Condensed Transcript

CUYAHOGA COUNTY, OHIO

Cheryl Austin, Administrator of
the Estate of Sonoma Davis, deceased,

Plaintiffs,

vs. Case No. 538701

MetroHealth Medical Center, et al.,

Defendants.

VIDEOCONFERENCED DEPOSITION OF

MICHAEL S. FIRSTENBERG, M.D.

June 28, 2005
3:00 p.m.

Kinko's
4516 Kenny Road
Columbus, Ohio

Shayna M. Storts, Registered Professional Reporter

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APPEARANCES:

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STIPULATIONS

It is stipulated by and between counsel for the respective parties herein that this deposition of MICHAEL S. FIRSTENBERG, M.D., a witness herein, called by the Plaintiffs under the statute, may be taken at this time and reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualifications of the Notary is waived.

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Videoconferenced Deposition of
Michael S. Firstenberg, M.D.
June 28, 2005

MICHAEL S. FIRSTENBERG, M.D., being by me first duly sworn, as hereinafter certified, testifies and says as follows:

CROSS-EXAMINATION

BY-MS.KOLIS:

Q. Doctor, for the record could you please state your complete name?

A. Sure. My name is Michael Sol Firstenberg.

Q. All right. And, Dr. Firstenberg, as you know, my name is Donna Kolis for identification purposes in the record. I do represent the estate of Sonoma Davis.

My purpose today in taking your deposition is to clarify what involvement you may have had with Cheryl Austin, Sonoma's mother, on I believe it's May 12, 2003.

Doctor, have you ever before today given a deposition?

A. No, I have not.

Q. Okay. I'm sure that Ms. Petrello, who is representing Metro, had an opportunity

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to explain the process, but since it is your first deposition, I just want to secure a couple things on the record.

Obviously you know that you've got to answer each and every question orally; correct?

A. Correct.

Q. All right. I assume that you know since you just rose your hand and took an oath that you are under oath just as if you were in a court of law; correct?

A. Correct.

Q. All right. Today, Doctor, do you have any obligations that may cause us not to be able to speak uninterrupted?

A. No.

Q. Okay. Fair enough. If for any reason you wish to take a break for personal reasons or to confer with your counsel, you should so indicate for the record and then you can have a break, all right?

A. Sounds good.

Q. Okay. Fair enough.

Let's talk briefly, Doctor, about the background and training that has led you

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to your current position; and candidly, I don't know what your current position is, so I guess we'll start there. What are you currently doing?

A. I am one of the fellows in cardiothoracic surgery down here at the Ohio State University.

Q. Okay. When did you begin that program?

A. I started it approximately two years ago.

Q. Okay. So maybe around July?

A. Of 2003.

Q. 1st?

A. Yeah.

Q. Of 2003. Just a couple months after you sought -- well, assuming that you saw Cheryl Austin; correct?

A. Correct.

Q. Before coming to Ohio State University two years ago, what program were you enrolled in?

A. I was a general surgery resident in the integrated general surgery program at the University Hospitals of Cleveland.

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Q. That program itself was how many years?

A. It's -- the path that I took was five clinical years with two additional research years.

Q. The research years, are those at the end? the beginning? the middle? How does that program run?

A. It's in the middle and it was between my second and third year, second and third clinical years.

Q. Okay. What type of research did you do?

A. I did two years working at the Cleveland Clinic in cardiovascular imaging, and ventricular or cardiovascular physiology.

Q. Okay. So when you were on service at Metro on May 12th, 2003, you were essentially in the home stretch of your general surgery integrated residency program; correct?

A. Yes, that is correct.

Q. Okay. Tell me how it is that through that program that you came to be at Metro.

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A. The way that the program works is you rotate through different hospitals on different rotations, each rotation has a different theme to it, and the program -- the university program it was the one that I was part of at the time because it's always changing, we rotated through University Hospitals, the Cleveland V.A., MetroHealth Medical Center, and while it was still open we rotated through Mount Sinai New York -- excuse me, Mount Sinai in Cleveland.

Q. Okay. Let's talk about your experience at Metro since that's obviously what this case is about. How long had you been at Metro at that point from -- I'm not asking the question very articulately. How frequently would you rotate through Metro?

A. Of the five years total in the program I think I probably spent probably close to half that, give or take a few months, actually at Metro in different capacities.

Q. On May 12th, 2003, what capacity were you functioning in at Metro?

A. During the day I was the chief

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resident on one of the general surgery services, and since I was on call that night I was on call -- the chief resident on call in the hospital.
Q. All right. So you were actually on the general surgery service; correct?
A. Correct.
Q. All right. Did you receive any training prior to that time in trauma surgery?
A. Yes, I've -- by that point I had already completed actually four formal months as the chief resident of the trauma service at Metro, in addition to trauma experience as a junior resident at Metro, as well as participating in trauma care at some of the other hospitals that we rotated through, all of which were trauma centers.
Q. Okay. You said that you had received four formal months in -- and I may be mishearing you because I'm writing --
A. Sure.
Q. -- and not looking at you, which is really poor practice. But four formal months in trauma surgery; correct?

