q. Have you reviewed anything for
15 purposes of the deposition today?

10:34:53

16 A. No.

17 Q. Have you, other than your attorney,
18 have you discussed this case with anyone else?
19 Other than your attorney. Since it's been
20 filed.

10:35:07

21 A. Yes.

22 Q. Who have you discussed it with?

23 A. Well, this case was filed and then
24 refiled, so after the original file, I remember
25 talking to Dr. Drake about it.

10:35:19

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

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

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

9 A. Right.

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

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

15 Q. Anyone else you discussed it with? 10:36:08

16 A. Not that I recall.

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

19 A. I don't recall that.

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

22 A. At the hospital.

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

25 A. In person. 10:36:31

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

3 A. Be more specific.

4 Q. What year, what month?

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

7 Q. Okay. Fair enough.

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

12 A. No.

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

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

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

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

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

1 one source that I would go to.

10:37:44

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

5 A. It really would depend on what I
6 needed to look up.

10:37:54

7 Q. How about labor and delivery
8 issues?

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

10:38:03

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

10:38:15

20 MR. SCHOBERT: Objection. Go
21 ahead.

10:38:43

22 A. I don't think there's one
23 particular text, but there are several good
24 obstetrical textbooks. Gaby has a good
25 textbook, Williams has a good textbook, and

10:38:49

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

10:39:00

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

10:39:09

8 A. Not that I know of.

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

10:39:29

11 A. I have not.

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

14 A. Yes.

15 Q. -- in 1998?

10:39:38

16 A. Yes.

17 Q. Do you have independent
18 recollection?

19 A. I think you'd have to be more
20 specific on exactly what you want me to recall.

10:39:45

21 Q. Okay.

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

24 THE WITNESS: I'm sorry.

25 MR. SCHOBERT: It's very loud in

10:39:53

1 here.

10:39:54

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

4 MR. SCHOBERT: It's this system
5 constantly moving the air. You can go ahead.

10:39:59

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

10:40:10

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

10:40:22

18 Q. Let's talk about prenatal. Did she
19 have her total prenatal care with Summit OB/GYN
20 Associates?

10:40:39

21 A. Yes.

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

24 A. Correct.

25 Q. So that if a patient comes to you

10:40:44

1 that's pregnant, they go through prenatal care
2 with your associate group, they're seeing
3 various doctors?

10:40:46

4 A. Right.

5 Q. They're not assigned to one
6 particular physician?

10:40:57

7 A. Right.

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

10:41:04

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

10:41:20

20 Q. And then if during their prenatal
21 care they need to be hospitalized, who would be
22 the attending physician from your group that
23 cares for them? The physician that has
24 coverage that day?

10:41:32

25 A. Correct.

10:41:43

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

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

6 A. I'm sorry, say that again.

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

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

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

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

22 Q. Yes.

23 A. Yes.

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

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

9 Q. Yes.

10 A. Yes.

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

15 A. During the daytime hours, that I
16 don't remember. Obviously I was on that night,
17 but I don't recall if I was the physician
18 during the daytime hours.

19 Q. Could you tell from the records in
20 front of you which physician in your group
21 would have been covering Mrs. Tarle during the
22 day of August 3rd, 1998?

23 A. The only thing I see in the records
24 was it may have been Dr. Terpylak was the
25 initial physician. Now, at what point we

1 switched during that day, I don't know.

10:43:56

2 Because --

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

5 MR. MARGOLIS: If it's there, he
6 can go through those.

10:44:09

7 Q. Maybe this is --

8 MR. SCHOBERT: He's got it.

9 Q. Oh, you have it?

10 A. Initial H & P form.

10:44:14

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

14 MR. MARGOLIS: No.

15 MR. SCHOBERT: No, he's looking at
16 something called medical record of patient for
17 delivery, section 2 of 2.

10:44:22

18 A. It's her history and physical.

19 MR. SCHOBERT: It's her history and
20 physical.

10:44:33

21 MR. FINELLI: Does it have it in
22 here?

23 MR. MARGOLIS: I don't see it.

24 Q. I'm just used to looking at medical
25 records. Here. Okay. I have the physical

10:44:47

1 exam.

10:44:57

2 A. Under remarks, page 2 of 2.

3 Q. Under remarks. Which starts off

4 24-year-old --

5 A. Right, and then it says --

10:45:10

6 Q. -- GIPO?

7 A. Then it says plan, says per

8 Dr. Terpylak patient to receive Pitocin and

9 Epidurac at 4 centimeters dilation and fluid

10 hydration.

10:45:21

11 Q. And that's signed by -- do you know

12 who signed that? Is that Dr. Sanders?

13 A. Looks like Sanders, yes.

14 Q. Sanders? So Terpylak, Dr. Terpylak

15 was one of your partners?

10:45:29

16 A. Right.

17 Q. So based on this information, you

18 would glean, then, that Dr. Terpylak was at

19 least on call when she was initially admitted

20 on August 3rd, 98?

10:45:38

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

22 Q. You would not have -- let me ask

23 you, do you have any records as far as call

24 schedules that you keep that would date back to

25 1998?

10:45:54

1 A. That I'm not sure about. I can
2 look.

10:45:55

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

10:46:06

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

10:46:24

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

10:46:41

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

18 MR. FINELLI: I'm sorry?

19 MR. SCHOBERT: Yes, I was looking
20 through my notes, but give me a moment to
21 check.

10:47:38

22 Q. 2030 on August 3rd would have been
23 8:30, correct? Is that?

24 MR. MARGOLIS: Yes.

25 Q. Okay. If you were called at 8:30

10:47:56

1 p.m. on August 3rd, 98, you would have at least
2 initiated your coverage at 6 p.m.?

10:48:01

3 A. Most likely.

4 Q. Because your call goes from either
5 12 noon or 6 p.m.?

10:48:08

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

10:48:22

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

14 A. Most likely, yes.

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

10:48:40

19 A. Not that I saw.

20 Q. If you would have taken over at
21 noon on August 3rd, your coverage would have
22 went until when, into August 4th? Noon of
23 August 4th?

10:48:57

24 A. Usually we would switch over the
25 following morning, about 7 a.m.

10:49:14

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

4 A. Right. Right.

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

9 A. Yes.

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

14 A. Yes.

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

21 MR. SCHOBERT: Specific to August
22 3rd and 4th during her hours? Because I think
23 there were later progress notes where her --

24 A. Postpartum.

25 MR. SCHOBERT: Postpartum. 10:50:14

1 A. Postpartum I think Dr. Mitchell saw
2 her once and I think Dr. Monte might have seen
3 her once.

10:50:15

4 Q. Let me narrow my question, then.
5 Any other doctors besides you and Dr. Terpylak
6 -- I am pronouncing that correct, right?

10:50:24

7 A. Terpylak.

8 Q. Involved in the care of Mrs. Tarle
9 from the time of her admission on August 3rd,
10 98 until the time she delivered on August 4th,
11 98, from your group?

10:50:33

12 A. Not that I'm aware of.

13 Q. Looking over her prenatal records,
14 you mentioned you had seen her one time. Were
15 there any abnormalities during her prenatal
16 care that was recorded or documented or
17 diagnosed?

10:50:46

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

20 Q. Do you understand my question?

10:51:00

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

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

25 A. From what I could see from the

10:51:10

1 chart, yes.

10:51:11

2 Q. She had no evidence of gestational
3 diabetes?

4 A. I'd have to refer back. I don't
5 recall.

10:51:18

6 Q. If you can look through her
7 prenatal records.

8 A. Her glucola was normal.

9 MR. MARGOLIS: I didn't hear.

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

10:51:44

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

14 A. Looks like she had a couple of
15 borderline blood pressures.

10:52:23

16 Q. Anything warranting medication?

17 A. No.

18 Q. Any evidence of preeclampsia?

19 A. I would say no.

20 Q. Was she cultured at all during her
21 prenatal care?

10:52:37

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

24 Q. That was negative. Any lab values
25 that were abnormal that were significant or

10:52:49

1 caused concern for you and your group?

10:52:52

2 A. Doesn't appear so.

3 Q. Any ultrasounds done during her
4 prenatal care?

5 A. Yes.

10:53:07

6 Q. Any abnormalities in the
7 ultrasounds?

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

10 Q. This was her first pregnancy,
11 correct?

10:54:03

12 A. I believe so.

13 Q. She would be considered a primip?

14 A. Right.

15 Q. And what does that refer to? What
16 does that mean?

10:54:12

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

19 Q. Based on your review of the
20 records, would it be fair to say that she had a
21 normal prenatal course?

10:54:22

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

25 Q. In general, during the course of

10:54:39

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

4 A. That's not unusual.

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

7 A. Not that I'm aware of.

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

11 A. No.

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

14 MR. SCHOBERT: Objection.

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

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

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

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

1 and laboratory values?

