

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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<p style="text-align: center;">1</p> <p style="text-align: center;">CUYAHOGA COUNTY, OHIO Cheryl Austin, Administrator of the Estate of Sonoma Davis, deceased,</p> <p style="text-align: center;">Plaintiffs,</p> <p style="text-align: center;">vs. Case No. 538701</p> <p style="text-align: center;">MetroHealth Medical Center, et al.,</p> <p style="text-align: center;">Defendants.</p> <p style="text-align: center;">----- VIDEOCONFERENCED DEPOSITION OF MICHAEL S. FIRSTENBERG, M.D. June 28, 2005 3:00 p.m.</p> <p style="text-align: center;">Kinko's 4516 Kenny Road Columbus, Ohio</p> <p style="text-align: center;">Shayna M. Storts, Registered Professional Reporter</p>	<p style="text-align: center;">3</p> <p style="text-align: center;">STIPULATIONS</p> <p>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.</p>
<p style="text-align: center;">2</p> <p>1 APPEARANCES:</p> <p>2</p> <p>3 ON BEHALF OF THE PLAINTIFFS.</p> <p>4 FRIEDMAN, DOMIANO & SMITH</p> <p>5 DONNA TAYLOR-KOLIS, ATTORNEY AT LAW</p> <p>6 1370 Ontario Street, 6th Floor</p> <p>7 Cleveland, Ohio 44113</p> <p>8</p> <p>9 ON BEHALF OF THE DEFENDANTS.</p> <p>10 SUTTER, O'CONNELL, MANNION & FARCHIONE</p> <p>11 COLLEEN H. PETRELLO, ATTORNEY AT LAW</p> <p>12 (Via videoconference)</p> <p>13 1301 East 9th Street, Suite 3600</p> <p>14 Cleveland, Ohio 44114</p> <p>15 (216) 928-4533</p> <p>16 cpetrello@sutter-law.com</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p style="text-align: center;">4</p> <p>1 Videoconferenced Deposition of</p> <p>2 Michael S. Firstenberg, M.D.</p> <p>3 June 28, 2005</p> <p>4 MICHAEL S. FIRSTENBERG, M.D., being</p> <p>5 by me first duly sworn, as hereinafter</p> <p>6 certified, testifies and says as follows:</p> <p>7 CROSS-EXAMINATION</p> <p>8 BY-MS.KOLIS:</p> <p>9 Q. Doctor, for the record could you</p> <p>10 please state your complete name?</p> <p>11 A. Sure. My name is Michael Sol</p> <p>12 Firstenberg.</p> <p>13 Q. All right. And, Dr. Firstenberg,</p> <p>14 as you know, my name is Donna Kolis for</p> <p>15 identification purposes in the record. I do</p> <p>16 represent the estate of Sonoma Davis.</p> <p>17 My purpose today in taking your</p> <p>18 deposition is to clarify what involvement you</p> <p>19 may have had with Cheryl Austin, Sonoma's</p> <p>20 mother, on I believe it's May 12, 2003.</p> <p>21 Doctor, have you ever before today</p> <p>22 given a deposition?</p> <p>23 A. No, I have not.</p> <p>24 Q. Okay. I'm sure that Ms. Petrello,</p> <p>25 who is representing Metro, had an opportunity</p>



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<p style="text-align: center;">5</p> <p>1 to explain the process, but since it is your 2 first deposition, I just want to secure a 3 couple things on the record. 4 Obviously you know that you've got 5 to answer each and every question orally; 6 correct? 7 A. Correct. 8 Q. All right. I assume that you know 9 since you just rose your hand and took an 10 oath that you are under oath just as if you 11 were in a court of law; correct? 12 A. Correct. 13 Q. All right. Today, Doctor, do you 14 have any obligations that may cause us not to 15 be able to speak uninterrupted? 16 A. No. 17 Q. Okay. Fair enough. If for any 18 reason you wish to take a break for personal 19 reasons or to confer with your counsel, you 20 should so indicate for the record and then 21 you can have a break, all right? 22 A. Sounds good. 23 Q. Okay. Fair enough. 24 Let's talk briefly, Doctor, about 25 the background and training that has led you</p>	<p style="text-align: center;">7</p> <p>1 Q. That program itself was how many 2 years? 3 A. It's -- the path that I took was 4 five clinical years with two additional 5 research years. 6 Q. The research years, are those at 7 the end? the beginning? the middle? How does 8 that program run? 9 A. It's in the middle and it was 10 between my second and third year, second and 11 third clinical years. 12 Q. Okay. What type of research did 13 you do? 14 A. I did two years working at the 15 Cleveland Clinic in cardiovascular imaging, and 16 ventricular or cardiovascular physiology. 17 Q. Okay. So when you were on service 18 at Metro on May 12th, 2003, you were 19 essentially in the home stretch of your 20 general surgery integrated residency program; 21 correct? 22 A. Yes, that is correct. 23 Q. Okay. Tell me how it is that 24 through that program that you came to be at 25 Metro.</p>
<p style="text-align: center;">6</p> <p>1 to your current position; and candidly, I 2 don't know what your current position is, so 3 I guess we'll start there. What are you 4 currently doing? 5 A. I am one of the fellows in 6 cardiothoracic surgery down here at the Ohio 7 State University. 8 Q. Okay. When did you begin that 9 program? 10 A. I started it approximately two 11 years ago. 12 Q. Okay. So maybe around July? 13 A. Of 2003. 14 Q. 1st? 15 A. Yeah. 16 Q. Of 2003. Just a couple months 17 after you sought -- well, assuming that you 18 saw Cheryl Austin; correct? 19 A. Correct. 20 Q. Before coming to Ohio State 21 University two years ago, what program were 22 you enrolled in? 23 A. I was a general surgery resident 24 in the integrated general surgery program at 25 the University Hospitals of Cleveland.</p>	<p style="text-align: center;">8</p> <p>1 A. The way that the program works is 2 you rotate through different hospitals on 3 different rotations, each rotation has a 4 different theme to it, and the program -- the 5 university program it was the one that I was 6 part of at the time because it's always 7 changing, we rotated through University 8 Hospitals, the Cleveland V.A., MetroHealth 9 Medical Center, and while it was still open 10 we rotated through Mount Sinai New York -- 11 excuse me, Mount Sinai in Cleveland. 12 Q. Okay. Let's talk about your 13 experience at Metro since that's obviously 14 what this case is about. How long had you 15 been at Metro at that point from -- I'm not 16 asking the question very articulately. How 17 frequently would you rotate through Metro? 18 A. Of the five years total in the 19 program I think I probably spent probably 20 close to half that, give or take a few 21 months, actually at Metro in different 22 capacities. 23 Q. On May 12th, 2003, what capacity 24 were you functioning in at Metro? 25 A. During the day I was the chief</p>



