0001

IN THE COURT OF COMMON PLEAS
OF WAYNE COUNTY, OHIO

ANGEL ROBBINS, etc , et al , x

Plaintiffs,

vs. No. 00CV0027

ANTHONY P. TIZZANO, M.D., et al.,

Defendants. x

Monday, November 12, 2001
Riverside, California

VIDEOTAPED TELEPHONE DEPOSITION OF:
BRUCE FLAMM, M.D.,
a witness, was called for telephonic examination by counsel on behalf of the Plaintiffs, pursuant to Notice and agreement of the parties as to time and date, taken at the home of the witness, 10445 Victoria Avenue, Riverside, California, commencing at approximately 1:40 o'clock, p.m., before PATRICIA L. HUBBARD, CSR #3400, a Certified Shorthand Reporter in and for the State of

0002

California. when were present on behalf of the respective parties

APPEARANCES OF COUNSEL

FOR THE PLAINTIFFS (via telephone)
BECKER & MISHKIND ESQUIRES
BY HOWARD D MISHKIND, ESQUIRE
660 West 2nd Street, Suite 660
Cleveland, Ohio 44113

FOR THE DEFENDANT. WOOSTER CLINIC

ROETZEL & ANDRESS, ESQUIRES
BY JOHN V JACKSON II, ESQUIRE
one Cleveland Center. 10th Floor
Cleveland, Ohio 44114

--continued--

0003

APPEARANCES OF COUNSEL (Continued)

FOR THE DEFENDANT. WOOSTER COMMUNITY HOSPITAL: (via tclcphone)

REMINGER & REMINGER, ESQUIRES
BY GREGORY ROSSI, ESQUIRE
200 Courtyard Square
80 South Summit Street
Akron, Ohio 44308

Also Present
Craig Schumacher, the video specialist

- 0 -

COPY

0004

I-N-D-E-X

- 0 -

0005

(1) Thereupon, (2) BRUCE FLAMM, M.D., (3) was called as a witness, having been (4) sworn was examined and testified (5) as follows:
(6) VIDEOTAPE OPERATOR: Good afternoon. We (7) are on the record at 1:42 P.M., November 12, 2001, (8) for the videotape deposition of Dr. Bruce Flamm.
(9) We are taping this deposition at 10445 Victoria (10) Avenue in Riverside in the action entitled Robbins (11) versus Tizzano, case number 00 CV 0027.
(12) My name is Craig Schumacher. I'm the (13) video production specialist from Schumacher Video (14) Litigation Services located at 2332 South Bentley (15) Avenue in West Los Angeles.
(16) This is tape number one of Volume I.
(17) Would counsel and all present please (18) identify yourselves for the record.
(19) MR. MISHKIND: Howard Mishkind. I am the (20) attorney for the plaintiffs.
(21) MR. ROSSI: This is Greg Rossi for Wooster (22) Community Hospital.

Page 7

(1) MR. JACKSON: John Jackson on behalf of (2) Dr. Tizzano and the Cleveland Clinic.
(3) THE WITNESS: Bruce Flamm, and I'm being (4) deposed.
(5) THE REPORTER: And Patricia Hubbard, the *(6)* court reporter.
(7) MR. JACKSON: Howard, let me caution one (8) thing, when were you speaking, I don't know if (9) it's your phone or if you're on a speaker phone, (10) but it cut in and out a little bit. So we'll let (11) you know if that happens.
(12) MR. MISHKIND: Okay. I have the -- the (13) handset up to my mouth or the speaker phone would (14) have a worse reception. So --
(15) MR. JACKSON: But it didn't happen with (16) Greg, and it just happened with you again. So, (17) you know, for some reason you're cutting in and (18) out. We're able to catch it, but it may cause a (19) problem here for the court reporter.
(20) MR. MISHKIND: I'll have to speak slowly (21) and elongate my words.
(22) ///