10:56:04

2 A. Again, I only saw her one time, so
3 from my own personal prenatal, she seemed to be
4 doing fine at that point in her pregnancy, but
5 again --

10:56:18

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

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

10:56:43

14 Q. How would you determine, based on a
15 prenatal record like this, as to whether or not
16 there may be some fetal compromise?

10:57:00

17 A. Sometimes you can't. Sometimes a
18 woman can be a completely normal prenatal
19 course and still have a baby that has some
20 problem that's unrecognized.

10:57:14

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

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

25 Q. How were her fetal heart tones

10:57:31

1 during the prenatal care?

10:57:31

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

4 Q. Did she require any stress testing
5 during her prenatal care?

10:57:38

6 A. Not that I'm aware of.

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

9 A. There are dozens of reasons to do
10 prenatal testing.

10:57:49

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

13 A. Any patient with diabetes requiring
14 insulin, patients postdate, INGR,
15 oligohydramnios, documented preeclampsia,
16 chronic hypertension.

10:58:14

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

20 A. Yes.

10:58:31

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

24 A. Not that I'm aware of.

25 Q. When do you do any amniocentesis

10:58:40

1 during prenatal care?

10:58:44

2 A. That also depends on the clinical
3 situation.

4 Q. What clinical situations would lend
5 itself to a patient having amniocentesis?

10:58:54

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

9 Q. And what would the reason be?

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

10:59:10

14 Q. Abnormal?

15 A. Triscreen.

10:59:27

16 Q. And what is that?

17 A. Triscreen is a screening test we do
18 in the second trimester to give us an
19 indication of whether or not the baby is at
20 risk for a chromosomal problem or birth defect.

10:59:37

21 Q. Anything else? Indication for
22 amniocentesis?

23 A. Fetal lung maturity late in the
24 pregnancy would be another reason to do an
25 amnio.

10:59:54

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

4 A. Correct.

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

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

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

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

15 Q. Doctor, I want you to -- well, 11:00:27
16 let's start with the history and physical when
17 she first came in on August 3rd. Can you tell
18 me the time she was admitted on August 3rd?
19 Not to confuse you, I think it's around 9 a.m.
20 in the morning, and correct me if I'm wrong. 11:00:52
21 If you look at the nurses notes, I think that
22 multidisciplinary assessment, it has time 09, I
23 believe. Do you have that?

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

1 records reflect, so if you want him to verify
2 that, that's fine. I'm not going to dispute.
3 That appears to be --

11:01:45

4 A. That sounds about right.

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

11:01:55

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

10 A. Dr. Sanders, yes.

11:02:12

11 Q. Dr. Sanders?

12 A. Dr. Sanders.

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

15 A. Correct.

11:02:29

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

18 A. It was a visual exam, so that's an
19 estimate, but that's what it says here in the
20 history and physical.

11:02:44

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

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

25 Q. Anything in the history and

11:02:57

1 physical exam that was not done that should
2 have been included?

11:02:58

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

5 Q. And when you say visually she was
6 two centimeters, that would have been done by
7 speculum exam and visualization?

11:03:34

8 A. Correct.

9 Q. Is that routine, to do a speculum
10 exam rather than a manual exam?

11:03:43

11 A. For membrane rupture it is, yes.

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

14 A. Correct.

15 Q. Do we know how long her membranes
16 were ruptured at that point?

11:03:55

17 A. It appears by history it was at
18 7:45 a.m.

19 Q. And you would not want to do a
20 manual exam on admission because of the
21 membranes rupturing, correct?

11:04:15

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

25 Q. Irrespective of whether the

11:04:31

1 membranes were ruptured or not?

11:04:40

2 A. Irrespective of whether the
3 membranes were ruptured.

4 Q. And why would you exclude a
5 digital?

11:04:40

6 A. Just to lower her risks for
7 infection.

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

11:04:48

12 A. That's the theory, yes.

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

15 A. It's difficult to tell effacement
16 and dilation with a digital exam. It's an
17 estimate.

11:05:05

18 Q. Can you tell station?

19 A. Not really.

20 Q. When is the first time we know --
21 strike that.

11:05:16

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

25 THE WITNESS: What section are her

11:06:06

1 progress notes in?

11:06:08

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

4 A. You want to know when her first
5 digital exam is, is that what you're asking me?

11:06:48

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

11:07:02

11 A. Right.

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

14 A. That's what it looks like from this
15 curve, yes.

11:07:10

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

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

11:07:21

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

24 A. Yes, that's what the nurse
25 documented, yes.

11:07:32

1 Q. With a circle, dilation of 2,
2 correct?

11:07:33

3 A. Right.

4 Q. And my question is, in order to
5 determine that station, a manual exam would
6 have had to have been done?

11:07:40

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

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

11:07:55

12 A. Nurse.

13 Q. The writing under the Friedman
14 curve, is that done by a physician or a nurse
15 or both?

11:08:09

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

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

11:08:19

21 A. That appears so.

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

24 A. Correct.

25 Q. Okay. So we know at 10 o'clock she

11:08:33

1 was at 2 dilation, minus 4 station. You would
2 agree that a minus 4 is very high?

11:08:37

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

5 A. That's true, that's what her
6 station was, and that's true, yes.

11:08:48

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

9 A. She was about four or five days
10 over her due date, yes.

11:08:59

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

13 A. Yes.

14 Q. So we have a primip who is on
15 admission minus station 4, past her due date by
16 4 days and at two centimeters dilation,
17 correct?

11:09:10

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

11:09:21

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

24 A. Right.

25 Q. Primips usually present in labor at

11:09:37

1 a station of minus 4, or are their heads
2 usually engaged, the babies' heads usually
3 engaged for primips?

11:09:40

4 A. Either or.

5 Q. The majority of primips that you
6 see that present themselves in labor, are the
7 babies' heads usually engaged?

11:09:50

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

11:10:06

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

14 A. They usually present at zero
15 station?

11:10:20

16 Q. Yes.

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

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

20 A. They usually present at higher than
21 the zero station.

11:10:26

22 Q. Minus 1?

23 A. Minus 1, minus 2, minus 3.

24 Q. Would it have been unusual for Mrs.
25 Tarle as a primip to present in labor on August

11:10:38

1 3rd with a minus 4 station?

11:10:40

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

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

11:10:54

9 A. No.

10 Q. Why not?

11:11:07

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

14 Q. How do you know she wasn't
15 contracting or not in labor?

11:11:29

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

20 On the H & P it says no
21 contractions.

11:12:03

22 MR. MARGOLIS: Where are you
23 reading?

24 MR. SCHOBERT: He said H & P.

25 A. H & P, it says no contractions.

11:12:10

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

2 THE WITNESS: This is her initial
3 history and physical.

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

6 MR. SCHOBERT: Yes.

7 (Discussion had off the record.)

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

12 MR. SCHOBERT: Yes.

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

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

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

19 Pitocin is oxytocin?

20 A. Correct. 11:16:17

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

23 A. Stimulate contractions.

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

1 A. To effect --

11:16:26

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

5 A. To stimulate contractions in order
6 to allow labor to progress.

11:16:35

7 Q. Is that synonymous with induction?

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

10 Q. What is the induction of labor?
11 Just the beginning of labor?

11:16:48

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

14 Q. Is there any protocol for the use
15 of Pitocin by Akron General Hospital? Any
16 manual or protocol?

11:17:03

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

19 Q. Pitocin would need to be started by
20 a physician's order, correct?

11:17:17

21 A. Yes.

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

25 MR. SCHOBERT: I'm going to object

11:17:38

1 to the from of the question, go ahead.

11:17:39

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

4 Q. Yeah, let me clean that up. Is
5 there any reason Pitocin would be
6 contraindicated based on the degree of dilation
7 that the primip presents?

11:17:49

8 A. Not that I'm aware of.

9 Q. Is there any degree -- is there any
10 contraindication to using Pitocin based on a
11 degree of effacement of a presentation of a
12 primip?

11:18:03

13 A. Not that I'm aware of.

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

11:18:14

17 A. Not that I'm aware of.

18 Q. Is there any contraindication to
19 using Pitocin in someone that has ruptured
20 membranes?

11:18:32

21 A. I think if it's just a normal
22 primigravida presentation, vertex presentation,
23 with no evidence of fetal distress or anything
24 like that, there's probably no contraindication
25 to it.