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A. I was the chief resident on the trauma service running the trauma service at the time.
MS. PETRELLO: At Metro.
A. At Metro.
Q. At Metro, okay. And when did that time period occur?
A. That was -- there were two two-month blocks that were during my fourth year. I would have to go back to the schedule, but I believe two months of it were at the beginning of my fourth year and then two months were a little bit later on in the year.
Q. Okay. It's not all that important. I was -- just if you knew, that was fine.
A. Yeah.
Q. Doctor, are you ATLS certified?
A. Currently I am not ATLS certified.
Q. When you say "currently," did you at one time obtain it and then not recertify?
A. Yes.
Q. Okay. When did you obtain initially your ATLS certification?

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A. During my time when I was doing research I got ATLS certified so that I could fly with the life flight service, and that certification was good for five years and at the end of five years I did not renew it.
Q. Can you tell me approximately what year your certification lapsed? I don't have a resume in front of me, that's why I'm asking.
A. Sure. I understand. It probably expired around July of 2003. I think it was still active at the time, but I would have to go back to again my records.
Q. Okay. Prior to starting at Metro -- starting at University Hospitals, obviously you must have gone to med school. Can you tell me where you went to medical school?
A. Went to Case Western Reserve University School of Medicine in Cleveland.
Q. What year did you finish?
A. 1996.
Q. Okay. All right. And did you enter that program at UH immediately following your graduation or did you do something else?
A. Immediately following.

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Q. I think those numbers -- yeah, you add seven that would make you finished in 2003. Okay.
All right. Dr. Firstenberg, in anticipation for today's deposition, what material did you review?
A. The parts of the chart that were provided for me, the medical record that were provided for me.
Q. Okay. All right. Do you have that in front of you?
A. Yes.
Q. Okay.
MS. PETRELLO: He's got my copy of the records, Donna.
BY MS. KOLIS:
Q. Okay. The way that you phrased it, once again, I sometimes read too much into answers; you read the parts of the chart that were furnished to you. Did you have the whole chart of the hospitalization?
A. Is this the whole chart?
Q. If you know.
A. I mean, I've seen entire charts of hospitalization and they can be thousands of

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pages of junk.
Q. Right.
A. And so --
Q. So you don't know?
MS. PETRELLO: Yeah. Donna, I probably -- although I don't remember, I probably did not send him the baby's chart. I probably only sent him the E.R. record and maybe the O.R. note. I'm not sure.
MS. KOLIS: Okay.
THE WITNESS: I do not recall seeing the baby's chart.
MS. KOLIS: Okay. That's fine.
BY MS. KOLIS:
Q. Doctor, did you actually evaluate and care for Cheryl Austin on the 12th in the emergency department or the trauma bay?
A. I helped participate in her care.
Q. Before she went upstairs to surgery?
A. I did see her before she went up to surgery, before she went up to O.B.
Q. Okay. Did you record notes or findings from your participation in that care?
A. The physical findings during her

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assessment were documented by one of the nurses in the emergency room as outlined in the chart, which is how they do things at Metro.
Q. Okay.
A. As well as a separate ancient history and physical is written by one of the junior residents.
Q. Okay. So the answer to the question, so that I'm clear about it, and I think you were clear in your answer, but I like the record to read a certain way, is that from the time she was admitted to Metro following the automobile accident but before she was taken upstairs to O.B., there is not a written note recorded by yourself; correct?
A. I don't believe I wrote a note in her care.
Q. Okay. All right. Given that you did not record notes yourself, or dictate a summary of the events that occurred, I'm going -- if it's okay with you, I'm going to call it "downstairs" so I don't have to quibble about whether it's E.D. or trauma. But while she was downstairs, on reading the

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chart did it refresh your recollection as to the event?
A. Yes.
Q. Can you approximate for me or give me the markers that would indicate to me when you actually arrived in the emergency department to assess the patient?
A. There is a -- there is a trifold in the chart which is the nursing documentation that indicates when I was paged and when my -- when they documented my arrival.
Q. Okay. Unfortunately, because I chose to be in Cleveland, I'm not sitting with you.
MS. PETRELLO: It's the trauma flow sheet, Donna.
THE WITNESS: Yeah.
MS. PETRELLO: You know where it has the trauma team signatures?
MS. KOLIS: That's exactly where I am. That's the page.
BY MS. KOLIS:
Q. So it indicates you were actually paged at 1701 and arrived at 1728, perhaps?

