STATE OF OHIO, COUNTY OF CUYAHOGA
IN THE COURT OF COMMON PLEAS

KARL McELFISH, II, Admin., etc.,	)	
Plaintiff,	)	
vs.	)	CASE NO. 465040
MERIDIA MEDICAL GROUP, et al.,	)	
Defendants.	)	

TELEPHONIC DEPOSITION
OF
BRUCE L. FLAMM, M.D.

LOCATION: GILLESPIE REPORTING & DOCUMENT MGMT., INC.
3333 Central Avenue, Ste. D
Riverside, CA 92506

DATE AND TIME: Tuesday, April 19, 2005
2:14 p.m. to 3:17 p.m.

PURSUANT TO: Notice

REPORTED BY: JUDITH W. GILLESPIE, CSR, RPR
CSR NO. 3710

JOB NO.: 64397JG

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(All exhibits are photocopies.)

Riverside, CA Tuesday, April 19, 2005

BRUCE L. FLAMM, M.D.,
called as a witness, having been sworn,
testified as follows:

EXAMINATION
(BY MR. BECKER)

Q. Mr. Becker here.
A. Hello.
Q. Would you please state your name for the record and spell your last name.
A. Bruce Flamm, F-l-a-m-m.
Q. What is your business address?
A. 10800 Magnolia Avenue, Riverside, California 92505.
Q. I understand you have been deposed before; correct?
A. Yes.
Q. Just to warn you on the process here, as you know, this is a question-and-answer session under oath. So it's very important that you understand the questions I ask. If the question doesn't make sense or is inartfully phrased, I want you to stop me and

tell me so, and I will pleased to attempt to rephrase or restate the question; fair enough?
A. Yes.
Q. However, unless you indicate otherwise to me, I'm going to assume that you have fully understood the question that has been posed, and you are giving me your best and most complete answer today; fair enough?
A. Yes.
Q. Doctor, do you have your complete file with you?
A. Yes.
Q. Did you create any notes?
A. Yes, I have some handwritten notes, three pages of notes.
Judith, if you could mark those notes as Exhibits 1-A, -B, and -C for me, please, and let me know when they have been marked.
(Plaintiff's (Flamm) Exhibit 1 was marked for identification.)
Q. Doctor, I'm showing you what has been marked as 1-A, 1-B and 1-C. Would you identify that for the record.
A. Yes, basically this is just a chronology of the care rendered to Sherry McElfish. The first page mainly deals with her prenatal care. The second page

deals mainly with the time up until her C-section on 9-17. And then the third page deals with her care after the C-section.

Q. All right. Is it simply a time line, so to speak, of material that you have actually extracted from the charts?

A. Yes, it's basically just a chronology. I don't think there are any opinions on these pages.

Q. All right. Do you have any notes where you have opinions other than your report?

A. No.

Q. And since drafting this report, have you looked at any additional new materials?

A. Not that I can recall. Oh, I'm sorry. I think there were some reports that may have arrived after I wrote my report. Let me look through my file here.

I have some reports of co-defendants' experts that would have arrived after I wrote my report. And I think that's all.

Q. Any depositions from any of the plaintiff's experts?

A. I don't believe so. No.

Q. Have you done any research in preparation for this deposition?

A. No.

Q. Doctor, I have a copy of your vitae. Do you have an extra copy in hand?

A. Yes.

MR. BECKER: Judith, if you will mark that vitae as Dr. Flamm's depo Exhibit No. 2. Let me know when you have completed that.

(Plaintiff's (Flamm) Exhibit 2 was marked for identification.)

Q. I am showing you what has been marked as Flamm's Exhibit 2. Would you identify that for the record.

A. Yes, this is a copy of my deposition --

MR. AUCIELLO: You mean CV.

THE WITNESS: I'm sorry. My CV. And I just want to make sure yours was 33 pages.

Q. You mean my copy of your vitae?

A. Correct.

Q. I don't have that in front of me.

A. This was updated fairly recently to bring it up to date for 2004, so your copy may not be as recent as this one.

Q. Actually, I did find it, and mine is 31 pages.

A. So this one has a little bit more recent

information on it.

Q. Fair enough. Have you written anything relevant to the subject matter of this case?

A. In some respects, yes.

Q. What is that?

A. A lot of my publications have had to do with cesarean section, timeliness of cesarean section or need for cesarean section delivery. That was certainly a factor in this case.

Q. Doctor, to save time here, can we agree that at the end of this deposition, if you would take your pen and so mark on Exhibit 2 those publications that you think are potentially relevant to the subject matter; would you agree to do that?

A. Yes.

Q. You have not written on the topic of preeclampsia or HELLP syndrome?

A. Well, excuse me one second. I have to be careful that I answer that correctly.

I haven't written any peer review articles on the subject of preeclampsia or HELLP syndrome. I may have written things in another format.

Q. What format would that be, sir?

A. I publish a monthly column in "OB-GYN News," and I have published that for about six years. And I

think I probably have published some things on PIH or preeclampsia in that column.