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1 resident on one of the general surgery
2 services, and since I was on call that night
3 I was on call -- the chief resident on call
4 in the hospital.

5 Q. All right. So you were actually
6 on the general surgery service; correct?

7 A. Correct.

8 Q. All right. Did you receive any
9 training prior to that time in trauma
10 surgery?

11 A. Yes, I've -- by that point I had
12 already completed actually four formal months
13 as the chief resident of the trauma service
14 at Metro, in addition to trauma experience as
15 a junior resident at Metro, as well as
16 participating in trauma care at some of the
17 other hospitals that we rotated through, all
18 of which were trauma centers.

19 Q. Okay. You said that you had
20 received four formal months in -- and I may
21 be mishearing you because I'm writing --

22 A. Sure.

23 Q. -- and not looking at you, which
24 is really poor practice. But four formal
25 months in trauma surgery; correct?

10

1 A. I was the chief resident on the
2 trauma service running the trauma service at
3 the time.

4 MS. PETRELLO: At Metro.

5 A. At Metro.

6 Q. At Metro, okay. And when did that
7 time period occur?

8 A. That was -- there were two
9 two-month blocks that were during my fourth
10 year. I would have to go back to the
11 schedule, but I believe two months of it were
12 at the beginning of my fourth year and then
13 two months were a little bit later on in the
14 year.

15 Q. Okay. It's not all that
16 important. I was -- just if you knew, that
17 was fine.

18 A. Yeah.

19 Q. Doctor, are you ATLS certified?

20 A. Currently I am not ATLS certified.

21 Q. When you say "currently," did you
22 at one time obtain it and then not recertify?

23 A. Yes.

24 Q. Okay. When did you obtain
25 initially your ATLS certification?

11

1 A. During my time when I was doing
2 research I got ATLS certified so that I could
3 fly with the life flight service, and that
4 certification was good for five years and at
5 the end of five years I did not renew it.

6 Q. Can you tell me approximately what
7 year your certification lapsed? I don't have
8 a resume in front of me, that's why I'm
9 asking.

10 A. Sure. I understand. It probably
11 expired around July of 2003. I think it was
12 still active at the time, but I would have
13 to go back to again my records.

14 Q. Okay. Prior to starting at Metro
15 -- starting at University Hospitals, obviously
16 you must have gone to med school. Can you
17 tell me where you went to medical school?

18 A. Went to Case Western Reserve
19 University School of Medicine in Cleveland.

20 Q. What year did you finish?

21 A. 1996.

22 Q. Okay. All right. And did you
23 enter that program at UH immediately following
24 your graduation or did you do something else?

25 A. Immediately following.

12

1 Q. I think those numbers -- yeah, you
2 add seven that would make you finished in
3 2003. Okay.

4 All right. Dr. Firstenberg, in
5 anticipation for today's deposition, what
6 material did you review?

7 A. The parts of the chart that were
8 provided for me, the medical record that were
9 provided for me.

10 Q. Okay. All right. Do you have
11 that in front of you?

12 A. Yes.

13 Q. Okay.

14 MS. PETRELLO: He's got my copy of
15 the records, Donna.

16 BY MS. KOLIS:

17 Q. Okay. The way that you phrased
18 it, once again, I sometimes read too much
19 into answers; you read the parts of the chart
20 that were furnished to you. Did you have
21 the whole chart of the hospitalization?

22 A. Is this the whole chart?

23 Q. If you know.

24 A. I mean, I've seen entire charts of
25 hospitalization and they can be thousands of



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1 pages of junk.

2 Q. Right.

3 A. And so --

4 Q. So you don't know?

5 MS. PETRELLO: Yeah. Donna, I
6 probably -- although I don't remember, I
7 probably did not send him the baby's chart.
8 I probably only sent him the E.R. record and
9 maybe the O.R. note. I'm not sure.

10 MS. KOLIS: Okay.

11 THE WITNESS: I do not recall
12 seeing the baby's chart.

13 MS. KOLIS: Okay. That's fine.

14 BY MS. KOLIS:

15 Q. Doctor, did you actually evaluate
16 and care for Cheryl Austin on the 12th in
17 the emergency department or the trauma bay?