11:18:58

1 Q. When a primip presents at station
2 4, are you able to determine whether it's a
3 vertex presentation?

11:19:00

4 A. Yes.

5 Q. By how?

11:19:08

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

8 Q. There was no ultrasound done here?
9 To determine whether she had a vertex
10 presentation?

11:19:29

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

14 Q. And you mentioned Leopold's?

15 A. Leopold's.

11:19:38

16 Q. What's that?

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

20 Q. Okay.

11:19:51

21 A. Try to palpate the fetal head.

22 Q. Is there any documentation on her
23 presentation whether or not Leopold's was done
24 or any documentation that says she had a vertex
25 presentation?

11:20:00

1 A. There is documentation of Leopold's
2 on the H & P. And actually there is
3 documentation by ultrasound here.

11:20:01

4 MR. SCHOBERT: Yes, I thought I saw
5 that somewhere.

11:20:11

6 Q. That's on physical exam?

7 A. Yes.

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

10 We talked about the benefit of
11 Pitocin as far as stimulating contractions,
12 correct?

11:20:21

13 A. (Nodding affirmatively.)

14 Q. Any other benefits?

15 A. After delivery, it helps to
16 minimize bleeding.

11:20:31

17 Q. How does it do that?

18 A. Just by stimulating, continuing to
19 stimulate the uterus to contract and cramp
20 down.

11:20:41

21 Q. So constrict the blood flow?

22 A. Correct.

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

25 A. The main risk would be

11:21:01

1 overstimulation of the uterus.

11:21:08

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

5 A. Overstimulation can lead to tonic
6 contraction which can affect blood flow to the
7 fetus.

11:21:18

8 Q. And affecting the blood flow of the
9 fetus could in effect put the fetus in
10 compromise or distress?

11:21:31

11 A. If it was prolonged, that is true.

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

15 A. That's true.

11:21:46

16 Q. And fetal hypoxemia is what?

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

19 Q. And what is fetal hypoxia?

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

11:21:59

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

25 A. That's true.

11:22:12

1 Q. What is fetal asphyxia?

11:22:12

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

5 Q. If you have fetal hypoxemia, can
6 that lead to fetal distress?

11:22:32

7 A. Yes.

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

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

11:22:52

14 Q. Well, you mentioned fetal hypoxia
15 is lack of oxygen in the tissues?

11:23:02

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

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

20 A. In the blood.

11:23:12

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

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

11:23:20

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

4 A. Say that again.

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

8 A. Sure it can.

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

13 A. Right.

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

16 A. That's true.

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

19 A. Correct. That's correct, yes.

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

22 A. That's correct.

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

25 MR. SCHOBERT: Yes. 11:24:21

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

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

7 Q. And what change in the contraction
8 pattern would alert you to whether or not there
9 is overstimulation of the uterus? The
10 frequency or the intensity? 11:24:46

11 A. The frequency of the contractions.

12 Q. So if you have a baseline rate of
13 contractions and they increase in frequency,
14 that may alert you to perhaps overstimulation
15 of the uterus if the patient is receiving 11:25:01
16 Pitocin?

17 A. Right, yeah, I mean if you have
18 contractions that are so frequent that it
19 starts to cause fetal heart rate decelerations,
20 that would be a situation where you are 11:25:15
21 probably overstimulating the uterus.

22 Q. And that leads into my next
23 question. What would you look for on fetal
24 heart tracings that would cause you concern to
25 think of overstimulation of the uterus by 11:25:26

1 Pitocin? 11:25:30

2 A. You would see a bradycardia.

3 Q. Bradycardia?

4 A. Right.

5 Q. Any other fetal heart tracings 11:25:37

6 other than bradycardia?

7 A. You're talking about a situation

8 where there's overstimulation of the uterus?

9 Q. (Nodding affirmatively.)

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

11 Q. With overstimulation of the

12 uterus --

13 A. Yes.

14 Q. -- with Pitocin?

15 Same question, could you see 11:25:57

16 variable decelerations?

17 A. Lasting variable decelerations are

18 more of a situation where the cord is getting

19 compressed, so it wouldn't necessarily go along

20 with overstimulation of the uterus. 11:26:14

21 Q. How about tachycardia?

22 MR. SCHOBERT: Just to finish your

23 question, so it's clear on the record,

24 tachycardia consistent with what, with

25 overstimulation? 11:26:27

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

4 MR. SCHOBERT: I just want to --

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

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

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

12 Q. How about a change in the
13 variability?

14 MR. SCHOBERT: Again, same --

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

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

19 MR. FINELLI: I'm sorry.

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

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

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

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

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

7 A. You --

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

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

15 MR. SCHOBERT: Objection. 11:27:52

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

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

1 change in conjunction with each other?

11:28:15

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

4 Q. Is there a risk of using Pitocin as
5 you continue on a time line? Beyond, beyond
6 what hour of use of Pitocin does the risk
7 increase?

11:28:30

8 MR. SCHOBERT: Object. Go ahead.

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

11:28:46

13 Q. So if you are using Pitocin for
14 four hours, the risk is the same as if you were
15 using Pitocin for 12 or 13 hours?

11:28:57

16 MR. SCHOBERT: Objection.

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

19 Q. Or compromise to the fetus.

20 MR. STRONG: I'm going to object to
21 that.

11:29:16

22 A. I'm not sure I understand exactly
23 what you're -- Pitocin by itself does not cause
24 compromise to the fetus. Is that what you
25 mean?

11:29:27

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

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

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

8 A. Not that I'm aware of.

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

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

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

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

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

1 MR. SCHOBERT: Fine.

11:30:14

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

5 A. No.

11:30:20

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

10 A. I have never seen a Pitocin
11 protocol at Akron General.

11:30:28

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

14 (Recess taken.)

15 Q. Doctor, just a few cleanup
16 questions. In the beginning we talked about a
17 case where you were deposed as a resident that
18 was dismissed, correct?

11:36:55

19 A. (Nodding affirmatively.)

20 Q. Do you know if any money was paid
21 out on your behalf on that case?

11:37:07

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

24 A. When you say on my behalf, you mean
25 there was a --

11:37:20

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

3 A. No.

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

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

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

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

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

15 A. No. 11:37:54

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

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

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

24 A. No, I don't.

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

1 Tarle, would have relied on the history and
2 physical examination, correct? Information
3 gleaned from the history and physical?

11:38:25

4 A. I don't think we would have relied
5 on it at all, to be honest with you.

11:38:33

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

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

11:38:46

12 Q. And you're saying you and your
13 group would not rely on the findings of the
14 history and physical examination as it pertains
15 to your care provided to Mrs. Tarle?

11:38:59

16 A. Not necessarily, no.

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

20 A. I'm not sure. I don't know.

11:39:17

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

23 A. Can you repeat your last question?

24 MR. SCHOBERT: He wants to know the
25 first time you can tell from the records of

11:39:32

1 anybody from your group, Terpylak or anybody
2 else from your group evaluating her after she
3 came to the hospital.

11:39:34

4 Q. Anyone from your group, yes.

5 A. You mean, you know, physically
6 walked in and saw her? Is that what you mean?

11:39:44

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

11:39:56

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

11:40:14

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

11:40:27

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

25 Q. And normally, as a physician, when

11:40:41

1 you evaluate a patient, you would document
2 that?

11:40:43

3 A. Normally, yes.

4 Q. When you do a vaginal exam or a
5 clinical exam on a patient, you would document
6 that in the chart?

11:40:49

7 A. Right.

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

11:40:56

12 A. Correct.

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

15 A. Correct.

11:41:06

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

19 A. She was already delivered by the
20 time we got there.

11:41:25

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

23 A. No.

24 Q. You can't tell from the records at
25 what point in time? But you can say that when

11:41:33

1 you arrived at the hospital she had already
2 delivered?

11:41:36

3 A. Correct.

4 Q. Who performed the surgery? Was it
5 Dr. McKelvey?

11:41:45

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

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

11:42:00

11:42:19

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

17 Q. Fair to say that the physicians
18 that were taking care of her from her admission
19 of August 3rd, 98 through the time, up through
20 the time she delivered on August 4th, 98 were
21 resident physicians?

11:42:30

22 A. Yes.

23 Q. There were no other attendings
24 outside of your group that were involved in the
25 care of her up through the time that she --

11:42:39

1 A. Dr. Cook was involved.

11:42:42

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

4 A. Correct.

5 Q. He had no involvement prior to the
6 surgery itself, correct?

11:42:50

7 A. Not that I'm aware of.

8 Q. Do you have any criticisms of
9 Dr. Cook relative to his care pertaining to
10 Mrs. Tarle August 4th, 98?

11:43:02

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

14 MR. MARGOLIS: I'm sorry.

15 A. I don't really have any criticisms
16 of him, but I don't know how involved he was
17 during the surgery, so --

11:43:33

18 Q. Okay. Fair enough.

19 Have you ever had any discussions
20 with Dr. Cook?

11:43:42

21 A. No.

22 MR. SCHOBERT: About this case you
23 mean?

24 Q. About this case, about Mrs. Tarle?

25 A. No.

11:43:46

1 Q. If you know, has any of your
2 partners had any discussions with Dr. Cook as
3 it pertains to the care of Mrs. Tarle?