Q. What is the name of the column

A. It's called "Clinical Pearls."

Q. Who publishes it?

A. Elsevier is the name of the publisher.

Q. Do they publish the "Journal of Perinatology"?

A. I believe that's correct, yes.

Q. And you are publishing something once a month or once a year?

A. Once a month.

Q. And you have been doing that consecutively for how many months?

A. Approximately six years.

Q. Okay. You think there may have been something on PIH or HELLP syndrome within your articles in "Clinical Pearls"?

A. Yes.

Q. Okay. As I was saying, as I read and interpret your vitae, you are not maternal/fetal trained?

A. Yes.

Q. You are what some people refer to as a generalist obstetrician?

A. Yes.
Q. You understand, sir, that Dr. Stine is maternal/fetal trained?
A. Yes.
Q. Can we agree, Doctor, that Dr. Stine should be -- should bring all her knowledge and training to bear when acting as a physician?
A. Yes.
Q. Would it be fair, sir, to say that Dr. Stine should be judged in her role at this hospital by what a similarly situated doctor who has maternal/fetal training would do and not do; correct?
A. I think that's fair within the context of what her role was, yes.
Q. And that leads me to my next question. How is it that you are familiar with what the standard of care is and knowledge of a maternal/fetal medicine physician?
A. Working with maternal/fetal medicine physicians since that subspecialty was formed about 20 or 25 years ago.
Q. All right. Let's jump on to the topic of medical-legal work. Would you share with me how long you have been doing medical-legal work?
A. About 15 years.

Q. How many cases do you review a year, on average?
A. Average would be about one or two a month.
Q. Has that been consistent over the 15 years?
A. It's been fairly consistent, yes.
Q. How many depositions do you give a year?
A. Approximately a third of the cases that are sent to me, I end up giving a deposition.
Q. So you might do six or eight depositions a year?
A. That's probably a pretty good guess, yes.
Q. How many times have you actually testified at court in a courtroom setting?
A. I think I have testified something like 10 or 15 times in an actual trial.
Q. Do you -- have you ever testified in federal court?
A. I believe I have.
Q. If it's recently, there is a rule that requires you to prepare a list for the last five years of the cases that you have reviewed. Have you ever done such a thing?
A. I think it was a federal court in Colorado that I testified in many years ago, and I was asked to make a list. I came up with the best summary I could

at that time.
Q. Do you still have a copy of that list?
A. No. After that trial, I disposed of it.
Q. Do you have any kind of a running tab or log sheet as to all the cases you have reviewed?
A. No.
Q. Can you give me a sense, first of all, as to the number -- the percentage of the cases you review per year for the medical provider versus the patient?
A. The vast majority are for the medical provider.
Q. Okay. Let's say in the last three years, how many plaintiffs' cases have you looked at?
A. In the last three years, I would say probably about half dozen or maybe eight.
Q. Have you given any depositions on behalf of the patient in the last three years?
A. Yes.
Q. Have you -- whether acting as an expert for the medical provider or the plaintiff, have you ever reviewed a case involving preeclampsia and HELLP syndrome prior to this one?
A. Yes.
Q. Can you think of any of the names of the attorneys' or plaintiffs' or defendants' names in

those cases?
A. I cannot, no.
Q. You think you have given expert testimony as a plaintiff's expert in a preeclampsia case?
A. No.
Q. It's only been as a medical provider expert?
A. I am not even sure I gave testimony. I may have just reviewed the case. There may have been more than one that involved PIH or hypertension, but I can't even recall if I gave a deposition.
Q. When you were writing your articles for this publication, and you say you may have written on the topic of HELLP or PIH, what was the source of your information? Did you cite any literature?
A. That, I can't recall. Usually in the nonpeer review publications, I don't usually cite literature. I guess occasionally I do. In peer review journals, almost certainly I would be citing literature.
Q. Doctor, have you managed women with HELLP syndrome?
A. Yes.
Q. Can you give me an approximate number of cases you have managed with HELLP syndrome over the years?
A. I'm trying to think of a ballpark way to

estimate this. I would say that I managed patients that have PIH, preeclampsia, probably at least once a month. Sometimes -- and this is in the hospital setting --

Q. Right.

A. -- maybe more frequently than that. Of those, a small percentage, maybe less than 10 percent, end up developing HELLP syndrome. But over the years, I'm sure I have managed at least dozens of patients with HELLP syndrome.

Q. How many years have you been practicing?

A. About 21 years, I believe, since I finished my residency.

Q. Have you ever had a patient die from HELLP syndrome?

A. No.

Q. Have you ever been sued for malpractice?

A. Yes.

Q. Have any of the cases involved an allegation of inappropriate management of either preeclampsia or failure to diagnosis preeclampsia?

A. No.

Q. Or management of HELLP syndrome?

A. No.

Q. Do you know how it was that Ernie happened to

contact you on this case?