18 A. I helped participate in her care.

19 Q. Before she went upstairs to
20 surgery?

21 A. I did see her before she went up
22 to surgery, before she went up to O.B.

23 Q. Okay. Did you record notes or
24 findings from your participation in that care?

25 A. The physical findings during her

14

1 assessment were documented by one of the
2 nurses in the emergency room as outlined in
3 the chart, which is how they do things at
4 Metro.

5 Q. Okay.

6 A. As well as a separate ancient
7 history and physical is written by one of the
8 junior residents.

9 Q. Okay. So the answer to the
10 question, so that I'm clear about it, and I
11 think you were clear in your answer, but I
12 like the record to read a certain way, is
13 that from the time she was admitted to Metro
14 following the automobile accident but before

15 she was taken upstairs to O.B., there is not
16 a written note recorded by yourself; correct?

17 A. I don't believe I wrote a note in
18 her care.

19 Q. Okay. All right. Given that you
20 did not record notes yourself, or dictate a
21 summary of the events that occurred, I'm
22 going -- if it's okay with you, I'm going to
23 call it "downstairs" so I don't have to
24 quibble about whether it's E.D. or trauma.
25 But while she was downstairs, on reading the

15

1 chart did it refresh your recollection as to
2 the event?

3 A. Yes.

4 Q. Can you approximate for me or give
5 me the markers that would indicate to me when
6 you actually arrived in the emergency
7 department to assess the patient?

8 A. There is a -- there is a trifold
9 in the chart which is the nursing
10 documentation that indicates when I was paged
11 and when my -- when they documented my
12 arrival.

13 Q. Okay. Unfortunately, because I
14 chose to be in Cleveland, I'm not sitting
15 with you.

16 MS. PETRELLO: It's the trauma
17 flow sheet, Donna.

18 THE WITNESS: Yeah.

19 MS. PETRELLO: You know where it
20 has the trauma team signatures?

21 MS. KOLIS: That's exactly where I
22 am. That's the page.

23 BY MS. KOLIS:

24 Q. So it indicates you were actually
25 paged at 1701 and arrived at 1728, perhaps?

16

1 A. Yes.

2 Q. I read that as an A, but I'm not
3 sure.

4 So that tells you approximately
5 when you arrived; is that a fair statement?

6 A. Usually that's when the nurses
7 notice that the people are there, but I think
8 that's a reasonable statement.

9 Q. All right. At the time that you
10 arrived in the emergency department, did you
11 speak with Cheryl Austin?

12 A. I am sure I said hello to her, as
13 is my customary.

14 Q. Okay. I probably should ask a
15 better question. Did you take an independent
16 history from her relative to the collision
17 and then her complaints following that event?

18 A. I did a brief assessment of the
19 situation and evaluated her.

20 Q. Okay. When you say you did a
21 brief assessment and evaluated the situation,
22 please tell me what you mean by that.

23 A. Well, I asked her if she had any
24 major medical problems, if she had any
25 previous surgeries, what was bothering her, if



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

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

14 A. Correct.

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

17 A. Yes. Yes.

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

21 A. Yes.

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

25 A. Well, I did notice that she was

18

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

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

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

11 Q. It probably is. Because
12 immediately following this sheet or probably
13 two or three into it where it shows the
14 initial assessment it shows that the abdomen

15 was assessed at 1716 and the findings were
16 positive bowel sounds with bilateral abdominal
17 pain -- bilateral lower abdominal pain;
18 correct?

19 A. Correct.

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

25 A. Well, she was lumped into a

19

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

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

8 A. Yeah.

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

13 A. Correct.

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

21 A. Yes.

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

20

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

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

5 A. Okay.

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

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

14 Q. Did Dr. Lewis discuss that with
15 you?

16 A. He did mention it.

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

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

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

25 A. We did ask OB/GYN to evaluate them



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

22

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

23

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

24

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



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1 or, you know -- I guess that's the best way
2 to ask it, the battery of tests or the order
3 of evaluation for this patient, who is in
4 charge, yourself or Dr. Lewis?

5 A. The -- technically Dr. Lewis is in
6 charge, but those decisions --

7 Q. Because he --

8 A. Because he is the attending.

9 Q. Okay.

10 A. And for -- well, in the context of
11 Level 2 trauma patients, which she was, the
12 trauma team serves as a consulting service.
13 And so any decisions as to what tests should
14 or should not be performed, those are usually
15 made in joint discussion between the trauma
16 team and the trauma team and the emergency
17 medicine team as represented by the emergency
18 medicine attending.

19 Q. Okay. And you were the consultant
20 for the trauma team; correct?

21 A. Correct.

22 Q. All right. And is it, in fact --
23 well, Dr. Gaglardi has indicated to me that
24 he was not in attendance downstairs. Is that
25 your recollection?

26

1 A. Correct.

2 Q. Did you at any time while Cheryl
3 was downstairs call Dr. Gaglardi for any
4 reason relative to this patient?

5 A. I don't remember talking to him
6 while she was down there.

7 Q. Okay. All right. In terms of --
8 we're just going to do it this way. I'm
9 going to read you some statements I think is
10 the easiest way for me to do it.

11 A. Okay.

12 Q. And see if you agree or disagree
13 in terms of what I'm saying.

14 Going back to -- looking at Cheryl

15 Austin, we've already established and you've
16 answered that her ABC's were stable; in other
17 words, she had a patent airway; correct?

18 A. Correct.

19 Q. Okay. Seemed to be adequately
20 ventilated; correct?

21 A. Correct.

22 Q. She had good effective circulatory
23 volume, as best you could tell?

24 A. Yes.

25 Q. Okay. Doctor, what would be a

27

1 sign and in a pregnant woman that a
2 significant blood loss was occurring?

