

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.)	
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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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PLAINTIFF'S EXHIBIT (FLAMM):

1 Handwritten notes of Dr. Bruce Flamm 5
2 pages

2 Curriculum Vitae of Bruce Lawrence 7
Flamm, M.D., FACOG, 33 pages

(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 please 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

1 deals mainly with the time up until her C-section on
2 9-17. And then the third page deals with her care
3 after the C-section.

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

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

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

11 A. No.

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

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

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

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

23 A. I don't believe so. No.

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

1 A. No.

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

4 A. Yes.

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

8 (Plaintiffs (Flamm) Exhibit 2 was
9 marked for identification.)

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

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

14 MR. AUCIELLO: You mean CV.

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

17 Q. You mean my copy of your vitae?

18 A. Correct.

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

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

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

25 A. So this one has a little bit more recent

1 information on it.

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

4 A. In some respects, yes.

5 Q. What is that?

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

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

15 A. Yes.

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

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

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

23 Q. What format would that be, sir?

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

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

3 Q. What is the name of the column

4 A. It's called "Clinical Pearls."

5 Q. Who publishes it?

6 A. Elsevier is the name of the publisher.

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

9 A. I believe that's correct, yes.

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

12 A. Once a month.

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

15 A. Approximately six years.

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

19 A. Yes.

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

23 A. Yes.

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

1 A. Yes.

2 Q. You understand, sir, that Dr. Stine is
3 maternal/fetal trained?

4 A. Yes.

5 Q. Can we agree, Doctor, that Dr. Stine should
6 be -- should bring all her knowledge and training to
7 bear when acting as a physician?

8 A. Yes.

9 Q. Would it be fair, sir, to say that Dr. Stine
10 should be judged in her role at this hospital by what
11 a similarly situated doctor who has maternal/fetal
12 training would do and not do; correct?

13 A. I think that's fair within the context of
14 what her role was, yes.

15 Q. And that leads me to my next question. How
16 is it that you are familiar with what the standard of
17 care is and knowledge of a maternal/fetal medicine
18 physician?

19 A. Working with maternal/fetal medicine
20 physicians since that subspecialty was formed about 20
21 or 25 years ago.

22 Q. All right. Let's jump on to the topic of
23 medical-legal work. Would you share with me how long
24 you have been doing medical-legal work?

25 A. About 15 years.

1 Q. How many cases do you review a year, on
2 average?

3 A. Average would be about one or two a month.

4 Q. Has that been consistent over the 15 years?

5 A. It's been fairly consistent, yes.

6 Q. How many depositions do you give a year?

7 A. Approximately a third of the cases that are
8 sent to me, I end up giving a deposition.

9 Q. So you might do six or eight depositions a
10 year?

11 A. That's probably a pretty good guess, yes.

12 Q. How many times have you actually testified at
13 court in a courtroom setting?

14 A. I think I have testified something like 10 or
15 15 times in an actual trial.

16 Q. Do you -- have you ever testified in federal
17 court?

18 A. I believe I have.

19 Q. If it's recently, there is a rule that
20 requires you to prepare a list for the last five years
21 of the cases that you have reviewed. Have you ever
22 done such a thing?

23 A. I think it was a federal court in Colorado
24 that I testified in many years ago, and I was asked to
25 make a list. I came up with the best summary I could

1 at that time.

2 Q. Do you still have a copy of that list?

3 A. No. After that trial, I disposed of it.

4 Q. Do you have any kind of a running tab or log
5 sheet as to all the cases you have reviewed?

6 A. No.

7 Q. Can you give me a sense, first of all, as to
8 the number -- the percentage of the cases you review
9 per year for the medical provider versus the patient?

10 A. The vast majority are for the medical
11 provider.

12 Q. Okay. Let's say in the last three years, how
13 many plaintiffs' cases have you looked at?

14 A. In the last three years, I would say probably
15 about half dozen or maybe eight.

16 Q. Have you given any depositions on behalf of
17 the patient in the last three years?

18 A. Yes.

19 Q. Have you -- whether acting as an expert for
20 the medical provider or the plaintiff, have you ever
21 reviewed a case involving preeclampsia and HELLP
22 syndrome prior to this one?