Page 8

(1) EXAMINATION (2) BY MR. MISHKIND:
(3) Q Doctor, would you please state your (4) name for the record.
(5) **A Bruce Flamm.**
(6) Q Doctor Flamm, my name is Howard (7) Mishkind. And as I indicated a moment ago, I (8) represent plaintiffs in this action.
(9) I appreciate you accommodating us by (10) virtue of the video and court reporting services.
(11) As you obviously know, I'm here in Cleveland and (12) doing a deposition over the phone is sometimes a (13) little bit cumbersome.
(14) I will let you finish your answers.
(15) I would only ask that you wait until I've (16) completed my question just so that we can avoid (17) any overlap that might take place.
(18) Is that fair?
(19) **A Yes.**
(20) **Q** Doctor, tell me, my understanding is (21) that you are an OB/GYN; is that correct?
(22) **A Yes, sir.**

Page 9

(1) Q And you are affiliated with Kaiser; (2) is that correct?
(3) **A Yes.**
(4) Q Are you an employee of Ohio -- of (5) Permanente Medical Group? Not Ohio. I've got (6) Ohio on my mind. Of Kaiser Permanente Medical (7) Group?
(8) **A I -- I am a partner physician in (9) Southern California Permanente Medical Group.**
(10) Q Okay. And Southern California (11) Permanente Medical Group is a group of physicians (12) that provide care to Kaiser patients in Southern (13) California; is that true?
(14) **A Yes.**
(15) Q I refer to Kaiser in Ohio as an (16) H.M.O.
(17) Is it the same in California?
(18) **A Yes.**
(19) Q Okay. How long have you been with (20) Kaiser?
(21) **A I believe approximately 17 to (22) 18**

years.

Page 10

Q Now, I have in front of me a C.V. I'm not exactly sure whether it was provided to me by Mr. Jackson or through other sources.

But in any event, do you have a current C.V. with you?

A Yes, I do.

Q You have it in front of you?

A Yes.

Q Okay. Is it an extra copy?

A Yes.

Q Could we mark that as an exhibit?

A Sure.

Q Okay. If you would hand that to the court reporter, and we can start with that as Plaintiff's Exhibit 1.

(Whereupon the document referred to was marked Plaintiff's Exhibit 1 by the Certified Shorthand Reporter for identification and is attached hereto.)

MR. JACKSON: Go ahead, Howard.

///

Page 11

BY MR. MISHKIND:

Q Okay. Doctor, the C.V. that I have reflects updates through -- in certain places through May of 2000, and then I also see some presentations through December of 2000.

Can you tell me --

MR. JACKSON: Howard, how many pages do you have?

MR. MISHKIND: Mine is 27 pages.

MR. JACKSON: All right. The C.V. that we have is 29 pages. So obviously there are updates.

MR. MISHKIND: That's fine.

Q Doctor, when was your C.V. last updated?

A Just within about the last month or two. And you may have a copy that's the update prior to the one that we just marked as an exhibit.

Q Okay. Doctor, have you been involved as an expert witness in Ohio other than this case?

A I have reviewed cases from Ohio, but I don't recall offhand if I actually testified in

Page 12

any of those cases.

Q Do you recall having your deposition taken as an expert in any Ohio cases?

A I can't recall. That certainly may be true over the years. I don't recall actually traveling to Ohio to testify, but I may have testified in an Ohio case out here.

Q Let's take recent time, for example, the year 2000 or 2001.

Have you served as an expert witness --

MR. JACKSON: You mean --

BY MR. MISHKIND:

Q -- in a case that is in the State of Ohio?

MR. JACKSON: Howard, I want to point out one thing. In discussing with the doctor that issue, he has -- he said that he has reviewed a case in Ohio. He does not know if he's been identified as an expert. And because of that, I would ask you not -- I'm not going to let him give the name of

Page 13

the attorney. I will find out if he has been identified. And if that's the case, then I will let you know. I will -- I will represent to you that I'll call you and tell you who the attorney is.

I don't know, and nor does he, whether he has just been consulted or whether he has actually been identified.

MR. MISHKIND: Okay. Well, that's really not where I was going, although I will ask just on that point --

Q I take it that you were contacted -- Doctor, you were contacted in the case that Mr. Jackson just alluded to by an attorney for the defendant, true?

A True.