3 A. Profound tachycardia; hypotension
4 that is refractory to various maneuvers;
5 altered mental status; evidence of decreased
6 peripheral circulation where pulse is; cold
7 and clammy skin; diaphoresis; impaired
8 capillary refill; obvious evidence of
9 hemorrhage. Those are the major things.

10 Q. Would you agree that because of
11 increased intravascular volume a pregnant
12 patient can lose a significant amount of
13 blood volume before they become tachycardic,
14 hypotensive or experience other signs of
15 hypovolemia?

16 MS. PETRELLO: Donna, I'm going to
17 object. No. 1, I don't know what you're
18 reading from. I think it's unfair. He
19 hasn't seen it; and also this is approaching
20 expert testimony. And he's not an expert.

21 MS. KOLIS: Well, I'm testing his
22 level of knowledge at the time that this
23 patient presented, and I can tell you, quite
24 frankly, where I'm reading from. I'm reading
25 from Chapter 11, Trauma in Women, ATLS, and

28

1 the pertinent in effect version for that
2 time. And I'm reading assessment and
3 management of pregnant women with blunt
4 abdominal trauma. That's exactly what I'm
5 reading from.

6 MS. PETRELLO: Okay. But we don't
7 have it in front of us, and you're only
8 taking one sentence and, quite frankly, that's
9 unfair to this witness. So to the extent
10 that --

11 MS. KOLIS: I don't know --

12 MS. PETRELLO: Just wait. To the
13 extent, Doctor, that you can answer that
14 question without seeing the entire chapter, go
15 ahead.

16 A. The evaluation of pregnant women
17 can be very challenging because of, one, the
18 reasons that you specify, the stress and
19 emotional aspects; and often the pain can
20 cloud and blunt some of those responses if
21 there's any drugs or substances on board. As
22 you can see, the entire picture can be very
23 cloudy, and that is why as a trauma team we
24 are obligated to use the extent of available
25 resources to try to make a comprehensive



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

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

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

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

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

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

20 Did that answer your question?

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

23 A. Well, we are there to advocate.

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

30

1 THE WITNESS: Okay.

2 BY MS. KOLIS:

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

6 A. Correct.

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

10 A. Potentially.

11 Q. Okay. So I want to know if
12 you're saying that you have no independent
13 obligation in a situation where we have the
14 presentation of a pregnant woman who is

15 reported to be 26 plus weeks pregnant to
16 assess the fetal well-being?

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

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

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1 26-week-old fetus.

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

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

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

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

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

24 MS. PETRELLO: Objection. Go
25 ahead.

32

1 BY MS. KOLIS:

2 Q. You can answer it.

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

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

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

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



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1 correct.

2 Q. Okay. In your training as a
3 trauma surgeon, and I'm going to limit it to
4 that -- I take it you have no OB/GYN
5 training. We'll start with that; correct?

6 A. Correct. I mean in the scope of
7 our general surgical training there is no
8 formal OB/GYN experience.

9 Q. Okay. In your medical training
10 and experience, whichever rotations it was,
11 what was your belief as to what you would be
12 looking for in order to recognize a possible
13 placental abruption?

14 A. Vaginal bleeding would be a concern
15 that there may be something going on;
16 obviously severe abdominal pain will place
17 abruption as somewhere in an extremely long
18 differential; and the very fact that she was
19 pregnant would, in my opinion, mandate getting
20 the OB/GYNs involved for just doing what they
21 do best, and that is assessing a pregnancy.

22 Q. Doctor, was a bedside fetal
23 ultrasound performed in the emergency
24 department?

25 A. I did not perform one, but it

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1 looks like from the documentation that I
2 think before I arrived they tried to get
3 heart tones.

4 Q. Okay. By ultrasound?

5 A. They -- yes, yes. And according
6 to the documentation it looks like that was
7 done after I had arrived, that they tried
8 getting heart tones.

9 Q. Can you tell me where in the
10 documentation you are looking?

11 A. That is the -- again, the trauma
12 flow sheet. It's the same page that we
13 referred to earlier that documents my arrival
14 to the emergency department -- the trauma
15 bay, excuse me.

16 Q. I take it you're referring to line
17 3 which says, "The bedside ultrasound shows
18 fetus" --

19 MS. PETRELLO: No. Donna, you
20 know the page that has the trauma team
21 signatures?

22 MS. KOLIS: Right.

23 MS. PETRELLO: And then right
24 above that it says 1745.

25 MS. KOLIS: Right.

35

1 MS. PETRELLO: And right below
2 that it says, "Fetal ultrasound per Dr.
3 Werner," that's what he's looking at.

4 MS. KOLIS: Right. My question
5 is: There's no findings from that, and I
6 can't find any fetal ultrasound findings in
7 the chart. That's why I'm asking.

8 MS. PETRELLO: Oh, you mean the
9 results? I'm not sure -- maybe ask your
10 question again, because I think we're both
11 confused.

12 MS. KOLIS: Right. Right.

13 BY MS. KOLIS:

14 Q. Well, I'm confused because of the
15 chart, so let me ask it this way: Did you
16 see someone perform a bedside fetal
17 ultrasound?

18 A. An ultrasound according to the
19 documentation -- I do not --

20 MS. PETRELLO: She's asking if you
21 saw it.

22 THE WITNESS: Yeah.

23 BY MS. KOLIS:

24 Q. Yeah, just asking if you saw it.

25 A. I don't remember specifically

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1 seeing it. I'm not denying what the
2 documentation says, I just don't remember
3 seeing it.