A. No.

Q. Have you reviewed cases in the Cleveland area for other defense firms?

A. Yes, I have.

Q. Can you give me some other names of defense firms you worked with?

A. Hold on one second. I recognized one of the firms from the deposition captions. I believe the Reminger and Reminger firm. And that's the only one I can think of offhand.

Q. Do you regularly work with midwives?

A. Yes, I do.

Q. Explain to me your practice, Doctor. Your group, whatever.

A. I do about 50 percent gynecology and 50 percent obstetrics. I'm also the director of the residency program. We do not have an independent OB-GYN residency program, but we have one third-year resident rotate through our hospital at all times from University of California at Irvine. I supervise that resident.

Up until about a few months ago, I was also the area research chairman, but I stepped down from that position. And that's basically my practice.

Q. Are you a solo practitioner?

A. Oh, no, I'm in a large group practice. We have now, I believe, 19 OB-GYN and eight or nine midwives in my practice.

Q. Are there rules and guidelines as to when a midwife can manage a patient and when there has to be actual direct co-management by a physician?

A. There are guidelines, yes.

Q. Are your guidelines reduced to writing?

A. I don't know the details of that, so I'm not sure.

Q. I'm assuming, then, that you didn't draft any of the guidelines?

A. Correct.

Q. Have you been a member of this group for a long time?

A. Yes.

Q. When you say you've got 19, you are employed by Kaiser Permanente in California?

A. Yes.

Q. So your employer is Kaiser Permanente?

A. Well, technically no. I'm a partner physician with a medical group that contracts with Kaiser Permanente. When I said 19 obstetricians, I meant just at my hospital. We probably have about 300

obstetricians in Southern California now, maybe more. I say definitely more now that I think about it.

Q. Doctor, would you agree that nurse midwives' care is primarily intended for healthy women?

A. Generally, women that are at fairly low risk. I think that would be a fair statement.

Q. Do they have like a risk criteria as to when people have to be referred to physicians within your group?

A. I think we have general agreements or consensus. For example, our midwives would probably continue to manage a patient if she became a gestational diabetic, but if she had to go on insulin, at that point we would probably switch the patient to a physician care. That's just a general agreement at my hospital. That might not even be true at other Kaiser hospitals. I don't know one way or the other.

Q. What about preeclampsia?

A. Preeclampsic patients are often co-managed. However, if the patient developed severe preeclampsia or HELLP syndrome, I believe that patient would then be turned over to physician management.

Q. How about a patient who is a chronic hypertensor?

A. I believe our midwives also handle chronic

hypertensive patients.
Q. Is HELLP syndrome a well-recognized complication of severe preeclampsia?
A. Yes.
Q. Can we agree that delaying a diagnosis of preeclampsia increases the risk of a patient developing HELLP syndrome?
A. I think that's true.
Q. Would you agree that DIC is a well-recognized complication of HELLP syndrome?
A. That's also true.
Q. Do you have an opinion, what's called a causation opinion, as to why Sherry McElfish expired or died? It's not stated in your report and that's why I am asking.
A. I'm frankly not convinced I know the answer to that, and that's why I did not put it in my report.
Q. At trial you will have no opinions thereof?
A. I don't think I would have an opinion that would rise to the level of a reasonable degree of medical certainty.
Q. Now, let's kind of go to the time -- your opinion is -- you are not going to speak to the standard of care of any other caregivers other than Dr. Stine; correct?

A. Correct.
Q. Let's go to this last -- to the hospitalization, her final hospitalization. Do you have those medical records handy?
A. Yes.
Q. What is the date that she was admitted?
A. 9-16-00.
Q. What time in your understanding did Dr. Stine have first hands-on care?
A. I saw a note in the chart: "Dr. Stine in room at 23:23," which would be 11:23 p.m.
Q. And what is your understanding as to when Dr. Stine made her assessment and concluded what a likely diagnosis of the patient was?
A. It looks to me like it was pretty quickly after that. I believe the magnesium sulfate bolus was given about ten minutes after that time.
Q. Okay. Can we agree, Doctor, that based on Dr. Stine's education and training, she should have immediately appreciated that this patient at time of her admission likely had very severe preeclampsia?
A. I think it would be reasonable to conclude she had preeclampsia. Without having the prenatal chart, and I don't know if she had it at that moment, it would be difficult to tell if the patient had

chronic hypertension with superimposed preeclampsia and if these blood pressures were terribly different than her previous pressures.
Q. When should there have been a suspicion? At what time should there have been a suspicion that this patient may well have the HELLP syndrome?
A. When her labs came back that were highly abnormal, I think at that point, certainly severe PIH diagnosis should be made.
Q. What time was that, sir?
A. I don't have that on my flow sheet. I know that there are some questions about the actual time that lab results came back. For example, I believe at about 12:30 in the morning, about an hour later, Dr. Stine ordered that blood be typed and crossed. And there was a question in her deposition about why she did that. She feels it may have been because she had gotten back some initial labs, but she is not sure.
Q. Is there a difference in your mind between type and screen and type and cross?
A. Yes.
Q. What is the difference?
A. Type and screen is a more rapid test to complete. It involves less complex technology in the