23 A. Yes.

24 Q. Can you think of any of the names of the
25 attorneys' or plaintiffs' or defendants' names in

1 those cases?

2 A. I cannot, no.

3 Q. You think you have given expert testimony as
4 a plaintiff's expert in a preeclampsia case?

5 A. No.

6 Q. It's only been as a medical provider expert?

7 A. I am not even sure I gave testimony. I may
8 have just reviewed the case. There may have been more
9 than one that involved PIH or hypertension, but I
10 can't even recall if I gave a deposition.

11 Q. When you were writing your articles for this
12 publication, and you say you may have written on the
13 topic of HELLP or PIH, what was the source of your
14 information? Did you cite any literature?

15 A. That, I can't recall. Usually in the nonpeer
16 review publications, I don't usually cite literature.
17 I guess occasionally I do. In peer review journals,
18 almost certainly I would be citing literature.

19 Q. Doctor, have you managed women with HELLP
20 syndrome?

21 A. Yes.

22 Q. Can you give me an approximate number of
23 cases you have managed with HELLP syndrome over the
24 years?

25 A. I'm trying to think of a ballpark way to

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

5 Q. Right.

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

11 Q. How many years have you been practicing?

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

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

16 A. No.

17 Q. Have you ever been sued for malpractice?

18 A. Yes.

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

22 A. No.

23 Q. Or management of HELLP syndrome?

24 A. No.

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

1 contact you on this case?

2 A. No.

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

5 A. Yes, I have.

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

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

12 Q. Do you regularly work with midwives?

13 A. Yes, I do.

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

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

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

1 Q. Are you a solo practitioner?

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

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

8 A. There are guidelines, yes.

9 Q. Are your guidelines reduced to writing?

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

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

14 A. Correct.

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

17 A. Yes.

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

20 A. Yes.

21 Q. So your employer is Kaiser Permanente?

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

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

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

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

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

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

18 Q. What about preeclampsia?

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

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

25 A. I believe our midwives also handle chronic

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

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

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

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

1 telling him to immediately come to the hospital?
 2 A. I think that as soon as Dr. Stine had an
 3 opportunity to evaluate the patient and come to some
 4 reasonable conclusions about the status, that she
 5 should be calling Dr. Bailin.

6 Q. What was her preliminary diagnosis after she
 7 had an opportunity to make an assessment?

8 A. Let me just quickly look at the chart,
 9 because I don't have that in my notes.

10 I'm looking at a document that's called
 11 Euclid Hospital history, with a second page saying
 12 "physical examination." And I believe this was
 13 written by Dr. Stine.

14 And the impression is IUP questionably 36
 15 versus 40 weeks. No. 2, severe preeclampsia. No. 3,
 16 discussing epigastric and chest pain. No. 4, rule out
 17 HELLP/abruption. And then finally, GBS, meaning Group
 18 B Strep positive.

19 Q. Is it your understanding those were her
 20 initial impressions prior to calling Dr. Bailin?

21 A. This is timed at about 11:50 p.m., and it
 22 looks like the call to Dr. Bailin was just after that,
 23 so, yes, I think that's correct.

24 Q. So clearly, Dr. Stine should have made it
 25 clear to Dr. Bailin that one of his patients is at the

1 emergency room with severe preeclampsia and
 2 potentially HELLP syndrome?

3 A. I thought she was in the labor and delivery
 4 area. I might be wrong about that. Not the emergency
 5 room.

6 Q. At the hospital. Forget the room, but at the
 7 hospital.

8 A. I think a call should make it clear to
 9 Dr. Bailin that his patient is there and then
 10 summarize basically the things we have been talking
 11 about.