11:43:46

4 A. Not that I'm aware.

5 Q. I think I asked you that, have you
6 discussed this case at all with your partners?
7 You mentioned Dr. Drake.

11:43:57

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

11:44:12

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

14 A. Yeah, that day, the day or two or
15 three right after the delivery. I think I may
16 have talked to them about it.

11:44:23

17 Q. Tell me the guidelines, if any, as
18 it pertains to the management and care of a
19 patient that your group practices when a
20 patient of yours is admitted with ruptured
21 membranes as a primip that gets admitted to the
22 labor and delivery floor.

11:44:43

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

25 (Record read.)

11:45:00

1 MR. SCHOBERT: Thank you.

11:45:10

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

4 Q. In general, what is your course of
5 management and care to a patient of yours who
6 is a primip with ruptured membranes who gets
7 admitted to the labor and delivery floor?

11:45:21

8 A. Really just depends on the clinical
9 situation.

10 Q. And what about her clinical
11 situation changes your answer?

11:45:34

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

14 A. You're -- I'm not sure I understand
15 exactly what you're asking me.

11:45:47

16 Q. I mean is there a standard, is
17 there any standard of care that you adhere to,
18 you or your group, as it pertains to the
19 management and care of your patients that are
20 admitted to labor and delivery?

11:46:02

21 MR. SCHOBERT: Objection.

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

11:46:16

1 goes into how we manage them. I can't say that
2 I would manage any one patient exactly as I
3 manage any other patient. It really just --

11:46:18

4 Q. Okay. How about a patient that
5 presents herself as Mrs. Tarle did? What's
6 your standard of care of management and
7 practice?

11:46:28

8 MR. SCHOBERT: Object. Go ahead.

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

11:46:55

11:47:15

18 Q. At any point in time would you not
19 want to evaluate her and examine her prior to
20 delivery?

11:47:29

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

24 Q. You or your group, when I refer to
25 you, I am referring to you or a member of your

11:47:40

1 group.

11:47:44

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

4 A. If the need arised, yes, I would do
5 that.

11:47:50

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

11:48:04

12 MR. SCHOBERT: Object, but go
13 ahead.

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

11:48:22

11:48:36

25 Q. So if the patient, such as Mrs.

11:48:59

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

8 A. That's fair to say.

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

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

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

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

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

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

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

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

16 MR. MARGOLIS: Sanders.

17 Q. And Sanders? Is it Sanders?

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

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

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

1 case, Mrs. Tarle's labor and delivery and her
2 admission, you relied on the care and
3 management of Mrs. Tarle as it was provided by
4 the residents, Dr. McKelvey and Dr. Drake and
5 Dr. Sanders?

11:51:47

11:52:00

6 MR. SCHOBERT: Objection.

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

9 Q. And you relied on that information?

10 A. Right.

11:52:10

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

13 A. Right.

14 Q. Do you know where you were on the
15 evening of August 3rd, 98? Were you home?

11:52:27

16 A. I was home.

17 Q. Do you know what year residents
18 Dr. McKelvey and Dr. Drake were on August 3rd,
19 1998?

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

11:52:48

25 Q. Could Dr. McKelvey have been a

11:52:59

1 second-year resident?

11:53:01

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

4 Q. And the residency year begins July
5 1 of that year, correct, of any particular
6 year?

11:53:12

7 A. Yes, in most cases, yes.

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

10 A. There are some residents that start
11 midyear for some reason.

11:53:23

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

11:53:39

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

18 Q. Were there any problems that arose
19 in the care of Mrs. Tarle that would have
20 required you, as part of your habit of
21 practicing, to come in and evaluate Mrs. Tarle?

11:53:54

22 A. I'm sorry, say that again.

23 Q. Were there any problems that arose
24 on behalf of Mrs. Tarle during her August 3rd,
25 98 admission which would have caused you to, as

11:54:10

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

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

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

9 A. Correct.

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

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

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

23 A. Phone calls.

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

1 A. Yes.

11:55:17

2 Q. Did you receive phone calls from
3 Dr. McKelvey?

4 A. Yes.

5 Q. Did you receive phone calls from
6 Dr. Drake?

11:55:22

7 A. Yes.

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

10 A. Not that I recall.

11:55:28

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

11:56:00

16 MR. SCHOBERT: Objection.

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

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

11:56:15

24 MR. SCHOBERT: Prior to when he
25 actually --

11:56:30

1 MR. FINELLI: Prior to the
2 delivery.

11:56:31

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

5 MR. FINELLI: Right.

11:56:34

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

8 MR. STRONG: Objection.

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

11:56:40

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

11:56:50

19 MR. STRONG: Objection.

20 MR. SCHOBERT: Objection. Go
21 ahead.

11:57:02

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

11:57:13

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

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

7 A. No.

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

10 A. No. 11:57:33

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

13 A. No.

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

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

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

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

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

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

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

16 A. Yes.

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

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

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

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

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

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

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

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

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

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

13 MR. SCHOBERT: Here it is.

14 A. Here it is.

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

18 A. Correct.

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

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

1 minute every 15 or 20 minutes until

12:00:31

2 contractions are every two, three minutes.

3 Q. So based on this order, the nurse
4 should make sure that contractions are
5 occurring at a frequency of every two to three
6 minutes?

12:00:41

7 MR. STRONG: Objection.

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

12:00:54

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

12:01:12

18 A. Let me look at the labor again.
19 She had this period of time between 7 o'clock
20 and midnight where she kind of fell off the
21 labor curve.

12:01:43

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

25 A. It would have helped her to

12:01:58

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

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

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

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

11 MR. SCHOBERT: All right.

12 A. I don't recall that.

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

16 A. That's correct.

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

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

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

1 A. Correct. 12:02:57

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

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

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

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

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

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

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

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

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

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

11 A. Usually.

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

14 A. I don't think it was.

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

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

19 Q. What are you looking at, Doctor?

20 A. Obstetric accountability record. 12:05:09

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

23 A. Right. So from -- it stayed pretty
24 much at the same level until around 12:15,
25 12:30, which is when she started to get back on 12:05:29

1 the labor curve.

12:05:31

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

3 A. A.m.

4 Q. Okay. On August 4th?

5 A. August 4th.

12:05:41

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

8 MR. SCHOBERT: Are you looking
9 there?

10 MR. FINELLI: Yes.

12:05:56

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

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

12:06:12

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

19 Q. Based on the Friedman curve that
20 you have in front of you, between 7 and 12 that
21 evening is there any documentation of any
22 change --

12:06:31

23 A. Not looking at the Friedman curve,
24 no.

25 Q. -- in the dilation?

12:06:43

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

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

7 A. No.

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

10 A. Yes. 12:07:01

11 Q. What was the change?

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

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

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

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

1 of labor?

12:08:00

2 A. No.

3 MR. STRONG: Objection.

4 Q. I'm sorry?

5 A. No.

12:08:03

6 Q. Why not?

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

10 Q. I'm asking between the period of 7
11 and --

12:08:12

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

15 Q. If you were treating her at around
16 11 p.m. or 11:30 p.m. and had noticed no change
17 in her labor from 7 p.m., would you have
18 considered that an arrest of labor at 11:30
19 p.m. that evening?

12:08:20

20 MR. SCHOBERT: Objection. Go
21 ahead.

12:08:37

22 MR. STRONG: Objection.

23 A. I don't think we considered that
24 arrest of labor. Yeah, I mean if we had, we
25 would have probably sectioned her at that

12:08:46

1 point.

12:08:47

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

5 A. Correct.

12:08:53

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

8 A. If --

9 MR. SCHOBERT: Objection. Go
10 ahead.

12:08:59

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

14 Q. She was in active phase at that
15 point, correct?

12:09:11

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

18 Q. What is active phase?

19 A. Well, it's kind of an arbitrary
20 definition, but it can be anywhere from four to
21 five centimeters to completely dilated.

12:09:24

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

25 A. Generally speaking, yes, that's

12:09:39

1 kind of how we define it, but --

12:09:41

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

5 A. Right.

12:09:50

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

9 A. You have to give me what your
10 definition of protracted labor is.

12:10:07

11 Q. What's your definition?

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

12:10:21

12:10:41

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

25 A. Right.

12:10:57

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

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

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

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

11 (Record read.)