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A. Yes.
Q. I read that as an A, but I'm not sure.
So that tells you approximately when you arrived; is that a fair statement?
A. Usually that's when the nurses notice that the people are there, but I think that's a reasonable statement.
Q. All right. At the time that you arrived in the emergency department, did you speak with Cheryl Austin?
A. I am sure I said hello to her, as is my customary.
Q. Okay. I probably should ask a better question. Did you take an independent history from her relative to the collision and then her complaints following that event?
A. I did a brief assessment of the situation and evaluated her.
Q. Okay. When you say you did a brief assessment and evaluated the situation, please tell me what you mean by that.
A. Well, I asked her if she had any major medical problems, if she had any previous surgeries, what was bothering her, if

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there was something in particular that was hurting. And then I did not go into -- I did not feel the need to repeat at length all the things that had already been done and documented, but just for my own understanding of what was going on getting a brief assessment as to where she was.

Q. All right. I guess my question is this -- and once again, I'm not going to ask it particularly well. It would appear from the charting in the record that the primary survey or initial assessment of the patient had, in fact, been completed --

A. Correct.

Q. -- before you arrived? Would you agree with that?

A. Yes. Yes.

Q. All right. Would you say that from ABC standpoint that Cheryl Austin seemed stable?

A. Yes.

Q. Okay. Was there anything significantly abnormal in your survey of this particular patient?

A. Well, I did notice that she was

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complaining of abdominal pain to my exam, and did notice that she had some variations in her blood pressure, but not in her heart rate; and that she seemed to be breathing quite comfortably.

Q. Okay. Now, just to be clear, I have documentation, and when you say "trifold," I don't have a trifold, I've got a photocopy.

A. I'm sure it's the same thing.

Q. It probably is. Because immediately following this sheet or probably two or three into it where it shows the initial assessment it shows that the abdomen was assessed at 1716 and the findings were positive bowel sounds with bilateral abdominal pain -- bilateral lower abdominal pain; correct?

A. Correct.

Q. Okay. Doctor, at the point that you did your brief second -- I'm going to call it a brief secondary survey, although it's not technically one. Did you have a differential diagnosis for the patient?

A. Well, she was lumped into a

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category of blunt abdominal trauma, meaning, you know, she had abdominal pain that we needed to figure out what the cause of it was, and there was a full spectrum that that consists of.

Q. Okay. So your heading as you say of this spectrum is blunt abdominal trauma?

A. Yeah.

Q. And you were considering ruling in or ruling out, I suppose, certain conditions that could cause or contribute to the bilateral lower abdominal pain; correct?

A. Correct.

Q. Doctor, to the best -- to your knowledge as to where you were educationally at that point, contained under the classification of blunt abdominal trauma in a person who is six months pregnant, should a consideration of abrupted placenta been within that differential also?

A. Yes.

Q. And that's something you knew because you were ATLS certified, and there's a chapter on blunt abdominal trauma in pregnancy, is there not?

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A. I'll take your word for it, but yes.

Q. I think it's Chapter 11. Yeah, it would be Chapter 11.

A. Okay.

Q. In reviewing the chart -- and I'm just asking things that you may or may not remember, but today is my only chance to know what you do or don't remember. Do you have a recollection of Dr. Lewis indicating that he could not find the fetal heart tones?

A. I recall a concern about difficulty in getting adequate fetal heart tones.

Q. Did Dr. Lewis discuss that with you?

A. He did mention it.

Q. Okay. Were you at that time or were you or had you been trained in the technique of obtaining fetal heart tones?

A. No, we relied on the OB/GYNs for their assessment of that.

Q. Okay. Doctor, did you at any point while Cheryl Austin was downstairs ask for an obstetrical consult?

A. We did ask OB/GYN to evaluate them

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-- evaluate her, excuse me.
Q. Okay. Have you been made aware of the content of the deposition testimony of other people in this case?
A. No, I haven't.
Q. Okay. To the best of your recollection, since there's not a recorded note, did you, yourself, personally call O.B. at any time while Cheryl was downstairs?
A. I think O.B. was already called -- according to the documentation, O.B. had already been called by the emergency room attending, Dr. Lewis.
Q. Can you tell me based upon what you're calling the documentation --
A. Yeah.
Q. -- each time you believe O.B. was called by Dr. Lewis?
A. Let me check here to get the timing.
Q. Sure.
A. I don't know if the documents --
MS. PETRELLO: Donna, let me just clarify something. Did you -- did you ask him if he's read the depositions or if they

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were discussed with him? Because I want to make sure that we've answered. He has not read the depositions. Have you?
THE WITNESS: No, no.
MS. PETRELLO: I didn't send you any depositions.
THE WITNESS: No, I did not get any of the depositions.
MS. PETRELLO: But in the course of our discussions I probably have shared with him some of the testimony so far. So I just want to make sure that that's clear, because I'm not sure, your answer (sic) may have been misleading. I can't remember exactly how you asked it.
THE WITNESS: I have not read the depositions by the other people. We're just trying to track a sense of the time here that they were called.
BY MS. KOLIS:
Q. Right, you may -- I'd be curious to tell whether you could tell by documentation what time O.B. was called?
A. According to Dr. Lewis's note, the attending, they were notified -- I'm just