12 Q. Right. She should have made -- Dr. Stine
 13 should have made it very clear to Dr. Bailin that your
 14 patient is here with at least severe preeclampsia,
 15 maybe HELLP syndrome, and she is acutely ill and she
 16 is severely ill. Is that fair?

17 A. Well, not necessarily at this point. Again,
 18 it's not clear to me that any of the labs were back
 19 for perhaps 30 or 40 minutes after that call was made.
 20 So what would be known at that time is that there were
 21 elevated blood pressures. But I don't know if
 22 Dr. Stine would have had access to prenatal records or
 23 blood pressures at that time.

24 So in theory, this patient may have had
 25 chronic hypertension with similar blood pressures, and

1 this may not have been an acute change in her
 2 condition. When the labs came back, that would change
 3 the impression.

4 Q. Well, she would have needed the labs back to
 5 make the -- for starting the process of thinking about
 6 HELLP syndrome; correct?

7 A. Not necessarily. You can certainly be
 8 thinking about that or entertaining the diagnosis, but
 9 she would need it to make the diagnosis.

10 Q. What is your understanding as to why she made
 11 the preliminary diagnosis of HELLP syndrome?

12 A. Well, in her notes she writes R/O HELLP,
 13 which means "rule out," so it would not mean that you
 14 made the diagnosis. It just means it's on your
 15 differential and you are thinking about it.

16 Q. You think about it simply because she says
 17 "severe preeclampsia"?

18 A. I can't speak for Dr. Stine, but probably
 19 since she has a patient that's having some epigastric
 20 pain and very high blood pressures, near term, I think
 21 a lot of people would be thinking about the potential
 22 of severe PIH and/or HELLP syndrome.

23 Q. Can we agree that even without the labs,
 24 Dr. Stine should have made it very clear to Dr. Bailin
 25 that one of your patients is here at the hospital.

1 She clearly has severe preeclampsia. She may have
 2 HELLP syndrome. She has epigastric pain and chest
 3 discomfort. And you need to be -- she is acutely and
 4 seriously ill. Should that have been relayed to
 5 Dr. Bailin?

6 A. Those are a lot of different individual
 7 premises. I think a lot of that does make sense. A
 8 lot of those things should be relayed. However,
 9 though, for example, the diagnosis of severe PIH is
 10 probable at that time. But it's possible that if this
 11 patient had elevated blood pressures in her prenatal
 12 care and had chronic hypertension, that this might not
 13 indicate severe PIH. In hindsight, that is the
 14 correct diagnosis.

15 Q. Right. But at least she made the
 16 diagnosis -- she didn't say rule out severe
 17 preeclampsia. She made the diagnosis of severe
 18 preeclampsia without the prenatal chart in front of
 19 her; correct?

20 A. Yes. That appears to be correct.

21 Q. So we can agree that when Dr. Stine called
 22 Dr. Bailin, she should have made it very clear that
 23 this patient has likely severe preeclampsia, she is
 24 acutely ill, and she needs your attention; correct?

25 A. I think that's a fair statement. Yes.

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

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

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

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

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

22 Q. Have you ever acted as a house obstetrician?

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

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

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

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

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

19 A. At what point in time?

20 Q. By the time she begins the induction.

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

1 Q. And HELLP syndrome?

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

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

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

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

25 MR. AUCIELLO: Objection. Go ahead.

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

6 Q. Did you read the anesthesiologist's
7 deposition?

8 A. Yes.

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

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

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

19 A. I recall seeing something to that effect.

20 Q. Does it make sense to you?

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

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

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

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

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

15 A. If a patient commented on that? No.

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

18 A. I'm sorry?

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

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

24 Q. When is that indicated?

25 A. There are rare cases where central monitoring

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

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

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

17 A. It would depend again on the particular
18 situation.

19 Q. You have done so in the past?

20 A. Have I consulted in the past?

21 Q. Yes. Have you called out for consultation?

22 A. Yes, I have.

23 Q. What kind of specialist would you call?

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

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

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

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

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

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

19 Q. What are the indications?

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

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

1 medication?