blood bank. Type and cross, conversely, takes a little bit longer to do. It's a little more thorough examination of the blood.
Q. So what is the difference in lay terms?
A. In lay terms, a type and screen is very frequently done in any patient that you are thinking that you might want to be giving blood on. And a type and cross would be done in a patient who you have a higher index of suspicion that you might want to be giving blood to.
Q. Does type and cross connote that the blood should be not only identified as appropriate for the patient, but brought out to the floor?
A. No.
Q. Is it your opinion that there needs a separate and distinct order to bring blood up to the floor?
A. Yes. For example, we might have a patient with a placenta previa in the hospital for weeks. And we might have blood type and cross for her the whole time she is in the hospital, but it would stay down in the blood bank.
Q. Should it have been clear to Dr. Stine that as soon as she made an assessment of Sherry McElfish, that she should be contacting her physician and

telling him to immediately come to the hospital?
A. I think that as soon as Dr. Stine had an opportunity to evaluate the patient and come to some reasonable conclusions about the status, that she should be calling Dr. Bailin.
Q. What was her preliminary diagnosis after she had an opportunity to make an assessment?
A. Let me just quickly look at the chart, because I don't have that in my notes.
I'm looking at a document that's called Euclid Hospital history, with a second page saying "physical examination." And I believe this was written by Dr. Stine.
And the impression is IUP questionably 36 versus 40 weeks. No. 2, severe preeclampsia. No. 3, discussing epigastric and chest pain. No. 4, rule out HELLP/abruption. And then finally, GBS, meaning Group B Strep positive.
Q. Is it your understanding those were her initial impressions prior to calling Dr. Bailin?
A. This is timed at about 11:50 p.m., and it looks like the call to Dr. Bailin was just after that, so, yes, I think that's correct.
Q. So clearly, Dr. Stine should have made it clear to Dr. Bailin that one of his patients is at the

emergency room with severe preeclampsia and potentially HELLP syndrome?
A. I thought she was in the labor and delivery area. I might be wrong about that. Not the emergency room.
Q. At the hospital. Forget the room, but at the hospital.
A. I think a call should make it clear to Dr. Bailin that his patient is there and then summarize basically the things we have been talking about.
Q. Right. She should have made -- Dr. Stine should have made it very clear to Dr. Bailin that your patient is here with at least severe preeclampsia, maybe HELLP syndrome, and she is acutely ill and she is severely ill. Is that fair?
A. Well, not necessarily at this point. Again, it's not clear to me that any of the labs were back for perhaps 30 or 40 minutes after that call was made. So what would be known at that time is that there were elevated blood pressures. But I don't know if Dr. Stine would have had access to prenatal records or blood pressures at that time.
So in theory, this patient may have had chronic hypertension with similar blood pressures, and

this may not have been an acute change in her condition. When the labs came back, that would change the impression.
Q. Well, she would have needed the labs back to make the -- for starting the process of thinking about HELLP syndrome; correct?
A. Not necessarily. You can certainly be thinking about that or entertaining the diagnosis, but she would need it to make the diagnosis.
Q. What is your understanding as to why she made the preliminary diagnosis of HELLP syndrome?
A. Well, in her notes she writes R/O HELLP, which means "rule out," so it would not mean that you made the diagnosis. It just means it's on your differential and you are thinking about it.
Q. You think about it simply because she says "severe preeclampsia"?
A. I can't speak for Dr. Stine, but probably since she has a patient that's having some epigastric pain and very high blood pressures, near term, I think a lot of people would be thinking about the potential of severe PIH and/or HELLP syndrome.
Q. Can we agree that even without the labs, Dr. Stine should have made it very clear to Dr. Bailin that one of your patients is here at the hospital.

She clearly has severe preeclampsia. She may have HELLP syndrome. She has epigastric pain and chest discomfort. And you need to be -- she is acutely and seriously ill. Should that have been relayed to Dr. Bailin?
A. Those are a lot of different individual premises. I think a lot of that does make sense. A lot of those things should be relayed. However, though, for example, the diagnosis of severe PIH is probable at that time. But it's possible that if this patient had elevated blood pressures in her prenatal care and had chronic hypertension, that this might not indicate severe PIH. In hindsight, that is the correct diagnosis.
Q. Right. But at least she made the diagnosis -- she didn't say rule out severe preeclampsia. She made the diagnosis of severe preeclampsia without the prenatal chart in front of her; correct?
A. Yes. That appears to be correct.
Q. So we can agree that when Dr. Stine called Dr. Bailin, she should have made it very clear that this patient has likely severe preeclampsia, she is acutely ill, and she needs your attention; correct?
A. I think that's a fair statement. Yes.

Q. Can we agree that Dr. Stine should have made it very clear, particularly given the epigastric pain, that Dr. Bailin should come immediately to the hospital?