12 (Recess taken.)

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

17 MR. SCHOBERT: Objection.

18 MR. STRONG: Objection.

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

21 A. I was thinking about my answer.

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

24 (Record read.)

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

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

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

6 MR. STRONG: Objection.

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

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

12 A. Because --

13 MR. SCHOBERT: Objection.

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

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

22 MR. STRONG: Objection.

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

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

1 MR. SCHOBERT: Assuming an arrest
2 of labor?

12:19:09

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

5 MR. SCHOBERT: All right.
6 Objection. Go ahead.

12:19:14

7 MR. STRONG: Objection.

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

12:19:21

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

12:19:45

17 MR. STRONG: Objection.

18 MR. SCHOBERT: Objection. Go
19 ahead.

20 A. Would that be standard of care?

12:19:57

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

25 A. At that time, yes.

12:20:05

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

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

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

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

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

23 A. Correct.

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

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

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

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

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

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

18 MR. SCHOBERT: Objection.

19 MR. STRONG: Objection.

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

21 A. Yeah, would you?

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

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

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

6 Q. And how would that play a role?

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

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

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

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

1 and answered. Go ahead.

12:23:51

2 A. Repeat it.

3 Q. Okay. You talked a little bit
4 about the knowledge that you received from the
5 physicians, the residents that were calling
6 you. Absent anything documented here, how is
7 it that you have recollection of what they told
8 you as far as the fetal heart tracings or the
9 reassuring patterns?

12:24:20

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

12:24:32

12:24:50

20 Q. So based on your recollection,
21 there was no concern in the phone conversations
22 you had with the residents relative to her care
23 from either Dr. McKelvey, Dr. Drake or
24 Dr. Sanders?

12:25:06

25 A. Not until she --

12:25:17

1 MR. STRONG: Objection. 12:25:18

2 A. -- went for a C section.

3 Q. If you look at the progress note, I

4 think it's 2225, when it says called Dr. Ferris

5 and discussed, and it has arrested status 12:25:36

6 crossed out?

7 A. Right.

8 Q. Was there ever concern expressed to

9 you that this patient had arrested in her

10 labor? 12:25:49

11 A. No, not that I recall.

12 Q. And if it was discussed with you,

13 your response would have been what?

14 MR. STRONG: Objection.

15 MR. SCHOBERT: Objection. 12:26:01

16 Hypothetical. Go ahead.

17 A. If Dr. Drake or Dr. McKelvey had

18 called me up and said that they felt that she

19 wasn't going to make it and that she was going

20 to need a C section, I would have come in to 12:26:11

21 assess it myself.

22 Q. Okay. Whose decision would it be

23 in Mrs. Tarle's situation as to whether or not

24 this patient goes for a C section? The

25 residents' or yours? 12:26:23

1 A. It's my decision.

12:26:24

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

5 A. Only in emergency.

12:26:31

6 Q. And what would constitute an
7 emergency?

8 A. A bad heart rate tracing. Or, you
9 know, that would be probably it, bad heart rate
10 tracing.

12:26:44

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

13 A. Heart rate tracing that looked like
14 there could be some fetal compromise or fetal
15 distress, if there was just any pattern that
16 would be deemed very nonreassuring and didn't
17 resolve to standard methods. It's a judgment
18 call.

12:26:59

19 Q. And if that is a consideration by
20 Dr. McKelvey or Dr. Drake, they can take that
21 patient for emergency C section?

12:27:16

22 A. Right, they would notify me in a
23 normal situation, they would notify me, tell me
24 what their concerns were, and if they really
25 felt like there was distress on the fetus, I

12:27:31

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

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

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

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

13 A. To tell me, yes.

14 Q. Even on an emergency basis?

15 A. Right. 12:27:59

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

22 MR. SCHOBERT: I'm going to object.

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

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

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

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

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

11 MR. SCHOBERT: Objection.

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

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

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

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

2 MR. FINELLI: Mrs. Tarle.

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

6 (Record read.)

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

9 A. That is a question?

10 Q. Uh-huh. 12:29:56

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

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

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

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

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

2 A. If there was a need, yes.

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

7 MR. SCHOBERT: Objection.

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

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

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

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

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

24 Q. Let's break it down this way:
25 Between the time she was admitted on August 3rd 12:31:1

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

4 A. To?

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

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

9 Q. If you had not received any
10 information, is Mrs. Tarle your responsibility, 12:31:50
11 as the attending physician?

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

15 Q. Yes. 12:32:08

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

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

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

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

1 MR. SCHOBERT: Objection. Asked
2 and answered. Go ahead.

3 A. Yes.

4 Q. She is your responsibility?

5 A. I am responsible for what's
6 happening based on the information that is
7 being given to me.

8 Q. And based on the information you
9 received on Mrs. Tarle from 6 p.m. to midnight
10 on August 3rd, is the care and management of
11 Mrs. Tarle your responsibility?

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

14 Q. Let's take it one at a time because
15 we were confused earlier. So between 9 a.m.
16 and 6 p.m. she would have been your
17 responsibility?

18 MR. SCHOBERT: Objection. Go
19 ahead.

20 A. Right.

21 MR. FINELLI: Did you pick that up?

22 THE NOTARY: Yes.

23 A. I mean I think the same as we
24 talked about before, sure, I mean decisions
25 based on the information are my responsibility.

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

3 Q. Because I was confused with your
4 answers, I'm breaking it down in these steps.
5 From 12 a.m. on August 4th, 98 through the time 12:33:26
6 that she delivers on August 4th, 98, was Mrs.
7 Tarle your responsibility, as far as her care
8 and treatment?

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

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

17 Q. So is your answer to your
18 question --

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

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

24 A. Consideration for CPD?

25 Q. Yes. 12:34:35

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

2 Q. At what point in time?

3 A. During that period of time where
4 she was falling off the labor curve, we were
5 considering it. 12:34:41

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

9 A. I mean CPD is along the same
10 continuums of arrest of labor or arrest of
11 dilation and labor, it's all basically the same
12 thing. We have already told you that and I
13 don't think that that was the case and the
14 record would reflect that that's true, she
15 didn't arrest, she got to complete dilation. 12:34:53

16 Q. What is CPD?

17 A. Cephalopelvic disproportion.

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

20 A. Well, I mean very generally it 12:35:01
21 means that the head is not going to fit through
22 the pelvis.

23 Q. Okay. How is that diagnosed?

24 A. It's a clinical diagnosis, clinical
25 diagnosis. In my mind, CPD is a diagnosis 12:35:07

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

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

6 A. Correct.

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

10 A. In what sense? 12:35:59

11 Q. In any sense, medical sense.

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

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

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

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

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

2 THE WITNESS: I'm not aware of

3 that.

4 MR. FINELLI: I want to mark this

5 as Plaintiffs' Exhibit 1. 12:37:00

6 A. I will tell you that all patients

7 have the opportunity to refuse having residents

8 take care of them. All patients have that

9 right.

10 - - - - -

11 (Thereupon, Ferris Deposition

12 Exhibit 1 was marked for purposes of

13 identification.)

14 - - - - -

15 MR. FINELLI: She can't -- 12:37:18

16 THE NOTARY: That's all right.

17 MR. SCHOBERT: You want to look at

18 it? He's going to ask you about it. That's

19 out of his chart.

20 MR. FINELLI: Was that the 12:37:34

21 original?

22 MR. SCHOBERT: Yes.

23 MR. FINELLI: I'm sorry, I would

24 have made a copy and marked it.

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

1 put it back in the chart.

12:37:39

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

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

12:37:45

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

9 Q. Doctor, you have been handed what's
10 been marked as Plaintiffs' Exhibit 1. Can you
11 identify that?

12:37:53

12 A. This is a document dated at the
13 time.

14 Q. Summarize, what's the content of
15 the document?

12:38:05

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

20 Q. Does it talk anything about the
21 labor and delivery or her hospitalization for
22 delivery?

12:38:25

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

12:38:34

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

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

8 A. I think so.

9 Q. Is there a consent form in these --

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

12 A. Yeah, the hospital.

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

15 A. I don't know. But I think -- 12:39:08

16 Q. Are you looking at the consent
17 form?

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

20 Q. And I guess my question is is there 12:40:06
21 anything in there that discusses resident care?

22 A. It talks about assistants, but I
23 don't know if it talks -- this is a hospital
24 form, so this is the first time I'm actually
25 looking at this, too. 12:40:11

1 Q. Other than assistants, any mention
2 of residents providing care?

12:41:14

3 A. I don't see anything.

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

12:41:23

9 MR. SCHOBERT: Object. That's not
10 what transpired.

12:41:34

11 A. I don't know.

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

12:41:43

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

20 Q. Because it's something you did not
21 discuss with her, correct?

12:41:59

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

24 Q. The Pitocin was discontinued at
25 approximately 1945 on August 3rd, correct?

12:42:09

1 Q. And you're saying from based on
2 fetal monitor strips 66340 through 66341, there
3 was evidence of variable decelerations?