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

5 Q. Do you do it?

6 A. Yes. Generally in my practice, if I have a
7 patient in labor and delivery with severe PIH, if her
8 systolic blood pressure is repetitively going above
9 160, I probably would treat that blood pressure, yes.

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

15 A. Yes, that was one of the considerations.

16 Q. What did you conclude?

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

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

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

1 call, but not a standard of care issue.

2 Q. That's fair enough.

3 Doctor, on the issue of once Dr. Stine
4 appreciated how severely ill this woman was, should
5 she herself have called for consultation while she
6 waited for Dr. Bailin to arrive at the hospital?

7 A. Not unless she felt she needed additional
8 assistance.

9 Q. Should she have felt that she needed
10 additional assistance, based on her clinical
11 condition?

12 A. You are talking about before the cesarean
13 section?

14 Q. Yes.

15 A. No, I don't believe so.

16 Q. Should Dr. Stine have appreciated a need to
17 bring in anesthesia at the same time that she ordered
18 the blood type and cross?

19 A. I'm sorry. Did you say to bring in
20 anesthesia?

21 Q. Bring in an anesthesiologist into the case.

22 A. No. Generally, we would involve the
23 anesthesiologist in a case like this if we were
24 planning to do a cesarean section, and eventually they
25 did that.

1 Q. Right, and I guess I'm saying to you, Doctor,
2 would you agree with me that based on Dr. Stine's
3 education, background and training, she should have
4 been anticipating an immediate cesarean section as
5 soon as she made her diagnosis of severe preeclampsia?

6 A. No, not necessarily. I think the key is that
7 you want to stabilize the mom and await a full crew.
8 You want to do this type of operation in the best
9 possible setting, particularly since this is now the
10 middle of the night. So I think what she did was
11 reasonable.

12 Q. She has to wait for the full crew, but you
13 have to call the crew to come; right? And you've got
14 to get the crew in there quickly; correct?

15 A. Yes. My understanding was the crew was
16 there, though.

17 Q. Who do you think composed the crew?

18 A. I'm talking about the team that does the
19 cesarean section, which would be the physician doing
20 the operation, their physician assistant -- generally
21 a physician assistant -- the anesthesiologist, the
22 scrub nurse and circulating nurse.

23 Q. What is your understanding as the last time
24 that Dr. Stine had hands-on care with this patient?

25 A. Well, my understanding is that Dr. Stine was

1 the assistant at the cesarean section. The baby was
2 delivered at 1:18 in the morning. After the delivery,
3 I believe there were some -- there was some
4 involvement with Dr. Stine, but that Dr. Bailin, the
5 primary physician, was there and was the primary
6 physician caring for Ms. McElfish.

7 Q. I'm not sure what your answer is to my
8 question. I will ask it again.

9 What is your understanding of the last time
10 that Dr. Stine was at bedside rendering hands-on care
11 either with or without Dr. Bailin?

12 A. She obviously would have been delivering
13 hands-on care during the cesarean operation. I guess
14 the baby time was 1:18. I don't have the time on my
15 notes when they completed the operation, but the
16 frequent observation record begins at 1:55 in the
17 morning. So I assume that the operation had been
18 completed and Dr. Stine would not have been rendering
19 hands-on care, at least as far as surgical care, at
20 that point.

21 I would have to then look in my notes. I
22 don't believe I have any other specific references to
23 Dr. Stine in my notes, so I would have to go by the
24 actual records to answer your question.

25 Q. Do you see where Sherry McElfish -- I think

1 it's either 2:00 or 2:30 a.m. -- became markedly
2 hypotensive?

3 A. Yes, I have that in my notes.

4 Q. Do you think that Dr. Stine should have
5 appreciated at that point, based on her education and
6 training, this patient needs to be in an ICU?