A. I don't know if I would say immediately. I think there are certainly some things that you would use the word "immediately" for. If you have, for example, a patient with a previous cesarean section who appears to be rupturing their uterus, you would tell a doctor, yes, we need you here immediately, as soon as you can get here. Run through red lights if you can do it safely.

In a situation like this, you would certainly want the primary physician, Dr. Bailin, to be aware of the status of the patient and hopefully coming into the hospital. But I don't know if the word "immediately" would be correct.

Q. Well, as long as he is coming within the hour or two, that would be okay for you?

A. As long as the mom and the baby are stable, yes.

Q. Have you ever acted as a house obstetrician?

A. I have not actually gone to a hospital and just taken call there, if that's what you mean. I do take in-house call about once a week, where I serve a

role of delivering babies. But I am the primary physician or a back-up physician for residents or midwives. I would not be serving the same role that Dr. Stine did.

Q. Can we agree, Doctor, if you would have been at this hospital, as soon as the labs came back showing -- confirming HELLP syndrome, that you would have been taking this patient immediately to the operating suite for delivery?

A. Not correct at all. The deposition of Dr. Stine -- she said that she felt it would be safer to have Dr. Bailin there, to have both surgeons available. Often these cases can result in very high blood loss. So the answer to your question would be no.

Q. Can we agree that Dr. Stine should have made it very clear to the anesthesiologist that this patient likely had HELLP syndrome?

A. At what point in time?

Q. By the time she begins the induction.

A. At the time of the cesarean section, the anesthesia for the cesarean section, I think it would be a good idea for the physician doing the obstetrical care to relay to the anesthesiologist that the patient has severe PIH, yes.

Q. And HELLP syndrome?

A. I don't know that that is a big differentiation. I think if you tell an anesthesiologist that a patient not only has PIH, but severe PIH, I think that has a certain connotation. Whether that would be changed by saying "HELLP syndrome," I don't know one way or other.

Q. You agree, Doctor, that the standard of care required to have Dr. Stine to at least make it clear to the anesthesiologist that this patient likely had severe PIH?

A. I'm not sure that is correct, either. My experience has been that the anesthesiologist will generally, since they are a physician, evaluate the situation independently. They are going to want to do their own evaluation of the patient. They would have certainly seen the blood pressures. And it would seem hard for me to believe that they would not have reached the conclusion that the patient had PIH.

Q. All right. But we agree that Dr. Stine, assuming -- can we agree that Dr. Stine had an independent responsibility to make sure the anesthesiologist was aware of it in the event she came in very late to the case?

MR. AUCIELLO: Objection. Go ahead.

A. That could be true. If there is something that would impact on the patient care and there is a reason why the anesthesiologist wouldn't know about it unless the obstetrician told them, then, yes, I would agree with that.

Q. Did you read the anesthesiologist's deposition?

A. Yes.

Q. Do you see -- did you see in the anesthesiologist's deposition that she would like to have known that the patient had severe preeclampsia at the time of the anesthesia?

A. I can't recall exactly what she said about that.

Q. Do you recall the anesthesiologist saying she may well have placed an internal -- a Swan-Ganz or central line in this patient had she known the patient had severe preeclampsia?

A. I recall seeing something to that effect.

Q. Does it make sense to you?

A. No, not necessarily. Actually what Dr. Stine said about that made more sense to me. In a patient with severe PIH, particularly if they are developing thrombocytopenia, that's not a patient you want to be shoving a large bore catheter into their large veins.

You have to be very careful about doing that. And you want to do that only if you feel that the risks are outweighed by the benefits. The very majority of patients with PIH and even severe PIH are managed well without invasive cardiovascular monitoring.

Q. Have you ever had one of your HELLP syndrome patients have central line monitoring?

A. On very rare occasions. It might more likely be an arterial blood pressure recording, but as far as a CVP, central venous pressure line, or Swan-Ganz line, very infrequently.

Q. If the patient complained of an absence of urine production at the time she came in, would that cause you to lean towards more central monitoring?

A. If a patient commented on that? No.

Q. If she can't recall when is the last time she peed?

A. I'm sorry?

Q. The patient can't recall the last time she urinated.

A. No, that wouldn't change my impression about whether I would be using central monitoring or recommending that.

Q. When is that indicated?

A. There are rare cases where central monitoring

may be indicated in the treatment of patients with PIH. If the physicians are having difficulty stabilizing a patient's condition and if the platelet count is such that it is felt that the patient is at fairly low risk to hemorrhage at the site where the invasive catheter is inserted, then the risk may be outweighed by the benefits.

But remember, in a patient with PIH, particularly severe PIH, anesthesiologists are frequently horrified about the thought of even doing an epidural. So the thought of shoving a large bore catheter into a huge vein I'm sure would not thrill most anesthesiologists.