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

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

8 Q. And that would be indicative of
9 cord compression?

10 A. Variable decelerations are
11 generally thought to be caused by cord
12 compression.

13 Q. And you agreed that cord
14 compression can cause compromise to fetal blood
15 flow? Talked about that earlier.

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

18 Q. And can lead to fetal hypoxia?

19 A. If it's prolonged.

20 Q. Would this be considered prolonged?

21 A. Not at all.

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

24 A. Minus 1.

25 Q. Would you expect a baby that's a

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

2 A. Baby can have cord compression at

3 any station.

4 Q. Was this information communicated

5 to you at the time? 12:48:53

6 A. I don't recall specifically.

7 Q. Or anytime thereafter?

8 MR. SCHOBERT: You mean turning Pit

9 off, that is what you're asking, Dan?

10 MR. FINELLI: Right, and on the 12:49:06

11 fetal heart tracings and the resuscitative

12 measures that were instituted.

13 MR. SCHOBERT: Do you have specific

14 recall of that today?

15 A. I don't recall at 1830 if I was 12:49:13

16 notified about that or not.

17 Q. At any time do you recall if you

18 were notified of this information?

19 MR. STRONG: Objection. Asked and

20 answered. 12:49:24

21 MR. SCHOBERT: Go ahead.

22 A. No, I don't recall if I was

23 notified about this. I do recall being

24 notified that the Pitocin was off.

25 MR. SCHOBERT: You heard that. He 12:49:34

1 said he does recall being told the Pitocin was 12:49:34
2 off at some point.

3 Q. Is this the type of information
4 that you would expect to be told about by the
5 residents, the change in fetal heart tracings, 12:49:45
6 resuscitative measures?

7 A. Usually, if it's persistent. I
8 mean if they have a patient like this who has
9 four or five variables and then it resolves,
10 they may not tell me about that. 12:49:56

11 MR. MARGOLIS: That's not
12 responsive to what you asked.

13 MR. FINELLI: Can you read that
14 back?

15 (Record read.) 12:50:09

16 Q. So based on your answer, due to the
17 fact that this wasn't prolonged, this is
18 information that may have not been conveyed to
19 you?

20 A. Possible. 12:50:43

21 Q. If this information was conveyed to
22 you, would it have impacted upon the decisions
23 in your care?

24 A. Not at all.

25 Q. Looking -- have you had a chance to 12:51:00

1 review the fetal monitor strips? 12:51:02

2 A. Yes.

3 Q. Is there -- were you ever told
4 during the course of her admission during labor
5 and delivery there were any strips that were 12:51:13
6 nonreassuring?

7 A. No, not until the very end.

8 Q. When she went for emergency
9 section?

10 A. Right. 12:51:26

11 Q. Up until the time she went for
12 emergency C section, based upon your review of
13 the fetal monitor strips, were there any
14 tracings that you interpreted as nonreassuring?

15 A. No. 12:51:37

16 Q. What is a nonreassuring pattern?

17 A. A lot of that has to do with
18 judgment and experience, but any persistent
19 severe variable decelerations, persistent late
20 decelerations with lack of variability would be 12:52:06
21 considered concerning, or a bradycardia like
22 she had.

23 Q. And you're stating most of that is
24 based upon experience as an OB-GYN physician?

25 A. Right. A lot of times you can see 12:52:21

1 a heart rate tracing, and even though it has 12:52:24
2 some of that features, those features, you may
3 not be as concerned about it as other times.
4 Based on the variability and other factors.

5 Q. And in this case you were relying, 12:52:40
6 as far as the interpretation of the fetal heart
7 tracings, on the experience of OB-GYN
8 residents?

9 A. Well, yes.

10 Q. At any point in time, other than 12:52:55
11 1830 on August 3rd, were there any, was there
12 any other point in time where resuscitative
13 measures were implemented on Mrs. Tarle, if you
14 know?

15 A. Looks like at 8:25 she was put on 12:53:39
16 her left side, had oxygen on.

17 Q. I'm sorry, what time?

18 A. 8:25.

19 Q. P.m.?

20 A. P.m. Go back all the way. 12:53:48

21 11:30, looks like they did the same
22 thing.

23 MR. SCHOBERT: What time?

24 THE WITNESS: 11:30.

25 Q. 11:30 p.m.? 12:54:45

1 A. P.m. 12:54:48

2 Q. Were those two instances in time,
3 as far as the resuscitative measures, conveyed
4 to you by the residents?

5 A. I don't recall if I was 12:55:12
6 specifically told about that or not.

7 Q. In the habit of your practice in
8 dealing with resident care, is that type of
9 information that is normally conveyed to you or
10 that you request? 12:55:24

11 A. Again, it really all depends on the
12 clinical situation. Sometimes, you know, we
13 see fetal heart rate decelerations so often
14 during the course of a labor that oftentimes
15 it's just done by the nurses without notifying 12:55:46
16 anybody. So I can't say whether we
17 specifically talk about it every single time it
18 happens. I would say that's probably not the
19 case, but --

20 Q. But in this case it was brought to 12:56:07
21 the resident's attention?

22 MR. STRONG: What was that
23 question? I didn't hear that.

24 MR. SCHOBERT: I believe the
25 question was -- 12:56:12

1 Q. In this case --

12:56:13

2 MR. SCHOBERT: -- I assume the
3 nurses brought it to the resident's attention,
4 that is the question?

5 MR. MARGOLIS: Yes, he said many
6 times the nurses don't even let anybody know
7 about the changes in the fetal heart rate.

12:56:17

8 MR. STRONG: I know, I just wanted
9 to hear what the question was.

10 Q. But in this case it was brought to
11 the resident's attention?

12:56:25

12 A. Doesn't say that.

13 MR. SCHOBERT: Well, again --

14 A. I don't know that that happened.
15 It doesn't say that anybody told the resident
16 about it.

12:56:36

17 Q. If you look at 2320 on the nursing
18 observation, are you with me, Doc?

19 A. Yes.

20 Q. You see where Dr. Drake was
21 notified?

12:56:56

22 A. Correct, he was notified of the
23 variable decelerations. Ten minutes later is
24 when she put the oxygen on, turned her.

25 Doesn't say anything about notifying anybody at

12:57:06

1 Q. Is that your answer? Would you
2 then agree with the question or disagree with
3 the question?

12:58:08

4 A. You're saying preservation. I
5 don't know that that's how I would word it.
6 You're assuming this baby was healthy when we
7 went in on this.

12:58:16

8 Q. I'm saying in general, during
9 labor, one of the goals of --

10 MR. SCHOBERT: Objection. Go
11 ahead.

12:58:27

12 A. The goal is to deliver the mother
13 and infant safely and healthy.

14 Q. And if there is fetal distress, the
15 remedy is certainly treating the underlying
16 cause or prompt delivery of the fetus?

12:58:41

17 MR. SCHOBERT: Objection.

18 A. I'd say that's fair to say.

19 Q. Would you agree the goal of fetal
20 heart monitoring is to detect fetal hypoxia at
21 its earliest stage?

12:58:51

22 A. I don't think fetal monitoring
23 detects fetal hypoxia. It detects
24 abnormalities in the fetal heart tracing which
25 could lead to a problem.

12:59:17

1 that point.

12:57:08

2 Q. You do agree that it says Dr. Drake
3 notified?

4 A. Yes.

5 Q. As you sit here today, you can't
6 tell us what Dr. Drake -- the information that
7 was notified to him?

12:57:14

8 A. I can't say one way or the other.

9 Q. Would you agree the goal to be
10 pursued constantly during labor is preservation
11 of fetal well-being by early detection and
12 relief of fetal distress?

12:57:28

13 MR. SCHOBERT: Objection. Go
14 ahead.

15 A. Can you say that again?

12:57:40

16 Q. Okay. The goal to be pursued
17 constantly during labor is preservation of
18 fetal well-being by early detection and relief
19 of fetal distress?

20 MR. SCHOBERT: Objection. Go
21 ahead.

12:57:54

22 Q. It's one of the goals; is it not?

23 A. I think the goal is to deliver a
24 healthy baby and a healthy mom, get the mom
25 through okay, is the goal.

12:58:04

1 Q. Okay. So the goal of fetal heart 12:59:20
2 monitoring is to detect abnormalities at the
3 earliest possible time?

4 A. Right.

5 Q. How do you determine evidence of 12:59:35
6 fetal distress during labor? Are there
7 specific things you look for?

8 A. I think we talked about this once.

9 MR. SCHOBERT: Yes, objection.

10 A. Severe persistent variable 12:59:46
11 decelerations, persistent late decelerations,
12 fetal bradycardia, prolonged absence of fetal
13 variability, would be some of the things you
14 would look for.