7 A. Well, my understanding is and my notes say at
8 2:30 Dr. Bailin aware and in room. Patient was alert
9 and talking. My understanding is Dr. Bailin was this
10 patient's primary physician, and Dr. Stine had just
11 been acting as a house officer assisting until
12 Dr. Bailin arrived.

13 Q. Let's try that question another way. Would
14 you agree with me, Doctor, by the time that Dr. Stine,
15 assuming she was in the room, appreciated this woman's
16 hypotension, that she should have suggested, based on
17 her additional training and skill, that this patient
18 needed to be in an intensive care setting?

19 A. No. Not even under that hypothetical, I
20 don't believe so, because the patient had just been
21 given a second dose of Apresoline about 15 minutes
22 prior to that. So a reasonable and prudent physician
23 might conclude that it may be a little bit of
24 overcorrecting from the Apresoline, which is designed
25 to drop the blood pressure.

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

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

9 A. Yes.

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

12 A. Yes, sometimes I do.

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

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

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

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

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

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

1 urea or is it not.

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

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

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

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

23 Q. Any other indications?

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

1 clinical situation.

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

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

12 Q. Have you had patients where they might have a
13 1-plus in a urine dip stick and do a 24-hour urine and
14 the urine be -- the protein be much higher?

15 A. I can't recall offhand. I have done a lot of
16 24-hour urines over 21 years, and there may have been
17 some dipping 1-plus, and then we were surprised by the
18 amount of protein. That could be true.

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

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

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

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

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

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

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

1 hit the hospital?

2 A. I believe she was complaining of difficulty
3 breathing, yes.

4 Q. So minimally, Dr. Stine should have made it
5 clear to Dr. Bailin that she was short of breath and
6 has epigastric pain and she likely has severe
7 preeclampsia?

8 A. No, not necessarily. Although she had
9 difficulty breathing, later they did a pulse/ox, and
10 it was 99 percent. Sometimes difficult breathing can
11 be a very significant warning sign, particularly if we
12 corroborate that with a pulse/ox that shows they have
13 a reason for having difficulty breathing.

14 Q. Doctor, I just want to know whether or not
15 Dr. Stine should have made it very clear to Dr. Bailin
16 that his patient appears to be severely and acutely
17 ill?

18 MR. AUCIELLO: Objection. Asked and
19 answered like three times, but go ahead.

20 Q. Can you answer that yes or no? In any
21 manner, any verbiage, should she have made it clear,
22 that message that Sherry was acutely and severely ill?

23 A. I think I have tried to answer that question.
24 I think it gets back to definitions here. What
25 adjectives have to be used? Did she have to say,

1 Dr. Stine, "Your patient is severely and acutely ill"?
2 What does "acutely ill" mean? If we look that up in a
3 medical dictionary, it would probably say something
4 that happens fairly quickly. It doesn't really have
5 to do with the gravity of the illness, as probably
6 many laypeople think. "Acutely" means "not
7 chronically." Would a physician -- would Dr. Stine
8 have to say to Dr. Bailin, Your patient is "acutely
9 ill" as opposed to "chronically ill" to comply with
10 the standard of care? No, I don't believe that's
11 true.

12 I think I understand the gist of what you
13 are saying, though, and I agree with you that
14 Dr. Stine would have to convey that Ms. McElfish was a
15 sick patient and that Dr. Bailin should come and
16 evaluate her.

17 Q. Should she have conveyed enough information
18 that Dr. Bailin got the message that Dr. Stine wants
19 him there immediately?

20 A. No. I tried to answer that question a bit
21 earlier when I gave an example of what -- some type of
22 things that could be occurring that it would be
23 standard of care -- by the standard of care mandatory
24 to convey to a physician that their presence is needed
25 immediately.

1 One example would be a suspected uterine
2 rupture. Another would be a baby heart rate that goes
3 down but doesn't come back up. Another example would
4 be a patient like this that began to have seizures and
5 became an eclamptic.

6 But I think what we are seeing in this
7 patient, I don't believe that by standard of care
8 Dr. Stine would have to say, "Dr. Bailin, we need you
9 here immediately."