Q Okay. Now, let's not talk about that case at all at this juncture.

(19) Let's talk about in the year 2000 or (20) 2001, just so that we don't go too far back in (21) time, but within the last 12 to 24 months has your (22) deposition been taken as an expert in any cases

Page 14

(1) that are in the State of Ohio?
(2) A Well, I can recall two cases in the (3) state of Ohio that would probably be that recent, (4) in the last year or two. But I don't recall if (5) I've given testimony -- deposition testimony in (6) either of those cases. I don't think I have, but (7) I'm not sure.
(8) I do remember the name of the (9) attorney in that case, and I'll be happy to (10) provide that to Mr. Jackson so he can verify if I (11) have testified or not.
(12) Q Well, if you -- the case that you're (13) thinking of that you have testified in in Ohio, (14) who is the attorney that you were working for in (15) that case?
(16) MR. JACKSON: Well, Howard, what he's (17) saying is that he doesn't know if he has (18) testified. He may have just been called recently (19) as a consultant in a case.
(20) That was the issue I was raising with (21) you before.
(22) ///

Page 15

(1) BY MR. MISHKIND:
(2) Q All Right. Doctor, do you recall (3) testifying in a case where you were retained by (4) the Law Firm of Almer and Byrne in the City of (5) Cleveland?
(6) A Almer and Byrne?
(7) Q Yes.
(8) A I do not recall that.
(9) Q Do you remember appearing as an (10) expert on behalf of Metro Health Medical Center (11) here in Cleveland, Ohio?
(12) A Appearing in Cleveland, Ohio?
(13) Q Serving as an expert where Metro (14) Health Medical Center in Cleveland, Ohio was a (15) defendant.
(16) A Do you know the name of the plaintiff (17) or the name of the -- the defense attorney? That (18) might help me.
(19) Q That's why I'm asking. I mentioned (20) the name of Almer and Byrne as the name of the (21) firm.
(22) A No, sir. That doesn't -- that does

Page 16

(1) not ring a bell at all. But sometimes I just know (2) the name of the attorney I'm dealing with and I (3) don't know the name of the firm.
(4) Q Okay. Does the name Jeff Van (5) Waggoner ring a bell to you?
(6) A I believe I have corresponded with (7) Mr. Van Waggoner. That sounds familiar.
(8) Q Okay. And does the name Metro Health (9) Medical Center as a hospital ring a bell to you as (10) a hospital that you served as an expert witness (11) defending a medical malpractice case?
(12) A I cannot recall. I certainly may (13) have. But Metro Health does not ring a bell right (14) at the moment.
(15) I certainly wouldn't deny -- if you (16) have a record saying that I was involved in a case (17) with Metro Health, then you may be absolutely (18) correct.
(19) Q Do you recall whether the case (20) involving Metro Health Medical Center was a VBAC (21) case or not?
(22) A No. Because I don't as I sit here

Page 17

(1) today recall anything about what you're talking (2) about.
(3) Q Do you recall ever having your (4) deposition taken in any cases in the State of Ohio (5) that involved VBAC issues?
(6) A Possibly so, because a large portion (7) of the cases that I'm asked to review involve VBAC (8) issues.
(9) Q Let's put aside the case that I'm (10) representing, the Metro Health Medical Center case (11) with Mr. Van Waggoner and this other possible case (12) that you may have been consulted on.
(13) To the best of your recollection, how (14) many other cases have you been retained as an (15) expert in a medical malpractice case

here in the (16) State of Ohio?
(17) A Over the last 15 years or so I know (18) that I've been contacted by attorneys in Ohio.
(19) There were a couple of attorneys in the Cleveland (20) area that have contacted me over the years. I (21) don't recall their names offhand. There was an (22) attorney I believe in the Dayton, Ohio area that

Page 18

(1) contacted me.
(2) But I can't recall any more than that (3) at this time.
(4) Q Do you believe in any of those cases (5) that you just referenced that your deposition was (6) taken in?
(7) A I do not know offhand. Very likely (8) that could be true.
(9) Q Do you keep any type of a record, (10) Doctor, of the cases you have testified in?
(11) A No, I don't.
(12) Q Tell me how many cases you are (13) currently serving as an expert witness in.
(14) A Well, this may be anticipating your (15) next question, but I -- over the years I probably (16) testified -- or, rather, reviewed something on the (17) order of 200 or 250 cases. And as a -- as an (18) estimate, I would say I've probably given (19) deposition testimony in somewhere between maybe a (20) third and a half of those.
(21) Q Okay. You've been doing this for (22) about 15 years?