4 Q. Okay. And would you agree with me
5 that in the note that constitutes the
6 emergency department and trauma department
7 downstairs assessment, there aren't any notes
8 that indicate what the fetal ultrasound
9 revealed --

10 A. Correct.

11 Q. -- if it occurred; right?

12 Who is Dr. Werner?

13 A. I believe she was one of the
14 emergency medicine residents at the time.

15 Q. Can emergency medicine residents
16 perform fetal ultrasound?

17 A. I don't know if that's within the
18 scope of their practice at the level of their
19 training, whether that is something that they
20 are adequately trained for.

21 Q. Okay. And you, yourself, don't do
22 fetal ultrasound; correct?

23 A. I do not do them.

24 Q. Okay. Okay. So you were going
25 way back to what you and I were talking



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1 about a little bit earlier. You had a broad
2 general diagnosis of blunt abdominal trauma?

3 A. Yes.

4 Q. Based upon her presentation of
5 pain; correct?

6 A. Correct.

7 Q. What did you think should happen
8 to evaluate that finding?

9 A. She needed a CAT scan of her
10 abdomen and pelvis.

11 Q. Okay. And was that your decision
12 or did you discuss it with Dr. Lewis? What
13 did you two do?

14 A. We jointly discussed it and we
15 agreed that that should be -- what should be
16 the step taken.

17 Q. Okay. Doctor, in the charting it
18 says, "Care assumed by trauma transport team
19 at 1805," on the same page, that same trauma
20 flow sheet.

21 A. Yes.

22 Q. Okay. My understanding from the
23 deposition of someone else is that the trauma
24 -- someone from the trauma team, specifically
25 Dr. Fulop and a nurse, would have taken

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1 Cheryl to the CAT scan; correct? You didn't
2 take her; right?

3 A. I did not take her.

4 Q. You don't recall being in the CT
5 room with the technician watching the film as
6 it ran by; correct?

7 A. I don't remember them showing up
8 on the monitor; correct.

9 Q. Okay. All right. Do you have a
10 recollection if it was busy in the E.D. that
11 day?

12 A. It seemed busy, but it didn't seem
13 disproportionately busy or out of control, so
14 to speak, from times that I remember at

15 Metro.

16 Q. Okay. In terms of nursing
17 documentation, which I'm sure you may have
18 had an opportunity to review, it seems that
19 Cheryl Austin was being monitored for blood
20 pressure, pulse, respiratory rate, temperature
21 and pulse ox from 1713 through 1805. Do you
22 know -- have you seen that page?

23 A. Yes, we're looking at it now.

24 Q. Okay. Great.
25 Were you aware of the bigeminy and

39

1 the trigeminy?

2 A. Yes.

3 Q. Okay. What were you attributing
4 that to?

5 A. There was some concern that she
6 may have sustained a cardiac contusion as
7 part of her injury.

8 Q. Okay. After 1605 would you agree
9 with me there is no documentation as to her
10 basic vitals; blood pressure, pulse,
11 respiratory rate, anything of that nature?

12 MS. PETRELLO: I think it's 1805.
13 I think you said 16 --

14 MS. KOLIS: I didn't mean to say
15 that. It was 6:05 or 1805, whichever you
16 want to make it.

17 A. I don't think that I have seen any
18 from that time on.

19 Q. Okay. In reviewing the CAT scan
20 results, if you did -- and have you had an
21 opportunity to review those?

22 A. Yes.

23 Q. Okay. Based upon the information
24 contained in that document and the deposition
25 testimony of another witness, it would appear

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1 that they got her in there and they didn't
2 encounter any difficulty in doing the CAT
3 scan. Would you agree with that?

4 A. It sounded like a pretty
5 straightforward exam.

6 Q. And you have had patients who have
7 had CTs at Metro prior to Cheryl; correct?

8 A. Correct.

9 Q. All right. Would you say that an
10 assessment that it takes approximately for an
11 abdominal and pelvic CT to be performed is
12 about maybe 20 minutes?

13 A. All told, probably a little bit
14 longer, maybe, you know, by the time you

15 bring the patient over if they have had, you
16 know, contrast, if they have had problems
17 with IVs. I mean, that time can be
18 extremely variable.

19 Q. Okay.

20 A. But the actual time to do the
21 procedure is probably only about 15, 20
22 minutes.

23 Q. Okay. In this particular instance
24 were you told what was found at the time of
25 CT?



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1 A. I went to go review the CAT scan
2 results myself with the radiologist.

3 Q. When did you do that?

4 A. She was still down in the
5 emergency department at the time, so the
6 exact time I don't recall, but it was in
7 that time window that she was still in the
8 emergency department.

9 Q. So Dr. Fulop didn't come back and
10 tell you what was seen on CT. Did you get
11 a phone call for you to come look at the
12 film or you just wanted to see it?

13 A. It's been my practice to try to go
14 over the scans myself as much as I could.

15 Q. Okay. But sitting here today, you
16 don't actually know what time that occurred;
17 correct? Do you know --

18 A. The exact time I don't know other
19 than she was still in the emergency
20 department at the time. So I mean, I can
21 narrow it down to, what is that, about a
22 half hour, 45-minute window. But it had been
23 after the scans had been printed out and
24 before she had gone upstairs. So probably
25 within -- like I said, probably within about

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1 somewhere in that 20-minute window.

2 Q. Okay. And based upon -- if you
3 know, based upon what you saw on the CAT
4 scan, what was your impression of the problem
5 or problems that Cheryl was having?