Q. When you manage your patients with severe preeclampsia and HELLP syndrome, do you call for consultation?

A. It would depend again on the particular situation.

Q. You have done so in the past?

A. Have I consulted in the past?

Q. Yes. Have you called out for consultation?

A. Yes, I have.

Q. What kind of specialist would you call?

A. It depends on the given circumstances. For example, if I have a patient with severe PIH, remote

from term, I have at times consulted with a maternal/fetal medicine specialist, particularly regarding timing of delivery. In the actual labor and delivery setting or in the postpartum setting, I have at times consulted with intensivists. This would be an ICU specialist. That would probably be the most frequent consults.

Q. Okay. The therapy for severe preeclampsia and HELLP syndrome is delivery as soon as possible?

A. That's the primary therapeutic mode, yes. Again, with the stipulation that if the patient is very remote from term, those cases can be very difficult and sometimes delivery is delayed.

Q. Do you administer anti-hypertensive medication to the patient that arrives at the hospital with severe preeclampsia?

A. It would depend on many factors, but at times I do, yes.

Q. What are the indications?

A. Generally speaking, we like to keep the systolic blood pressure under 160. I have seen some articles that say under 180. And the diastolic blood pressure under 110.

Q. When the systolic is about 160, then the standard of care is to administer hypertensive

medication?

A. I'm not sure I would say that's the standard of care. I think many physicians do it. The goal is to try to avoid a maternal stroke.

Q. Do you do it?

A. Yes. Generally in my practice, if I have a patient in labor and delivery with severe PIH, if her systolic blood pressure is repetitively going above 160, I probably would treat that blood pressure, yes.

Q. Did you analyze this case from the perspective, among other things, as to whether Dr. Stine should have administered anti-hypertensive medication at some time before she transferred the care to Dr. Bailin?

A. Yes, that was one of the considerations.

Q. What did you conclude?

A. I felt that it was optional, but not mandatory.

Q. You would have done it, but it was optional?

A. Well, her diastolic blood pressures, some of them were in the 90s, there was one 102 and 104. Clearly, these are all below 110. On the other hand, she was having systolics in the 170s and one that was 180. I think personally I might have given her a little bit of Apresoline. I think that's a judgment

call, but not a standard of care issue.
Q. That's fair enough.
Doctor, on the issue of once Dr. Stine appreciated how severely ill this woman was, should she herself have called for consultation while she waited for Dr. Bailin to arrive at the hospital?
A. Not unless she felt she needed additional assistance.
Q. Should she have felt that she needed additional assistance, based on her clinical condition?
A. You are talking about before the cesarean section?
Q. Yes.
A. No, I don't believe so.
Q. Should Dr. Stine have appreciated a need to bring in anesthesia at the same time that she ordered the blood type and cross?
A. I'm sorry. Did you say to bring in anesthesia?
Q. Bring in an anesthesiologist into the case.
A. No. Generally, we would involve the anesthesiologist in a case like this if we were planning to do a cesarean section, and eventually they did that.

Q. Right, and I guess I'm saying to you, Doctor, would you agree with me that based on Dr. Stine's education, background and training, she should have been anticipating an immediate cesarean section as soon as she made her diagnosis of severe preeclampsia?
A. No, not necessarily. I think the key is that you want to stabilize the mom and await a full crew. You want to do this type of operation in the best possible setting, particularly since this is now the middle of the night. So I think what she did was reasonable.
Q. She has to wait for the full crew, but you have to call the crew to come; right? And you've got to get the crew in there quickly; correct?
A. Yes. My understanding was the crew was there, though.
Q. Who do you think composed the crew?
A. I'm talking about the team that does the cesarean section, which would be the physician doing the operation, their physician assistant -- generally a physician assistant -- the anesthesiologist, the scrub nurse and circulating nurse.
Q. What is your understanding as the last time that Dr. Stine had hands-on care with this patient?
A. Well, my understanding is that Dr. Stine was

the assistant at the cesarean section. The baby was delivered at 1:18 in the morning. After the delivery, I believe there were some -- there was some involvement with Dr. Stine, but that Dr. Bailin, the primary physician, was there and was the primary physician caring for Ms. McElfish.
Q. I'm not sure what your answer is to my question. I will ask it again.
What is your understanding of the last time that Dr. Stine was at bedside rendering hands-on care either with or without Dr. Bailin?
A. She obviously would have been delivering hands-on care during the cesarean operation. I guess the baby time was 1:18. I don't have the time on my notes when they completed the operation, but the frequent observation record begins at 1:55 in the morning. So I assume that the operation had been completed and Dr. Stine would not have been rendering hands-on care, at least as far as surgical care, at that point.
I would have to then look in my notes. I don't believe I have any other specific references to Dr. Stine in my notes, so I would have to go by the actual records to answer your question.
Q. Do you see where Sherry McElfish -- I think