Page 19

(1) A Somewhere between 10 and 15, yes.
(2) Q And you've had your deposition (3) taken -- I'm sorry -- how many times, did you say?
(4) A Something on the order of maybe a (5) third to a half of all the cases I've been (6) involved with. And that would be -- so a third to (7) a half of maybe 200 and -- 200 to 250.
(8) Q Of those cases how many have been (9) VBAC cases?
(10) A A significant number, but I could not (11) pin it down.
(12) Q More than 50 percent?
(13) A I would say less than 50 percent.
(14) Q Have you ever testified outside of (15) the area of obstetrics and gynecology as an (16) expert?
(17) A I don't believe so.
(18) Q You're sure?
(19) A Outside of the area of obstetrics and (20) gynecology?
(21) Q In other words, let me -- let me (22) frame it better.

Page 20

(1) Have you ever testified as an expert (2) relative to issues other than pertaining to (3) obstetrics and gynecology?
(4) A I can't recall that I ever have, no.
(5) Q What about trial appearances? How (6) many times have you testified at trial as an (7) expert witness?
(8) A Probably on the order of somewhere (9) between 10 and 20 over all the years I've been (10) involved with cases.
(11) Q Have you ever testified as an expert (12) at deposition for a plaintiff?
(13) A No.
(14) Q Have you ever testified at trial as (15) an expert for a plaintiff?
(16) A No.
(17) Q Now, you mentioned a moment ago that (18) you've reviewed between 200 and 250 cases.
(19) Currently how many cases do you have, (20) roughly, that you are involved in in one aspect or (21) another, the early stages or the late stages?
(22) A Several dozen cases that are probably

Page 21

(1) still pending in some way, shape or form.
(2) Q And have any of those cases, (3) Doctor -- are any of them as the expert witness (4) for plaintiff?
(5) A No. But I -- just so that this is (6) not taken out of context, since I -- I've been (7) just saying "no" to these all the

time when you (8) asked a similar question, it's not by my personal (9) preference on my part or any reason why I wouldn't (10) want to do that.
(11) I've only been contacted by plaintiff (12) attorneys on the order of maybe 10 or 15 times (13) over the last 10 or 15 years. That isn't by my (14) choice. That's just what -- what comes to me.
(15) Q Doctor, I'm not implying anything.
(16) It was a simple question, and your answers were (17) direct and to the point. So don't read anything (18) more into it than what I'm asking. Okay?
(19) A Yes, sir.
(20) Q Okay. Doctor, in looking at the C.V. (21) that I have in front of me, again, recognizing (22) that it's a couple pages outdated and a few

---

Page 22

(1) presentations, et cetera, behind, I did note that (2) you had presented in December of 2000 in Tucson, (3) Arizona, a lecture on risk management in (4) obstetrics and gynecology.
(5) Do you remember a little bit less (6) than a year ago giving a presentation and a (7) lecture?
(8) A Yes. Yes, I do.
(9) Q And do you happen to have a (10) recollection whether or not Dr. Elliot, (11) plaintiff's expert, was present for that lecture?
(12) A I don't recall seeing John Elliot at (13) that meeting. He may have been there, but I don't (14) recall seeing him there.
(15) Q Do you know Dr. Elliot?
(16) A I did many years ago. We trained in (17) the same institution about **20** years ago.
(18) Q Has it been that long since you've (19) had any professional contact with him?
(20) A Professional contact, yes, that's (21) true. We may have said "hello" at meetings over (22) the years.