6 A. When I reviewed the scans with the
7 radiologist I remember we had noticed that
8 her major solid organs all appeared to be
9 intact, particularly the spleen, the liver,
10 some of the lower cuts of the lung; that,
11 however, we did appreciate some fluid in the
12 abdomen, but particularly in the context of
13 somebody who is 26 weeks pregnant I remember
14 there being some discussion as to what the

15 significance of that was as we typically
16 don't get routine CAT scans in a patient at
17 that point in their --

18 Q. Pregnancy; right?

19 A. -- pregnancies, yeah.

20 Q. Okay. Did you actually -- after
21 you reviewed the findings with the
22 radiologist, did you have a recollection of
23 speaking with Cheryl Austin again?

24 A. Yes.

25 Q. Speaking -- I'm sorry, speaking

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1 with Cheryl Austin again before you saw her
2 in surgery upstairs?

3 A. After I went over the CAT scan
4 results and looked at the CAT scan I went to
5 go back and to see how she was doing, to see
6 how she felt, felt her belly again, and told
7 her that we were going to be getting her up
8 to O.B. to be assessed.

9 Q. Okay. And when you saw her,
10 Doctor, do you remember it being that she was
11 in a hallway at that point?

12 A. She was -- the way that the
13 emergency room at Metro was -- well, was set
14 up, because they have since redecorated, is
15 that there was the central nursing station,
16 and if you can imagine sort of an H type
17 configuration, she was in one of the prongs
18 of the H right in front of the nursing
19 station. If we had a map I could probably
20 identify it, but she was essentially in front
21 of the nursing station.

22 Q. Okay. And she was not being
23 monitored at that point; correct?

24 A. To be honest with you, I don't
25 remember if she had had a portable monitor on

44

1 her or not. But...

2 Q. If she was being --

3 A. I don't know.

4 Q. There are no recorded findings
5 after 1805; correct?

6 A. From what I've seen in the
7 documentation, I haven't seen anything
8 indicating that she was.

9 Q. All right. And then you --

10 MS. PETRELLO: Hang on a second.
11 Do you need to get those?

12 THE WITNESS: No, no. Yeah.
13 They know I'm not at the hospital. Yeah.
14 That's fine.

15 MS. PETRELLO: Because that makes
16 the third time it went off.

17 (Brief interruption.)

18 BY MS. KOLIS:

19 Q. Did you then go tell Dr. Lewis
20 what you saw on the CAT scan?

21 A. I believe discussing with him that
22 there was some fluid in the abdomen.

23 Q. Okay. Because the charting
24 reflects it's not you, but it is at 7:10, or
25 however you want to call it, the time Dr.



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<p style="text-align: center;">45</p> <p>1 Lewis is recorded as saying she can go to 2 O.B.; correct? 3 A. Yes. 4 Q. All right. How soon after Cheryl 5 was transferred up to O.B. were you alerted 6 to the fact that you might have to attend a 7 surgery? 8 A. They called us back probably about 9 -- probably about 10 to 15 minutes or so 10 after she had arrived up there. 11 Q. Okay. As you sit here today, in 12 recalling the events, did anyone on the O.B. 13 team ask you why she didn't come up earlier? 14 A. No, I don't recall that. 15 Q. At the time that you attended 16 Cheryl Austin for this what I call the trauma 17 part of the surgery or the consultation, were 18 you aware of the fact -- you became aware 19 that she had had an abrupted placenta; 20 correct? 21 A. Not while she was -- not at any 22 point that she had gone up to L and D. I 23 don't think I understand the question, but... 24 Q. Right. I didn't ask it well. 25 You became aware once you got to</p>	<p style="text-align: center;">47</p> <p>1 probably -- as I was not responsible at that 2 point for her ongoing care, it was more -- 3 just more trying to just comfort her and 4 reassure her. 5 Q. Reassure her that what? 6 A. That she was doing well and 7 that -- 8 Q. Oh. 9 A. -- from our evaluation that we 10 were happy with how she was doing. 11 Q. Doctor, do you know how long it 12 takes from the time of an abruption to when 13 a baby will become hypoxic, or is there a 14 time frame? 15 MS. PETRELLO: Objection. If you 16 know. 17 A. I don't know the exact time. It 18 would be speculation. 19 Q. Okay. Other than Cheryl Austin, 20 at any time prior to that date, and I don't 21 care about anything that's happened to you 22 after that date, have you ever been involved 23 in a situation where you were evaluating a 24 patient in an emergency department potentially 25 for a placental abruption?</p>
<p style="text-align: center;">46</p> <p>1 the surgery that there had been an abrupted 2 placenta; correct? 3 A. Correct. 4 Q. Okay. And did you inquire about 5 the condition of the child? 6 A. Yes. 7 Q. And what did you find out? 8 A. That the Apgar scores were 9 suboptimal and that they were going to be 10 taking the child off to the neonatal 11 intensive care unit. 12 Q. After the surgery did you write 13 any notes in the progress notes? 14 A. I probably wrote a progress note, 15 and I know I dictated an operative note, as 16 well as writing her a postoperative orders 17 and admission to the ICU. 18 Q. Okay. Did you talk with Cheryl 19 after the surgery? 20 A. I talked to her once she arose 21 from anesthesia; I talked to her in the ICU 22 the following morning. 23 Q. Do you recall what the two of you 24 talked about? 25 A. I don't recall, but it was</p>	<p style="text-align: center;">48</p> <p>1 A. In the scope of a trauma or 2 overall? 3 Q. Yes. No. First of all, just in 4 the context of a trauma. 5 A. Well, as we discussed previously, 6 complications of pregnancy such as that always 7 need to be included in the differential when 8 you're evaluating any trauma patient as either 9 a cause of their trauma or as a secondary 10 factor to it. 11 Q. Once again, bad question on my 12 part. I'm asking you if you ever previously 13 participated in, and I think you probably 14 answered it, but it's the way I asked the 15 question -- if prior to the time you had the 16 opportunity to be involved in the care of 17 Cheryl Austin, do you recall another occasion 18 where you would have been evaluating somebody 19 for the same potential placental abruption? 20 MS. PETRELLO: Do you understand 21 her question? You seem a little confused. 22 THE WITNESS: I'm still a little 23 confused by your question. I apologize. 24 MS. PETRELLO: She just wants to 25 know if you -- prior to this case, whether</p>



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1 or not you were involved in a pregnant trauma
2 patient.