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reading, OB/GYN were phoned, informed of the patient's status on arrival -- upon her arrival to the trauma bay.
Q. Dr. Firstenberg --
A. So it sounded like without having the exact time documented, it sounds relatively early in her assessment.
Q. Right. Just so that you and I are clear, you are reading from Gregory Lewis's discharge summary; correct?
A. Correct.
Q. Or the summary note?
A. Yes.
Q. The typed note?
A. Correct.
Q. And because I guarantee you that I have not seen anything listed where it says in handwriting "placed phone call to O.B." and that's why I was curious as to if you had seen something I hadn't seen or if you actually knew what time they were called?
MS. PETRELLO: Wait a second, Donna.
Do you need to get that?
THE WITNESS: No.

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MS. PETRELLO: Are you sure?
THE WITNESS: Yeah.
MS. KOLIS: That's all right.
MS. PETRELLO: That was his beeper.
MS. KOLIS: I figured as much.
BY MS. KOLIS:
Q. Right. So you really don't know what time they were called?
A. I don't know what time they were called.
Q. Did you get the sense, if you can reconstruct it, given there's no documentation that I'm aware of -- is your recollection that by the time you arrived at 1728 that Dr. Lewis had already encountered difficulty obtaining fetal heart tone?
A. The -- my assessment was that they had already attempted to evaluate her -- they had already completed a primary and secondary survey; and that there was some concern about whether they had adequately heard her fetal heart tones.
Q. Okay. In terms of who made the primary decision as to what battery of tests

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or, you know -- I guess that's the best way to ask it, the battery of tests or the order of evaluation for this patient, who is in charge, yourself or Dr. Lewis?
A. The -- technically Dr. Lewis is in charge, but those decisions --
Q. Because be --
A. Because he is the attending.
Q. Okay.
A. And for -- well, in the context of Level 2 trauma patients, which she was, the trauma team serves as a consulting service. And so any decisions as to what tests should or should not be performed, those are usually made in joint discussion between the trauma team and the trauma team and the emergency medicine team as represented by the emergency medicine attending.
Q. Okay. And you were the consultant for the trauma team; correct?
A. Correct.
Q. All right. And is it, in fact -- well, Dr. Gaglardi has indicated to me that he was not in attendance downstairs. Is that your recollection?

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A. Correct.
Q. Did you at any time while Cheryl was downstairs call Dr. Gaglardi for any reason relative to this patient?
A. I don't remember talking to him while she was down there.
Q. Okay. All right. In terms of -- we're just going to do it this way. I'm going to read you some statements I think is the easiest way for me to do it.
A. Okay.
Q. And see if you agree or disagree in terms of what I'm saying.
Going back to -- looking at Cheryl Austin, we've already established and you've answered that her ABC's were stable; in other words, she had a patent airway; correct?
A. Correct.
Q. Okay. Seemed to be adequately ventilated; correct?
A. Correct.
Q. She had good effective circulatory volume, as best you could tell?
A. Yes.
Q. Okay. Doctor, what would be a

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sign and in a pregnant woman that a significant blood loss was occurring?
A. Profound tachycardia; hypotension that is refractory to various maneuvers; altered mental status; evidence of decreased peripheral circulation where pulse is; cold and clammy skin; diaphoresis; impaired capillary refill; obvious evidence of hemorrhage. Those are the major things.
Q. Would you agree that because of increased intravascular volume a pregnant patient can lose a significant amount of blood volume before they become tachycardic, hypotensive or experience other signs of hypovolemia?
MS. PETRELLO: Donna, I'm going to object. No. 1, I don't know what you're reading from. I think it's unfair. He hasn't seen it; and also this is approaching expert testimony. And he's not an expert.
MS. KOLIS: Well, I'm testing his level of knowledge at the time that this patient presented, and I can tell you, quite frankly, where I'm reading from. I'm reading from Chapter 11, Trauma in Women, ATLS, and

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the pertinent in effect version for that time. And I'm reading assessment and management of pregnant women with blunt abdominal trauma. That's exactly what I'm reading from.
MS. PETRELLO: Okay. But we don't have it in front of us, and you're only taking one sentence and, quite frankly, that's unfair to this witness. So to the extent that --
MS. KOLIS: I don't know --
MS. PETRELLO: Just wait. To the extent, Doctor, that you can answer that question without seeing the entire chapter, go ahead.
A. The evaluation of pregnant women can be very challenging because of, one, the reasons that you specify, the stress and emotional aspects; and often the pain can cloud and blunt some of those responses if there's any drugs or substances on board. As you can see, the entire picture can be very cloudy, and that is why as a trauma team we are obligated to use the extent of available resources to try to make a comprehensive

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evaluation without relying on any one piece or even a couple of pieces of information to potentially make misleading decisions.

Q. Okay. Thank you very much for that answer.

Would you agree with me that in the emergency department/trauma service that there were, in fact, two patients there that day, Cheryl Austin and her child?