it's either 2:00 or 2:30 a.m. -- became markedly hypotensive?
A. Yes, I have that in my notes.
Q. Do you think that Dr. Stine should have appreciated at that point, based on her education and training, this patient needs to be in an ICU?
A. Well, my understanding is and my notes say at 2:30 Dr. Bailin aware and in room. Patient was alert and talking. My understanding is Dr. Bailin was this patient's primary physician, and Dr. Stine had just been acting as a house officer assisting until Dr. Bailin arrived.
Q. Let's try that question another way. Would you agree with me, Doctor, by the time that Dr. Stine, assuming she was in the room, appreciated this woman's hypotension, that she should have suggested, based on her additional training and skill, that this patient needed to be in an intensive care setting?
A. No. Not even under that hypothetical, I don't believe so, because the patient had just been given a second dose of Apresoline about 15 minutes prior to that. So a reasonable and prudent physician might conclude that it may be a little bit of overcorrecting from the Apresoline, which is designed to drop the blood pressure.

If Ms. McElfish had pressures, as she had in the 200 over 120 range, and without being given any Apresoline or any other drug to drop her blood pressure, suddenly dropped her pressure to 81 over 39, yes, I think any physician at that point would have been much more concerned.

Q. You mentioned that you see patients for preeclampsia in the hospital?

A. Yes.

Q. You send your patients to the hospital to assist in ruling out preeclampsia?

A. Yes, sometimes I do.

Q. When you do that, do you send them there for at least a day so they can do repeated labs, repeated blood pressures, and 24-hour urine?

A. No. The vast majority of the patients I send to labor and delivery are there for a few hours, often until we can get several more blood pressure evaluations and until we can get some labs.

Q. You don't do 24-hour urines on your patients when you expect preeclampsia?

A. Occasionally I do. I did two days ago. But it's a judgment call. It depends on the situation.

Q. I didn't hear the end of that.

A. It's a judgment call, and it depends on the

clinical situation.

Q. What were the circumstances of the one that you just did a 24-hour urine on?

A. This is a patient whose blood pressures were mainly normal. She had a couple elevated blood pressures that would fit the criteria for hypertension. But the majority of her blood pressures were normal. But she kept spilling 3-plus protein on her dip stick. And so I was trying to determine, was that 3-plus real or was it false, perhaps just from vaginal discharge.

Q. Have you had patients where they might have a 1-plus in a urine dip stick and do a 24-hour urine and the urine be -- the protein be much higher?

A. I can't recall offhand. I have done a lot of 24-hour urines over 21 years, and there may have been some dipping 1-plus, and then we were surprised by the amount of protein. That could be true.

Q. What is your understanding as to the indications for a 24-hour urine?

A. It can be helpful in different respects. The example I gave, I think is nowadays one of the most common indications, when you are trying to determine, is protein urea that you are detecting on a patient-collected dip stick evaluation significant protein

urea or is it not.

The patient I was talking about weighed over 300 pounds. And in a patient like that, it's very hard for them to collect a truly clean sample. More often than not, what happens is you do the 24-hour urine and find out that it was spurious, that really they are not spilling any significant protein in their urine.

Q. Any other indications for 24-hour urine? You already told me about that.

A. One would be to confirm quantitatively how much protein the patient is spilling in her urine. Some physicians want to know that the patient is spilling greater than .3 grams or 300 milligrams of protein in 24 hours before they call it significant protein urea. Other physicians will use the dip stick reading.

Another use of the 24-hour urine for protein collection would be to differentiate mild PIH from severe PIH. If a patient is spilling more than 5 grams in 24 hours, by definition she would have severe PIH.

Q. Any other indications?

A. There are many more reasons why doctors might order a 24-hour urine. Sometimes we are looking at

creatinine clearance to check kidney function. There are many other possibilities.

Q. Let's go back, Doctor, to that phone call from Dr. Stine to Dr. Bailin. Should she have made it very clear to Dr. Bailin that his patient is acutely and severely ill when she made that first phone call?

A. I read Dr. Stine's deposition. And I know that there was some discussion about the exact adjectives that should be used or might have been used to describe her condition. She was ill, but to what degree -- I mean, what adjective should have been used in the phone call?

In my mind, actual data is often more helpful than someone's impression. When I say a patient is severely ill, that might mean something different to different people. They may want to hear a patient is "moribund," to mean they should get to the hospital right away. I think it's more helpful to give over the phone what we are dealing with. So if Dr. Stine, for example, had mentioned about what levels the blood pressures were running, I think that would be a very quantitative way to describe the patient's condition.