3 MS. KOLIS: Right.

4 THE WITNESS: Who abrupted?

5 MS. KOLIS: Yes, more simply
6 asked.

7 MS. PETRELLO: But I think his
8 confusion is the abruption part. I mean,
9 because that's what you said. You're talking
10 -- and I'm not trying to ask your question
11 for you, Donna, but you're talking about
12 abdominal pain in a trauma pregnant patient;
13 true?

14 MS. KOLIS: Right. Exactly.

15 MS. PETRELLO: Okay. So were you
16 -- did you --

17 THE WITNESS: I have -- prior to
18 that point I had evaluated pregnant trauma
19 patients before. Does that answer your
20 question?

21 BY MS. KOLIS:

22 Q. Yes, it does.

23 Had any of them have lower
24 abdominal pain as one of their presenting
25 symptoms?

50

1 A. Yes.

2 Q. Okay.

3 A. They probably all do.

4 Q. Is it your recollection -- oh,
5 okay. I see what you're saying.

6 In those instances, do you recall
7 O.B. coming downstairs to evaluate the
8 patient?

9 A. Depending on the circumstances,
10 sometimes they come down. Other times they
11 would just wait for us to finish our
12 assessment of the patient prior to sending
13 them upstairs -- and send them upstairs.
14 That's up to their -- their judgment.

15 Q. The inability of a physician in an
16 emergency room department to obtain fetal
17 heart tones, what does that suggest to you?
18 What could it possibly suggest?

19 MS. PETRELLO: In a trauma
20 patient?

21 A. In a trauma patient or --

22 Q. Yes.

23 A. Or in -- you've got the full
24 spectrum of poor application of available
25 technology to -- well, which is most commonly

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1 the cause, to actual problems with the fetus.

2 Q. Okay. Of the two possibilities
3 that you suggested, poor application of
4 technology and actual problems with the fetus,
5 which one is more dangerous to the fetus?

6 MS. PETRELLO: Wait. I don't
7 think he listed just two. I think he said
8 there's a spectrum and that went from this to
9 that. So he didn't just say there were two
10 things.

11 BY MS. KOLIS:

12 Q. Well, in your spectrum, if you
13 can't obtain fetal heart tones and the
14 possibility exists as a reason that you can't
15 is actually a problem with the fetus, isn't
16 that the most dangerous situation of all of
17 those in the spectrum?

18 MS. PETRELLO: Objection.

19 BY MS. KOLIS:

20 Q. I mean, it's a pretty simple
21 question.

22 MS. PETRELLO: No, it's not,
23 Donna. There are so many assumptions in
24 there.

25 If you can answer that, go ahead.

52

1 I mean, you're talking about a make-believe
2 patient, so...

3 BY MS. KOLIS:

4 Q. Well, this is not exactly a
5 make-believe patient, but I'm just saying that
6 when a doctor is considering what the reason
7 is that they can't obtain fetal heart tones,
8 the most dangerous one would be a problem
9 with the fetus?

10 MS. PETRELLO: But, Donna, in what
11 kind of a patient? Okay. Is the patient
12 conscious? Is the patient unconscious? Is
13 the patient hemorrhaging? I mean, what was
14 the mechanism of injury? I mean, you're just
15 taking one symptom. So to the extent that
16 he can answer that question, go ahead.

17 A. An adequately trained person who
18 can, to the best of their ability, assess a
19 fetus and raise the concern of potential
20 physiologic instability is very concerning.

21 MS. KOLIS: Yes. Doctor, I don't
22 have any further questions for you. Thank
23 you for making the time today for this
24 deposition. And I wish you well in your
25 career.