A. It was just Cheryl Austin. Our obligation was to Cheryl.

Q. Okay. You do not believe that a trauma doctor has an independent responsibility to assess the fetus?

A. That is why we get consultants involved. Our focus -- the focus -- I mean, obviously those things play into our decision-making, but our primary focus is the care and well-being of the mother.

Did that answer your question?

Q. Well, I think that may have. I don't know that I like the answer, but...

A. Well, we are there to advocate.

MS. PETRELLO: That's all right. You've answered the question.

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THE WITNESS: Okay.

BY MS. KOLIS:

Q. Let's do it a different way. Cheryl Austin is complaining of lower abdominal pain; correct?

A. Correct.

Q. You've already admitted that that is potentially a sign of an abrupted placenta; correct?

A. Potentially.

Q. Okay. So I want to know if you're saying that you have no independent obligation in a situation where we have the presentation of a pregnant woman who is reported to be 26 plus weeks pregnant to assess the fetal well-being?

MS. PETRELLO: Objection. Asked and answered. Go ahead. Go ahead. You can tell her again.

A. Our obligation is to the well-being of the mother and to advocate for her survival, so to speak, and well-being. And that is why we get consultants involved who serve as advocates for other factors that involved; in this particular case, her

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26-week-old fetus.

Q. Doctor, who was the consultant for Sonoma Davis downstairs in the hospital?

A. That would be -- that's the role of the OB/GYNs.

Q. Well, correct me if I'm not wrong, there was no consultant in attendance for this child downstairs in the hospital; correct?

A. Our obligation was to make sure that the mother, as is outlined in the practice of trauma, gets the best care so that she can survive to then potentially deliver and make sure that she does the best that she can. And then when we are satisfied that she does not have immediately and potentially life-threatening injuries, then we can shift our focus to some of the other issues, which in this particular case is her unborn baby.

Q. Whose responsibility is it to get a consultant downstairs to evaluate fetal well-being?

MS. PETRELLO: Objection. Go ahead.

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BY MS. KOLIS:

Q. You can answer it.

A. I don't understand what you mean by getting somebody downstairs. I mean, physically going -- I mean, we call consultants all the time. We give them the information that is readily available. If that information changes, we call them back. And as experts in their particular areas, they rely on that information to whether they feel they need to come down right away or whether they need to wait for other issues to resolve first. We can't physically drag somebody down.

Q. Did you -- okay. That's a fair enough answer.

And I gather from what I have read from Dr. Lewis's discharge summary your recollection and his own testimony, which you haven't seen, is that at least two phone calls were placed to O.B., but they advised that you should just continue with your evaluation, and when you were done that you could have her come upstairs; correct?

A. I believe that's what's documented,

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correct.
Q. Okay. In your training as a trauma surgeon, and I'm going to limit it to that -- I take it you have no OB/GYN training. We'll start with that; correct?
A. Correct. I mean in the scope of our general surgical training there is no formal OB/GYN experience.
Q. Okay. In your medical training and experience, whichever rotations it was, what was your belief as to what you would be looking for in order to recognize a possible placental abruption?
A. Vaginal bleeding would be a concern that there may be something going on; obviously severe abdominal pain will place abruption as somewhere in an extremely long differential; and the very fact that she was pregnant would, in my opinion, mandate getting the OB/GYNs involved for just doing what they do best, and that is assessing a pregnancy.
Q. Doctor, was a bedside fetal ultrasound performed in the emergency department?
A. I did not perform one, but it

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looks like from the documentation that I think before I arrived they tried to get heart tones.
Q. Okay. By ultrasound?
A. They -- yes, yes. And according to the documentation it looks like that was done after I had arrived, that they tried getting heart tones.
Q. Can you tell me where in the documentation you are looking?
A. That is the -- again, the trauma flow sheet. It's the same page that we referred to earlier that documents my arrival to the emergency department -- the trauma bay, excuse me.
Q. I take it you're referring to line 3 which says, "The bedside ultrasound shows fetus" --
MS. PETRELLO: No. Donna, you know the page that has the trauma team signatures?
MS. KOLIS: Right.
MS. PETRELLO: And then right above that it says 1745.
MS. KOLIS: Right.