Page 23

(1) Q Have you and he been experts in the (2) same case over the years?
(3) A I believe that would be true.
(4) Q On how many occasions do you recall (5) that you and he were experts on the same case?
(6) A I wouldn't have a clue. I just (7) recall coming across his name over the years from (8) time to time.
(9) Q If you have an opinion, tell me. If (10) you don't, I'll accept that.
(11) But do you have an opinion as to (12) Dr. Elliot's reputation as an OB/GYN?
(13) A I have no information on that.
(14) You're talking about currently, his (15) practice?
(16) Q Yes.
(17) A I have no information. I know that (18) thinking back **20** years, I had a very high regard (19) for him, but I don't know anything about his (20) career currently.
(21) Q Do you have any reason based upon any (22) information in terms of his clinical practice to

---

Page *24*

(1) have any less of a regard for him than you (2) previously had?
(3) A No, I don't.
(4) Q Okay. While we're talking about the (5) experts in this case, do you know any of the other (6) experts that have been identified by any of the (7) parties in this case, Dr. Flamm?
(8) A I don't believe so.
(9) Q Do you know who the other experts (10) are?
(11) A The experts that I am aware of, (12) Dr. David Burkons, who I don't believe I know. I (13) may have met him at a meeting.
(14) Sometimes if I give a lecture, (15) doctors will come up to me at the end of the (16) lecture, and we'll chat. But other than that, I (17) don't think I know him.
(18) Another expert that I'm aware of is, (19) I believe, Joanne Zelton, a nursing expert. I (20) don't believe I know or met Nurse Zelton.
(21) I have not seen a deposition from (22) Justin Lavin, but I believe he may be an expert in

---

Page 25

(1) this case. And I know of him, but I don't

believe I've met him.
Q How do you know of Dr. Lavin?
A When I first started doing my VBAC research back about 20 years ago, I reviewed the world literature up until that point. And Dr. Lavin had just done a review of the literature. So I quoted his -- his review several times.
Q Have you ever had occasion to -- to talk with Dr. Lavin relative to the issue of VBAC?
A I don't recall we have. Again, over the course of two decades we may have chatted at a meeting, but I don't recall it.
Q Doctor, the various presentations that you have given over the years that are outlined in your C.V., do you maintain any type of a file with regard to outlines or hand-outs that are disseminated at the presentation?
A No, I don't have any file, no.
Q When was the last time that you presented at any medical conference or outing; in

---

Page 26

other words, where a group of physicians were gathered -- (inaudible comment) -- or lecture?
MR. JACKSON: The last part of your question broke off, Howard.
BY MR. MISHKIND:
Q Okay. My question, Doctor, was when was the last time that he gave any type of a presentation or lecture to a medical group?
A The -- I believe the last lecture I gave was October, last month. And it was in Redmond, Washington.
And that's on the new copy of the of the C.V. that you're going to get as an exhibit.
Q Was it on VBAC?
A That was on VBAC, yes.
Q And did you present any written material or outline to the group?
A I often will send months ahead of time copies of my papers. I may have also sent them an outline. I don't recall.
Q Before October when was the last time that you had presented -- and I'm not going to go

---

Page 27

through line and verse the C.V., rest assured.
A I believe the time previous to that was June of this year. And that was -- I was an invited guest speaker in Norway at the Norwegian Society of OB/GYN.
Q Are you scheduled in the near future for the balance of this year to give any presentations on VBAC issues?
A No. Mercifully, for the next few weeks and out this year I have no more lectures scheduled.
Q Doctor, a couple more questions about your medical-legal background.
When was the last time that you had a deposition taken?
A It must be several weeks ago.
Q Now, if I take the average you've given me before in terms of the number of depositions and I try to break that down on a yearly basis, what would be your best estimate as to how frequently you're giving depositions in the year 2001?

Page 28

A Typically something like one a month.
It obviously varies from month-to-month, but I think that would be fairly typical.
Q And do you have any other depositions scheduled for the remainder of this year?
A I believe I have one more scheduled in December.
Q What other states in the United States are you currently serving as an expert where your deposition has been taken or you know that you have been identified as an expert other than the State of Ohio?
A Many other states. I -- I don't know that I could list them. Probably several other states.
Q How much do you charge, Doctor, an hour for your review?
A $300 an hour.
Q What about for deposition?