15 Q. How about fetal scalp blood pH? 12:59:58

16 A. Fetal scalp blood pH is done at
17 specific times based on the heart rate tracing.

18 Q. When is it indicated to do fetal
19 scalp blood gauge determinations?

20 A. At any point in time that the 13:00:12
21 physician taking care of the patient wants more
22 information as to the well-being of the baby.
23 Based on the heart rate tracing.

24 Q. And at what point in time would
25 they want information, based on what type of 13:00:26

1 fetal heart tracing?

13:00:29

2 A. Well, it's like we talked about.

3 Q. I'm sorry?

4 A. Just like in those instances like
5 that we talked about. If there's persistent
6 variations of the fetal heart rate tracings to
7 cause them enough concern to see if the baby is
8 tolerating labor okay or not.

13:00:39

9 Q. So in bradycardia, a fetal heart
10 tracing in bradycardia, you would want to get a
11 fetal heart pH?

13:00:53

12 MR. SCHOBERT: Objection.

13 A. Depends on the situation. Not on
14 every bradycardia would you do that.

15 Q. On which bradycardia would you want
16 to do that?

13:01:02

17 MR. SCHOBERT: Objection.

18 MR. FINELLI: If he doesn't want to
19 give me a specific answer, then I'm going to
20 play general with him.

13:01:09

21 MR. SCHOBERT: I think in general
22 the question is --

23 A. There's no way to give a specific
24 answer.

25 MR. SCHOBERT: They're very

13:01:14

1 general. I mean he's told you that sometimes
2 you do it and sometimes you don't. If you give
3 him a specific example, maybe then --

13:01:15

4 Q. At any point during Mrs. Tarle's
5 care would you have wanted to obtain a fetal
6 scalp blood pH?

13:01:24

7 A. No, but I do recall discussing that
8 with Dr. Drake at one point.

9 Q. When?

10 A. I don't recall exactly when the
11 time was. But I do recall him telling me about
12 the fetal heart rate tracing and I asked him
13 specifically do you think we need to do a pH,
14 and he said no, I think the pattern looks good.

13:01:35

15 Q. So it was you that brought up the
16 option of obtaining a fetal scalp blood gauge?

13:01:49

17 A. Right.

18 Q. And it was Dr. Drake that said he
19 didn't think it was necessary?

20 A. Right.

13:02:00

21 Q. And based on his observation and
22 his experience, you decided not to get a fetal
23 scalp blood gauge?

24 A. Right.

25 Q. You don't recall what time?

13:02:14

1 A. I don't recall what time.

13:02:16

2 Q. But at some -- he had some concern
3 with the fetal heart tracing at that point in
4 time?

5 A. No, he called to update me on her
6 care and I asked him if he thought that it
7 was -- that we should do one, and he said no,
8 really it doesn't look like it's necessary
9 right now. We'll keep an eye on it.

13:02:23

10 Q. What is amnio infusion?

13:02:38

11 A. It's infusion of saline into the
12 uterus to try to hydrodistend it a little bit
13 to resolve variable decelerations due to cord
14 compression.

15 Q. Was there any indication in Mrs.
16 Tarle's care to provide amnio infusion?

13:02:57

17 A. Her variable decelerations were
18 never persistent, so probably not. And after
19 midnight her pattern looked great, so I don't
20 think there was any indication to do it.

13:03:17

21 Q. When do you, during labor and
22 delivery, when do you institute tocolytic
23 agents?

24 MR. STRONG: Total what?

25 MR. SCHOBERT: Tocolytic agents.

13:03:36

1 A. Tocolytic agents? 13:03:38

2 Q. Right.

3 A. To try to stop premature labor.

4 And occasionally we'll give the tocolytic agent

5 when we think we have a hypertonic uterus, 13:03:48

6 overstimulated uterus.

7 Q. So I guess other than premature, in

8 someone that is due gestationalwise or even

9 late, when would you give a tocolytic agent?

10 A. You'll have to say that again. 13:04:11

11 Rephrase it.

12 Q. You talked about someone in a

13 premature status. Someone that is in labor and

14 delivery that is due or that is actually late,

15 when would you give a, what indication would 13:04:21

16 you have to give a tocolytic agent?

17 A. I would say only in a situation

18 where you felt the uterus was hyperstimulated.

19 Q. And how does a tocolytic agent act?

20 A. It acts to relax the uterine 13:04:34

21 muscle.

22 Q. And improves fetal oxygenation?

23 A. Well, it will improve blood flow,

24 and thereby possibly improve fetal oxygenation.

25 Q. Was there any indication during 13:04:48

1 Mrs. Tarle's care for her to receive tocolytic
2 agents?

13:04:50

3 A. There was a reason to give a
4 tocolytic agent when she went into bradycardia.

5 Q. I'm sorry?

13:04:59

6 A. It was reasonable to give a
7 tocolytic agent when she went into the
8 bradycardia at the end.

9 Q. Anytime before that?

10 A. Not that I could see.

13:05:19

11 MR. FINELLI: Let's take a
12 one-minute break. I'm almost done.

13 (Recess taken.)

14 Q. Doctor, when you are reviewing,
15 during a patient's labor and delivery, when you
16 are reviewing the fetal heart tracings, you're
17 doing that as you are taking in the whole
18 clinical picture, are you not, you're just not
19 reviewing the tracings --

13:11:50

20 A. Right.

13:12:02

21 Q. -- in snippets, you're reviewing
22 the tracings as it relates to the clinical
23 picture as far as her station, her dilation,
24 and what's taken place prior to her course of
25 labor, correct?

13:12:13

1 A. Sure. 13:12:14

2 Q. Okay. Now, I think you mentioned
3 earlier, when you arrived at the hospital, the
4 baby was already delivered?

5 A. Correct. 13:12:24

6 Q. Were you there at all during the
7 resuscitative period for the baby?

8 A. Briefly.

9 Q. Can you tell me your knowledge of
10 what happened during the resuscitation of the
11 baby? 13:12:33

12 MR. SCHOBERT: You're asking his
13 recollections versus his review of the chart?

14 Q. His knowledge, yeah. Your
15 recollection. 13:12:44

16 A. I mean I haven't reviewed anything
17 as far as the chart goes, but my recollection
18 was that the baby's heart rate was fine.

19 Q. When?

20 A. When I walked into the
21 resuscitation room. They had made mention what
22 the heart rate was, I don't know what it was,
23 whether it was 140s or something, normal.

24 Q. Can you tell me at what point in
25 time post delivery did you walk into the 13:13:07

1 resuscitation room?

13:13:11

2 A. I don't know that for sure. I'm
3 not sure how much time had elapsed between the
4 time the baby was born and the time I had
5 walked in there. It was minutes. Whether it
6 was two minutes or ten minutes, I don't know.

13:13:20

7 Q. When you walked in, was the baby
8 already tubed?

9 A. Yes.

10 Q. And tell me what else you recall.

13:13:33

11 A. I recall that they had, they were
12 having some trouble ventilating the baby. And
13 there was mention that they weren't getting a
14 lot of chest rise. And so then I remember they
15 removed the tube and tried to bag the baby,
16 still weren't getting a lot of chest rise, and
17 the anesthesiologist intubated the baby and got
18 it going better.

13:13:55

19 Q. Who was involved with the
20 resuscitation care at that point?

13:14:08

21 A. McKelvey was there, there was one
22 or two nurses there, there was someone from
23 anesthesia there.

24 Q. Did you partake at all in the
25 resuscitative efforts?

13:14:23

1 A. No. 13:14:24

2 Q. What was your role once you got to
3 the hospital? What did you do?

4 A. Well, my main responsibility is to
5 the mom, the baby was being taken care of, so I 13:14:35
6 just briefly checked on the baby and then I
7 scrubbed into the case.

8 Q. At what point in time, when you
9 scrubbed in on the case, where were they as far
10 as the care of Mrs. Tarle in the OR? 13:14:56

11 A. Where were they?

12 Q. I mean were they closing, were
13 they --

14 A. Oh, no. No. Really nothing more
15 had been done other than the delivery. I mean 13:15:11
16 I scrubbed in and basically finished the C
17 section from that point. They hadn't put any
18 sutures in even in the uterus yet, I don't
19 think.