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MS. PETRELLO: And right below that it says, "Fetal ultrasound per Dr. Werner," that's what he's looking at.
MS. KOLIS: Right. My question is: There's no findings from that, and I can't find any fetal ultrasound findings in the chart. That's why I'm asking.
MS. PETRELLO: Oh, you mean the results? I'm not sure -- maybe ask your question again, because I think we're both confused.
MS. KOLIS: Right. Right.
BY MS. KOLIS:
Q. Well, I'm confused because of the chart, so let me ask it this way: Did you see someone perform a bedside fetal ultrasound?
A. An ultrasound according to the documentation -- I do not --
MS. PETRELLO: She's asking if you saw it.
THE WITNESS: Yeah.
BY MS. KOLIS:
Q. Yeah, just asking if you saw it.
A. I don't remember specifically

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seeing it. I'm not denying what the documentation says, I just don't remember seeing it.
Q. Okay. And would you agree with me that in the note that constitutes the emergency department and trauma department downstairs assessment, there aren't any notes that indicate what the fetal ultrasound revealed --
A. Correct.
Q. -- if it occurred; right?
Who is Dr. Werner?
A. I believe she was one of the emergency medicine residents at the time.
Q. Can emergency medicine residents perform fetal ultrasound?
A. I don't know if that's within the scope of their practice at the level of their training, whether that is something that they are adequately trained for.
Q. Okay. And you, yourself, don't do fetal ultrasound; correct?
A. I do not do them.
Q. Okay. Okay. So you were going way back to what you and I were talking

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about a little bit earlier. You had a broad general diagnosis of blunt abdominal trauma?
A. Yes.
Q. Based upon her presentation of pain; correct?
A. Correct.
Q. What did you think should happen to evaluate that finding?
A. She needed a CAT scan of her abdomen and pelvis.
Q. Okay. And was that your decision or did you discuss it with Dr. Lewis? What did you two do?
A. We jointly discussed it and we agreed that that should be -- what should be the step taken.
Q. Okay. Doctor, in the charting it says, "Care assumed by trauma transport team at 1805," on the same page, that same trauma flow sheet.
A. Yes.
Q. Okay. My understanding from the deposition of someone else is that the trauma -- someone from the trauma team, specifically Dr. Fulop and a nurse, would have taken

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Cheryl to the CAT scan; correct? You didn't take her; right?
A. I did not take her.
Q. You don't recall being in the CT room with the technician watching the film as it ran by; correct?
A. I don't remember them showing up on the monitor, correct.
Q. Okay. All right. Do you have a recollection if it was busy in the E.D. that day?
A. It seemed busy, but it didn't seem disproportionately busy or out of control, so to speak, from times that I remember at Metro.
Q. Okay. In terms of nursing documentation, which I'm sure you may have had an opportunity to review, it seems that Cheryl Austin was being monitored for blood pressure, pulse, respiratory rate, temperature and pulse ox from 1713 through 1805. Do you know -- have you seen that page?
A. Yes, we're looking at it now.
Q. Okay. Great.
Were you aware of the bigeminy and

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the trigeminy?
A. Yes.
Q. Okay. What were you attributing that to?
A. There was some concern that she may have sustained a cardiac contusion as part of her injury.
Q. Okay. After 1605 would you agree with me there is no documentation as to her basic vitals; blood pressure, pulse, respiratory rate, anything of that nature?
MS. PETRELLO: I think it's 1805. I think you said 16 --
MS. KOLIS: I didn't mean to say that. It was 6:05 or 1805, whichever you want to make it.
A. I don't think that I have seen any from that time on.
Q. Okay. In reviewing the CAT scan results, if you did -- and have you had an opportunity to review those?
A. Yes.
Q. Okay. Based upon the information contained in that document and the deposition testimony of another witness, it would appear

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that they got her in there and they didn't encounter any difficulty in doing the CAT scan. Would you agree with that?
A. It sounded like a pretty straightforward exam.
Q. And you have had patients who have had CTs at Metro prior to Cheryl; correct?
A. Correct.
Q. All right. Would you say that an assessment that it takes approximately for an abdominal and pelvic CT to be performed is about maybe 20 minutes?
A. All told, probably a little bit longer, maybe, you know, by the time you bring the patient over if they have had, you know, contrast, if they have had problems with IVs. I mean, that time can be extremely variable.
Q. Okay.
A. But the actual time to do the procedure is probably only about 15, 20 minutes.
Q. Okay. In this particular instance were you told what was found at the time of CT?

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A. I went to go review the CAT scan results myself with the radiologist.
Q. When did you do that?
A. She was still down in the emergency department at the time, so the exact time I don't recall, but it was in that time window that she was still in the emergency department.
Q. So Dr. Fulop didn't come back and tell you what was seen on CT. Did you get a phone call for you to come look at the film or you just wanted to see it?
A. It's been my practice to try to go over the scans myself as much as I could.
Q. Okay. But sitting here today, you don't actually know what time that occurred; correct? Do you know --
A. The exact time I don't know other than she was still in the emergency department at the time. So I mean, I can narrow it down to, what is that, about a half hour, 45-minute window. But it had been after the scans had been printed out and before she had gone upstairs. So probably within -- like I said, probably within about