Q. But Dr. Stine should have made it very clear that the woman was -- was she short of breath when she

hit the hospital?
A. I believe she was complaining of difficulty breathing, yes.
Q. So minimally, Dr. Stine should have made it clear to Dr. Bailin that she was short of breath and has epigastric pain and she likely has severe preeclampsia?
A. No, not necessarily. Although she had difficulty breathing, later they did a pulse/ox, and it was 99 percent. Sometimes difficult breathing can be a very significant warning sign, particularly if we corroborate that with a pulse/ox that shows they have a reason for having difficulty breathing.
Q. Doctor, I just want to know whether or not Dr. Stine should have made it very clear to Dr. Bailin that his patient appears to be severely and acutely ill?
MR. AUCIELLO: Objection. Asked and answered like three times, but go ahead.
Q. Can you answer that yes or no? In any manner, any verbiage, should she have made it clear, that message that Sherry was acutely and severely ill?
A. I think I have tried to answer that question. I think it gets back to definitions here. What adjectives have to be used? Did she have to say,

Dr. Stine, "Your patient is severely and acutely ill"? What does "acutely ill" mean? If we look that up in a medical dictionary, it would probably say something that happens fairly quickly. It doesn't really have to do with the gravity of the illness, as probably many laypeople think. "Acutely" means "not chronically." Would a physician -- would Dr. Stine have to say to Dr. Bailin, Your patient is "acutely ill" as opposed to "chronically ill" to comply with the standard of care? No, I don't believe that's true.
I think I understand the gist of what you are saying, though, and I agree with you that Dr. Stine would have to convey that Ms. McElfish was a sick patient and that Dr. Bailin should come and evaluate her.
Q. Should she have conveyed enough information that Dr. Bailin got the message that Dr. Stine wants him there immediately?
A. No. I tried to answer that question a bit earlier when I gave an example of what -- some type of things that could be occurring that it would be standard of care -- by the standard of care mandatory to convey to a physician that their presence is needed immediately.

One example would be a suspected uterine rupture. Another would be a baby heart rate that goes down but doesn't come back up. Another example would be a patient like this that began to have seizures and became an eclamptic.
But I think what we are seeing in this patient, I don't believe that by standard of care Dr. Stine would have to say, "Dr. Bailin, we need you here immediately."
Q. If you were called by a house obstetrician regarding one of your patients and they presented with severe preeclampsia to the hospital and with epigastric pain and difficulty breathing, would you have wanted that house doctor to relay to you or convey to you the message that you should get here immediately?
A. I first have to ask if you are talking hypothetically, because when I take call, I take call in the hospital.
Q. Hypothetical now.
A. Hypothetically, if I had a patient like Ms. McElfish that came into the hospital, I would like to have a general synopsis of her status conveyed to me. That's the best way I could describe what I would like to be told.

Q. All right. We can agree if the anesthesiologist was brought in at the last minute, thinking that this was simply an emergency cesarean section, that Dr. Stine should have made it clear to that anesthesiologist that this patient has severe preeclampsia; correct?
MR. AUCIELLO: Objection.
THE WITNESS: No. I tried to address that before. I think there may be things that an anesthesiologist might not be privy to. For example, perhaps a pelvic exam had been recently done but not yet recorded. And an anesthesiologist would have no way to know what that pelvic exam showed. But if there are data, like blood pressure elevations which are written all over the chart and probably also on the blood pressure recording and the fetal monitor strip, I don't believe by standard of care it was mandated that one doctor tell another doctor that the blood pressures are elevated.
Q. But hypothetically, Dr. Stine should have appreciated that the anesthesiologist didn't have the opportunity to study the chart when she was brought into this case. At that point under this hypothetical, Dr. Stine should have made it clear to that anesthesiologist about the likely severe

preeclampsia. Yes?
A. I can envision a case where that would be true. I'm not sure at all that it happened in this case.
Q. All right. Doctor, that's it. I'm done. Anybody else have any questions?
MR. WALTERS: I do not.
MS. MALNAR: I don't have any questions.
MR. AUCIELLO: We will reserve the right to read it and go from there. Thank you.
THE REPORTER: Any copies needed of this?
MR. BECKER: This is Becker. I'll take a copy.
MR. WALTERS: This is Steve Walters, I'll take a copy.
MS. MALMAR: This is P.J. I'll take a copy. With a minuscript, please.
MR. TREU: I'll take one.
MR. AUCIELLO: Copy.

(The deposition was concluded at 3:17 p.m..)
-OOO-

I, BRUCE L. FLAMM, M.D., hereby certify under

penalty of perjury that I have read the foregoing transcript. Corrections, if any, were noted in ink, and the same is now a full, true, and correct transcript of my testimony.
Executed this _____ day of _____, 2005, at _____, California.

_____
BRUCE L. FLAMM, M.D.

REPORTER'S CERTIFICATE

I, Judith W. Gillespie, a Certified Shorthand Reporter, No. 3710, for the State of California, do hereby certify:
That prior to being examined, the witness named in the foregoing deposition was sworn by me to testify to the truth, the whole truth, and nothing but the truth;
That the said deposition was taken down by me in stenotype at the time and place therein stated and was thereafter reduced to printing under my direction.
I further certify that I am not of counsel or attorney for either of the parties hereto or in any way interested in the event of this cause, and that I am not related to either of the parties hereto.
In witness whereof, I have hereunto subscribed my name this 28th day of April, 2005.

_____
JUDITH W. GILLESPIE, CSR, RPR
CSR NO. 3710