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<p style="text-align: center;">53</p> <p>1 THE WITNESS: Thank you very much.</p> <p>2 MS. PETRELLO: You have the right</p> <p>3 to read or waive signature. He's going to</p> <p>4 read.</p> <p>5 MS. KOLIS: And we'll do it 30</p> <p>6 days, Colleen, okay?</p> <p>7 MS. PETRELLO: Yeah.</p> <p>8 (Signature not waived.)</p> <p>9 And, thereupon, the deposition was</p> <p>10 concluded at approximately 3:52 p.m.</p> <p>11 .</p> <p>12 .</p> <p>13 .</p> <p>14 .</p> <p>15 .</p> <p>16 .</p> <p>17 .</p> <p>18 .</p> <p>19 .</p> <p>20 .</p> <p>21 .</p> <p>22 .</p> <p>23 .</p> <p>24 .</p> <p>25 .</p>	<p style="text-align: center;">55</p> <p>1 CAPTION</p> <p>2 The Deposition of Michael S.</p> <p>3 Firstenberg, M.D., taken in the matter, on</p> <p>4 the date, and at the time and place set out</p> <p>5 on the title page hereof.</p> <p>6 It was requested that the deposition</p> <p>7 be taken by the reporter and that same be</p> <p>8 reduced to typewritten form.</p> <p>9 It was agreed by and between counsel</p> <p>10 and the parties that the Deponent will read</p> <p>11 and sign the transcript of said deposition.</p> <p>12 .</p> <p>13 .</p> <p>14 .</p> <p>15 .</p> <p>16 .</p> <p>17 .</p> <p>18 .</p> <p>19 .</p> <p>20 .</p> <p>21 .</p> <p>22 .</p> <p>23 .</p> <p>24 .</p> <p>25 .</p>
<p style="text-align: center;">54</p> <p>1 CERTIFICATE</p> <p>2 State of Ohio:</p> <p>3 SS:</p> <p>4 County of Franklin:</p> <p>5 I, Shayna M. Storts, Notary Public in and for the</p> <p>6 State of Ohio, duly commissioned and qualified, certify that</p> <p>7 the within named MICHAEL S. FIRSTENBERG, M.D., was by me duly</p> <p>8 sworn to testify to the whole truth in the cause aforesaid;</p> <p>9 that the testimony was taken down by me in stenotypy in the</p> <p>10 presence of said witness, afterwards transcribed upon a</p> <p>11 computer; that the foregoing is a true and correct transcript</p> <p>12 of the testimony given by said witness taken at the time and</p> <p>13 place in the foregoing caption specified.</p> <p>14 I certify that I am not a relative, employee, or</p> <p>15 attorney of any of the parties hereto, or of any attorney or</p> <p>16 counsel employed by the parties, or financially interested in</p> <p>17 the action.</p> <p>18 IN WITNESS WHEREOF, I have set my hand and affixed</p> <p>19 my seal of office at Columbus, Ohio, on this 11th day of</p> <p>20 July, 2005.</p> <p>21 _____</p> <p>22 SHAYNA M. STORTS, Notary Public</p> <p>23 in and for the State of Ohio</p> <p>24 and Registered Professional Reporter.</p> <p>25 My Commission expires June 12, 2008.</p>	<p style="text-align: center;">56</p> <p>1 CERTIFICATE</p> <p>2 STATE OF :</p> <p>3 COUNTY/CITY OF :</p> <p>4 Before me, this day, personally</p> <p>5 appeared, Michael S. Firstenberg, M.D., who,</p> <p>6 being duly sworn, states that the foregoing</p> <p>7 transcript of his/her Deposition, taken in</p> <p>8 the matter, on the date, and at the time and</p> <p>9 place set out on the title page hereof,</p> <p>10 constitutes a true and accurate transcript of</p> <p>11 said deposition.</p> <p>12</p> <p>13</p> <p>14 Michael S. Firstenberg, M.D.</p> <p>15</p> <p>16 SUBSCRIBED and SWORN to before me this</p> <p>17 day of , 2005 in the</p> <p>18 jurisdiction aforesaid.</p> <p>19</p> <p>20 My Commission Expires Notary Public</p> <p>21 .</p> <p>22 .</p> <p>23 .</p> <p>24 .</p> <p>25 .</p>



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<p style="text-align: center;">57</p> <p>1</p> <p>2</p> <p>3 DEPOSITION ERRATA SHEET</p> <p>4</p> <p>5 RE: SetDepo, Inc.</p> <p>6 File No. 6597</p> <p>7 Case Caption: Cheryl Austin vs. MetroHealth</p> <p>8 Medical Center, et al.</p> <p>9</p> <p>10 Deponent: Michael S. Firstenberg, M.D.</p> <p>11 Deposition Date: June 28, 2005</p> <p>12</p> <p>13 To the Reporter:</p> <p>14 I have read the entire transcript of my</p> <p>15 Deposition taken in the captioned matter or</p> <p>16 the same has been read to me. I request</p> <p>17 that the following changes be entered upon</p> <p>18 the record for the reasons indicated. I</p> <p>19 have signed my name to the Errata Sheet and</p> <p>20 the appropriate Certificate and authorize you</p> <p>21 to attach both to the original transcript.</p> <p>22</p> <p>23 Page No. Line No. Change to:</p> <p>24</p> <p>25 Reason for change:</p>	<p style="text-align: center;">59</p> <p>1 Reason for change:</p> <p>2 Page No. Line No. Change to:</p> <p>3</p> <p>4 Reason for change:</p> <p>5 Page No. Line No. Change to:</p> <p>6</p> <p>7 Reason for change:</p> <p>8</p> <p>9</p> <p>10 SIGNATURE: _____ DATE: _____</p> <p>11 Michael S. Firstenberg, M.D.</p>
<p style="text-align: center;">58</p> <p>1 Page No. Line No. Change to:</p> <p>2</p> <p>3 Reason for change:</p> <p>4 Page No. Line No. Change to:</p> <p>5</p> <p>6 Reason for change:</p> <p>7 Page No. Line No. Change to:</p> <p>8</p> <p>9 Reason for change:</p> <p>10 Page No. Line No. Change to:</p> <p>11</p> <p>12 Reason for change:</p> <p>13 Deposition of Michael S. Firstenberg, M.D.</p> <p>14</p> <p>15 Page No. Line No. Change to:</p> <p>16</p> <p>17 Reason for change:</p> <p>18 Page No. Line No. Change to:</p> <p>19</p> <p>20 Reason for change:</p> <p>21 Page No. Line No. Change to:</p> <p>22</p> <p>23 Reason for change:</p> <p>24 Page No. Line No. Change to:</p> <p>25</p>	



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