10 Q. If you were called by a house obstetrician
11 regarding one of your patients and they presented with
12 severe preeclampsia to the hospital and with
13 epigastric pain and difficulty breathing, would you
14 have wanted that house doctor to relay to you or
15 convey to you the message that you should get here
16 immediately?

17 A. I first have to ask if you are talking
18 hypothetically, because when I take call, I take call
19 in the hospital.

20 Q. Hypothetical now.

21 A. Hypothetically, if I had a patient like
22 Ms. McElfish that came into the hospital, I would like
23 to have a general synopsis of her status conveyed to
24 me. That's the best way I could describe what I would
25 like to be told.

1 Q. All right. We can agree if the
2 anesthesiologist was brought in at the last minute,
3 thinking that this was simply an emergency cesarean
4 section, that Dr. Stine should have made it clear to
5 that anesthesiologist that this patient has severe
6 preeclampsia; correct?

7 MR. AUCIELLO: Objection.

8 THE WITNESS: No. I tried to address
9 that before. I think there may be things that an
10 anesthesiologist might not be privy to. For example,
11 perhaps a pelvic exam had been recently done but not
12 yet recorded. And an anesthesiologist would have no
13 way to know what that pelvic exam showed. But if
14 there are data, like blood pressure elevations which
15 are written all over the chart and probably also on
16 the blood pressure recording and the fetal monitor
17 strip, I don't believe by standard of care it was
18 mandated that one doctor tell another doctor that the
19 blood pressures are elevated.

20 Q. But hypothetically, Dr. Stine should have
21 appreciated that the anesthesiologist didn't have the
22 opportunity to study the chart when she was brought
23 into this case. At that point under this
24 hypothetical, Dr. Stine should have made it clear to
25 that anesthesiologist about the likely severe

1 preeclampsia. Yes?

2 A. I can envision a case where that would be
3 true. I'm not sure at all that it happened in this
4 case.

5 Q. All right. Doctor, that's it. I'm done.
6 Anybody else have any questions?

7 MR. WALTERS: I do not.

8 MS. MALNAR: I don't have any questions.

9 MR. AUCIELLO: We will reserve the right
10 to read it and go from there. Thank you.

11 THE REPORTER: Any copies needed of
12 this?

13 MR. BECKER: This is Becker. I'll take
14 a copy.

15 MR. WALTERS: This is Steve Walters,
16 I'll take a copy.

17 MS. MALMAR: This is P.J. I'll take a
18 copy. With a minuscrypt, please.

19 MR. TREU: I'll take one.

20 MR. AUCIELLO: Copy.

21
22 (The deposition was concluded at 3:17 p.m.)
23 -000-

24
25 I, BRUCE L. FLAMM, M.D., hereby certify under

1 penalty of perjury that I have read the foregoing
2 transcript. Corrections, if any, were noted in ink,
3 and the same is now a full, true, and correct
4 transcript of my testimony.

5 Executed this _____ day of _____,
6 2005, at _____, California.

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12 BRUCE L. FLAMM, M.D.
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REPORTER'S CERTIFICATE

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3
4 I, Judith W. Gillespie, a Certified Shorthand
5 Reporter, No. 3710, for the State of California, do
6 hereby certify:

7 That prior to being examined, the witness named
8 in the foregoing deposition was sworn by me to testify
9 to the truth, the whole truth, and nothing but the
10 truth;

11 That the said deposition was taken down by me
12 in stenotype at the time and place therein stated and
13 was thereafter reduced to printing under my direction.

14 I further certify that I am not of counsel or
15 attorney for either of the parties hereto or in any
16 way interested in the event of this cause, and that I
17 am not related to either of the parties hereto.

18 In witness whereof, I have hereunto subscribed
19 my name this 28th day of April, 2005.
20
21
22

23 _____
24 JUDITH W. GILLESPIE, CSR, RPR
25 CSR NO. 3710

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