20 Q. When you scrubbed in, who was in 13:15:24
21 the room as far as physicians taking care of
22 her?

23 A. Dr. Cook and Dr. Drake were still
24 with the mother.

25 Q. And what did you do when you went 13:15:35

1 in?

13:15:37

2 A. When I scrubbed into the case?

3 Q. Yes. Right.

4 A. I just finished the C section with
5 Dr. Drake. Dr. Cook scrubbed out at that
6 point.

13:15:42

7 Q. So Dr. Cook scrubbed out when you
8 scrubbed in?

9 A. Right.

10 Q. And you completed the closure of
11 the uterus?

13:15:52

12 A. Closure of the uterus and the rest
13 of the case.

14 Q. Were there any complications to
15 Mrs. Tarle at the point in time when you
16 scrubbed in?

13:15:59

17 A. There was some concern about the
18 bladder, but it turned out to be fine. There
19 was no -- they thought there might have been an
20 injury to the bladder, but there wasn't, so
21 there was really no complication.

13:16:11

22 Q. Was the placenta already removed?

23 A. Yeah.

24 Q. Was there any evidence of abruptio
25 placentae?

13:16:24

1 A. It was conveyed to me that they
2 thought she had abrupted. Now, I don't recall
3 there being any, I don't recall there being any
4 visible evidence other than there wasn't a lot
5 of blood left in the umbilical cord.

13:16:25

13:16:38

6 Q. And not a lot of blood left in the
7 umbilical cord, is that pathognomonic for
8 abruptio placentae?

9 A. Not at all.

10 Q. At any point in time up to her time
11 that she went for surgery, did she have any
12 vaginal bleeding or hemorrhaging? During her
13 labor.

13:16:50

14 A. Oh, not that I was made aware of,
15 no.

13:17:04

16 Q. When you determine that a patient
17 needs to go to emergency C section and you're
18 in the hospital, what is the checklist that you
19 go through? Who are the people you notify?
20 What do you do?

13:17:16

21 MR. MARGOLIS: In Akron General.

22 A. You would notify anesthesia, you
23 would notify either the nursery or a
24 neonatologist, depending on your -- depending
25 on what the situation was. And of course you

13:17:32

1 would ask the labor and delivery personnel to 13:17:39
2 get a room ready, stuff like that.

3 Q. So you would notify anesthesia, an
4 anesthesiologist. Do you do that personally or
5 do you have somebody do that? 13:17:49

6 A. Usually we just delegate a nurse to
7 do that as we're getting ready for the C
8 section.

9 Q. I see. So in general, generally
10 it's the nurse's responsibility to notify 13:17:58
11 anesthesia, or an anesthesiologist?

12 A. That's generally how it works.

13 Q. And you also mentioned you either
14 notified nursery or a neonatologist?

15 A. Right. 13:18:10

16 Q. If a neonatologist is not in the
17 hospital, you notify nursery?

18 A. Right. Yes.

19 Q. You notify nursery irrespective of
20 whether a neonatologist is in the hospital or 13:18:21
21 not?

22 A. Right. Yes.

23 Q. If a neonatologist is not in the
24 hospital, do you notify a neonatologist?

25 A. It depends on the situation, 13:18:29

1 oftentimes we will, it really just depends on 13:18:32
2 what your index of suspicion is as far as what
3 the baby's going to -- how the baby is going to
4 do.

5 Q. In Mrs. Tarle's case, was there an 13:18:44
6 index of suspicion where a neonatologist should
7 have been notified?

8 A. I think the neonatologist was
9 notified because of the heart rate tracing, the
10 degree of the bradycardia. 13:18:56

11 Q. Do you know if a neonatologist was
12 in the hospital at the time that she went to
13 emergency C section?

14 A. I don't know. I don't know that
15 for sure. I don't think there was one in the 13:19:06
16 hospital at the time.

17 Q. We know that Dr. McKelvey initiated
18 the emergency C section, but eventually she
19 scrubs out to assist in the resuscitative
20 efforts of the baby? 13:19:32

21 A. Right.

22 Q. Is that normal for the surgeon to
23 scrub out and assist in the resuscitative
24 efforts?

25 A. It's not normal for the attending 13:19:38

1 surgeon to do that. It would be normal for an 13:19:40
2 upper level resident to scrub out to do that.

3 Q. But in this case she was the
4 primary surgeon on the case, correct?

5 A. Well, I would say Dr. Cook would 13:19:53
6 have been the primary surgeon. He was the
7 acting attending at the time.

8 Q. So is it your knowledge, are you
9 saying that Dr. Cook was in the operating room
10 at the beginning of the emergency C section? 13:20:04

11 A. I don't know about that. But once
12 he was scrubbed in, I mean he would have stayed
13 in with the mother.

14 Q. And it would not have been unusual
15 for Dr. McKelvey to have scrubbed out and do 13:20:18
16 resuscitative efforts?

17 A. Right.

18 Q. Do you have any criticisms of how
19 any physicians or surgeons performed in the
20 emergency room? And we talked about Dr. Cook, 13:20:28
21 and you said you didn't have any criticisms of
22 him. Anyone else?

23 A. Not really. I think they did it as
24 quickly and as efficiently as they could, so
25 no, I don't really have any criticisms about 13:20:47

1 the C section itself.

13:20:50

2 Q. Do you have any criticisms of
3 anyone involved in the resuscitative efforts of
4 the baby?

5 MR. SCHOBERT: Objection.

13:20:55

6 A. I wasn't there the whole time, so I
7 have a hard time answering that question, like
8 I said. The only thing that I saw that I guess
9 would be at all concerning was that they were
10 just having a little troubling ventilating
11 during that brief period of time that I was
12 there, but, you know, what had happened prior
13 to that or after that, it's hard for me to
14 comment on the whole thing.

13:21:10

15 Q. We talked about the surgeon
16 scrubbing out. Is it normal or is it routine
17 for the anesthesiologist to scrub out on the
18 case to assist in the resuscitative measures?

13:21:30

19 A. There was probably an anesthetist
20 in the room with the patient, with Michele, the
21 mother, so, you know, honestly, that's the
22 first and only child I've ever had at Akron
23 General where resuscitation was required of
24 that degree, so I don't know if they usually
25 have an anesthesiologist there to help or not.

13:21:45

13:22:04

1 Q. But if I heard you correctly, you
2 are saying besides the anesthesiologist, there
3 was also an anesthetist?

13:22:08

4 A. I think there was an anesthetist
5 with, you know, still back with the C section.

13:22:17

6 Q. Right, in the OR room?

7 A. Right.

8 Q. Do you have an opinion as to what
9 caused the neurological deficits in this baby?

10 A. I don't have an opinion on that.

13:22:30

11 MR. SCHOBERT: And he won't. If
12 that will change, I will tell you, but I don't
13 expect to ask him that question.

14 (Discussion had off the record.)

15 MR. FINELLI: I have no further
16 questions.

13:23:05

17 MR. SCHOBERT: Rick?

18 MR. STRONG: I have no questions
19 today.

20 MR. SCHOBERT: Doctor, you have the
21 right to review the transcript, and I would
22 advise you to exercise that right.

13:23:08

23 THE WITNESS: Yes, I will review
24 it.

25 (Deposition concluded at 1:23 p.m.)

1 CERTIFICATE

2 The State of Ohio,)

3 SS:

4 County of Cuyahoga.)

5
6 I, Denise M. Munguia, a Notary
7 Public within and for the State of Ohio, duly
8 commissioned and qualified, do hereby certify
9 that the within named witness, EDWARD FERRIS,
10 M.D., was by me first duly sworn to testify the
11 truth, the whole truth and nothing but the
12 truth in the cause aforesaid; that the
13 testimony then given by the above-referenced
14 witness was by me reduced to stenotypy in the
15 presence of said witness; afterwards
16 transcribed, and that the foregoing is a true
17 and correct transcription of the testimony so
18 given by the above-referenced witness.

19 I do further certify that this
20 deposition was taken at the time and place in
21 the foregoing caption specified and was
22 completed without adjournment.

1 I do further certify that I am not
2 a relative, counsel or attorney for either
3 party, or otherwise interested in the event of
4 this action.

5 IN WITNESS WHEREOF, I have hereunto
6 set my hand and affixed my seal of office at
7 Cleveland, Ohio, on this 17th day of
8 January, 2002.

9
10
11
12
13 Denise M. Munguia

14 Denise M. Munguia, Notary Public
15 within and for the State of Ohio
16

17 My commission expires May 23, 2005.
18
19
20
21
22
23
24
25

I N D E X

EXAMINATION OF EDWARD FERRIS, M.D.

BY MR. FINELLI..... 4:6

Exhibit 1 was marked..... 107:12

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.

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