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somewhere in that 20-minute window.
Q. Okay. And based upon -- if you know, based upon what you saw on the CAT scan, what was your impression of the problem or problems that Cheryl was having?
A. When I reviewed the scans with the radiologist I remember we had noticed that her major solid organs all appeared to be intact, particularly the spleen, the liver, some of the lower cuts of the lung; that, however, we did appreciate some fluid in the abdomen, but particularly in the context of somebody who is 26 weeks pregnant I remember there being some discussion as to what the significance of that was as we typically don't get routine CAT scans in a patient at that point in their --
Q. Pregnancy; right?
A. -- pregnancies, yeah.
Q. Okay. Did you actually -- after you reviewed the findings with the radiologist, did you have a recollection of speaking with Cheryl Austin again?
A. Yes.
Q. Speaking -- I'm sorry, speaking

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with Cheryl Austin again before you saw her in surgery upstairs?
A. After I went over the CAT scan results and looked at the CAT scan I went to go back and to see how she was doing, to see how she felt, felt her belly again, and told her that we were going to be getting her up to O.B. to be assessed.
Q. Okay. And when you saw her, Doctor, do you remember it being that she was in a hallway at that point?
A. She was -- the way that the emergency room at Metro was -- well, was set up, because they have since redecorated, is that there was the central nursing station, and if you can imagine sort of an H type configuration, she was in one of the prongs of the H right in front of the nursing station. If we had a map I could probably identify it, but she was essentially in front of the nursing station.
Q. Okay. And she was not being monitored at that point; correct?
A. To be honest with you, I don't remember if she had had a portable monitor on

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her or not. But...
Q. If she was being --
A. I don't know.
Q. There are no recorded findings after 1805; correct?
A. From what I've seen in the documentation, I haven't seen anything indicating that she was.
Q. All right. And then you --
MS. PETRELLO: Hang on a second. Do you need to get those?
THE WITNESS: No, no. Yeah. They know I'm not at the hospital. Yeah. That's fine.
MS. PETRELLO: Because that makes the third time it went off.
(Brief interruption.)
BY MS. KOLIS:
Q. Did you then go tell Dr. Lewis what you saw on the CAT scan?
A. I believe discussing with him that there was some fluid in the abdomen.
Q. Okay. Because the charting reflects it's not you, but it is at 7:10, or however you want to call it, the time Dr.

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Lewis is recorded as saying she can go to O.B.; correct?
A. Yes.
Q. All right. How soon after Cheryl was transferred up to O.B. were you alerted to the fact that you might have to attend a surgery?
A. They called us back probably about -- probably about 10 to 15 minutes or so after she had arrived up there.
Q. Okay. As you sit here today, in recalling the events, did anyone on the O.B. team ask you why she didn't come up earlier?
A. No, I don't recall that.
Q. At the time that you attended Cheryl Austin for this what I call the trauma part of the surgery or the consultation, were you aware of the fact -- you became aware that she had had an abrupted placenta; correct?
A. Not while she was -- not at any point that she had gone up to L and D. I don't think I understand the question, but...
Q. Right. I didn't ask it well.
You became aware once you got to

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the surgery that there had been an abrupted placenta; correct?
A. Correct.
Q. Okay. And did you inquire about the condition of the child?
A. Yes.
Q. And what did you find out?
A. That the Apgar scores were suboptimal and that they were going to be taking the child off to the neonatal intensive care unit.
Q. After the surgery did you write any notes in the progress notes?
A. I probably wrote a progress note, and I know I dictated an operative note, as well as writing her a postoperative orders and admission to the ICU.
Q. Okay. Did you talk with Cheryl after the surgery?
A. I talked to her once she arose from anesthesia; I talked to her in the ICU the following morning.
Q. Do you recall what the two of you talked about?
A. I don't recall, but it was

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probably -- as I was not responsible at that point for her ongoing care, it was more -- just more trying to just comfort her and reassure her.
Q. Reassure her that what?
A. That she was doing well and that --
Q. Oh.
A. -- from our evaluation that we were happy with how she was doing.
Q. Doctor, do you know how long it takes from the time of an abruption to when a baby will become hypoxic, or is there a time frame?
MS. PETRELLO: Objection. If you know.
A. I don't know the exact time. It would be speculation.
Q. Okay. Other than Cheryl Austin, at any time prior to that date, and I don't care about anything that's happened to you after that date, have you ever been involved in a situation where you were evaluating a patient in an emergency department potentially for a placental abruption?

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A. In the scope of a trauma or overall?
Q. Yes. No. First of all, just in the context of a trauma.
A. Well, as we discussed previously, complications of pregnancy such as that always need to be included in the differential when you're evaluating any trauma patient as either a cause of their trauma or as a secondary factor to it.
Q. Once again, bad question on my part. I'm asking you if you ever previously participated in, and I think you probably answered it, but it's the way I asked the question -- if prior to the time you had the opportunity to be involved in the care of Cheryl Austin, do you recall another occasion where you would have been evaluating somebody for the same potential placental abruption?
MS. PETRELLO: Do you understand her question? You seem a little confused.
THE WITNESS: I'm still a little confused by your question. I apologize.
MS. PETRELLO: She just wants to know if you -- prior to this case, whether

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or not you were involved in a pregnant trauma patient.
MS. KOLIS: Right.
THE WITNESS: Who abrupted?
MS. KOLIS: Yes, more simply asked.
MS. PETRELLO: But I think his confusion is the abruption part. I mean, because that's what you said. You're talking -- and I'm not trying to ask your question for you, Donna, but you're talking about abdominal pain in a trauma pregnant patient; true?
MS. KOLIS: Right. Exactly.
MS. PETRELLO: Okay. So were you -- did you --
THE WITNESS: I have -- prior to that point I had evaluated pregnant trauma patients before. Does that answer your question?
BY MS. KOLIS:
Q. Yes, it does.
Had any of them have lower abdominal pain as one of their presenting symptoms?

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A. Yes.
Q. Okay.
A. They probably all do.
Q. Is it your recollection -- oh, okay. I see what you're saying.
In those instances, do you recall O.B. coming downstairs to evaluate the patient?
A. Depending on the circumstances, sometimes they come down. Other times they would just wait for us to finish our assessment of the patient prior to sending them upstairs -- and send them upstairs. That's up to their -- their judgment.
Q. The inability of a physician in an emergency room department to obtain fetal heart tones, what does that suggest to you? What could it possibly suggest?
MS. PETRELLO: In a trauma patient?
A. In a trauma patient or --
Q. Yes.
A. Or in -- you've got the full spectrum of poor application of available technology to -- well, which is most commonly

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the cause, to actual problems with the fetus.
Q. Okay. Of the two possibilities that you suggested, poor application of technology and actual problems with the fetus, which one is more dangerous to the fetus?
MS. PETRELLO: Wait. I don't think he listed just two. I think he said there's a spectrum and that went from this to that. So he didn't just say there were two things.
BY MS. KOLIS:
Q. Well, in your spectrum, if you can't obtain fetal heart tones and the possibility exists as a reason that you can't is actually a problem with the fetus, isn't that the most dangerous situation of all of those in the spectrum?
MS. PETRELLO: Objection.
BY MS. KOLIS:
Q. I mean, it's a pretty simple question.
MS. PETRELLO: No, it's not, Donna. There are so many assumptions in there.
If you can answer that, go ahead.

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I mean, you're talking about a make-believe patient, so...
BY MS. KOLIS:
Q. Well, this is not exactly a make-believe patient, but I'm just saying that when a doctor is considering what the reason is that they can't obtain fetal heart tones, the most dangerous one would be a problem with the fetus?
MS. PETRELLO: But, Donna, in what kind of a patient? Okay. Is the patient conscious? Is the patient unconscious? Is the patient hemorrhaging? I mean, what was the mechanism of injury? I mean, you're just taking one symptom. So to the extent that he can answer that question, go ahead.
A. An adequately trained person who can, to the best of their ability, assess a fetus and raise the concern of potential physiologic instability is very concerning.
MS. KOLIS: Yes. Doctor, I don't have any further questions for you. Thank you for making the time today for this deposition. And I wish you well in your career.

THE WITNESS: Thank you very much.
MS. PETRELLO: You have the right to read or waive signature. He's going to read.
MS. KOLIS: And we'll do it 30 days, Colleen, okay?
MS. PETRELLO: Yeah.
(Signature not waived.)
And, thereupon, the deposition was concluded at approximately 3:52 p.m.

CERTIFICATE

State of Ohio:
SS:
County of Franklin:

I, Shayna M. Storts, Notary Public in and for the State of Ohio, duly commissioned and qualified, certify that the within named MICHAEL S. FIRSTENBERG, M.D., was by me duly sworn to testify to the whole truth in the cause aforesaid; that the testimony was taken down by me in stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony given by said witness taken at the time and place in the foregoing caption specified.

I certify that I am not a relative, employee, or attorney of any of the parties hereto, or of any attorney or counsel employed by the parties, or financially interested in the action.

IN WITNESS WHEREOF, I have set my hand and affixed my seal of office at Columbus, Ohio, on this 11th day of July, 2005.

_____

SHAYNA M. STORTS, Notary Public
In and for the State of Ohio
and Registered Professional Reporter.
My Commission expires June 12, 2008.

CAPTION

The Deposition of Michael S. Firstenberg, M.D., 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.

CERTIFICATE

STATE OF :
COUNTY/CITY OF :

Before me, this day, personally appeared, Michael S. Firstenberg, M.D., who, being duly sworn, states that the foregoing transcript of his/her Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition.

Michael S. Firstenberg, M.D.

SUBSCRIBED and SWORN to before me this day of , 2005 in the jurisdiction aforesaid.

My Commission Expires Notary Public

DEPOSITION ERRATA SHEET

RE: SetDepo, Inc.
File No. 6597
Case Caption: Cheryl Austin vs. MetroHealth Medical Center, et al.

Deponent: Michael S. Firstenberg, M.D.
Deposition Date: June 28, 2005

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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Michael S. Firstenberg, M.D.