(20) **A $400 an hour.**
(21) Q And for appearance at trial?
(22) **A The same, $400.**

Page 29

(1) Q When you testify in Ohio in January, (2) you'll be charging $400 per hour for your (3) testimony?
(4) **A Correct.**
(5) Q Doctor, recognizing that I'm not --
(6) (inaudible comment) --
(7) (Off-the-record discussion.)
(8) BY MR. MISHKIND:
(9) Q I want to try to get an idea of what (10) information you have reviewed, Doctor.
(11) But first, if you would tell me, when (12) were you first contacted by Mr. Jackson in this (13) case?
(14) **A I believe it was in March of this (15) year.**
(16) Q And on what do you base that?
(17) **A I'm basing that on a cover letter (18) that I'm looking at, which was a cover letter when (19) a lot of the records arrived. And it's dated (20) March 28, 2001.**
(21) Q Do you know how Mr. Jackson was (22) introduced to you?

Page 30

(1) **A No, sir.**
(2) Q Have you ever worked with Mr. Jackson (3) before this case?
(4) **A I don't believe so, no.**
(5) Q Did Mr. Jackson indicate to you at (6) any time how it was that he obtained your name?
(7) **A No.**
(8) Q Are you currently working with (9) Mr. Jackson or anyone from his firm on any other (10) case?
(11) **A No.**
(12) Q You have a cover letter dated March (13) 28, 2001; is that true?
(14) **A Yes.**
(15) Q And do you have all of the material (16) with you that you have reviewed in this case?
(17) **A Yes, I do.**
(18) Q Is it right in front of you now?
(19) **A Yes.**
(20) Q I'm going to have you in a moment (21) identify for me what you have reviewed.
(22) But before you do that tell me what

Page 31

(1) notes you have made in connection with your review (2) of this case.
(3) **A I have four pages of notes, and I (4) have them right in front of me.**
(5) Q Okay. Do you write like a doctor?
(6) MR. JACKSON: As opposed to what, Howard?
(7) MR. MISHKIND: I don't know.
(8) Q Is your handwriting legible?
(9) **A Usually my handwriting is probably (10) similar to other doctors, and not very legible.**
(11) But this is mostly printed.
(12) MR. JACKSON: Howard, let me -- let me (13) represent to you that I can read his notes.
(14) MR. MISHKIND: Well, I'm not sure whether (15) that gets us any closer to --
(16) MR. JACKSON: No. I think what -- are you (17) looking for whether you want him to read through (18) all these? Is that where you're headed?
(19) I can tell you that in my opinion (20) they're legible. I don't think you'll have any (21) trouble if that's what your question is.
(22) ///

Page 32

(1) BY MR. MISHKIND:
(2) Q Are the four pages of notes, is this (3) the entirety of what you have written down in (4) connection with your review?
(5) **A Yes. And it's pretty much all (6) printed. So I think you probably will be able to (7) read this pretty easily.**
(8) Q Is there any information that you --
(9) that you have had in this case that is not with (10) you today?
(11) In other words, is there anything (12) that you've reviewed or seen in connection with (13) this case that you do not have with you today?
(14) **A I don't believe so, no.**
(15) Q Are there any notes that you created (16) or letters that you prepared that you do not have (17) with you today?

(18) A No.
(19) Q Have you written any letters to (20) Mr. Jackson?
(21) A I don't believe so.
(22) Q The four pages of notes that are

Page 33

(1) printed notes, if you would hand those to the (2) court reporter so we can have those marked as (3) Exhibits 2, 3, 4 and 5.
(4) (Whereupon the documents referred (5) to were marked Plaintiff's (6) Exhibits 2 through 5 by the (7) Certified Shorthand Reporter for (8) identification and are attached (9) hereto.)
(10) MR. JACKSON: Go ahead, Howard.
(11) BY MR. MISHKIND:
(12) Q Okay. Doctor, are Exhibits 2, 3, 4 (13) and 5 the notes that you printed in connection (14) with your review in this case?
(15) A Yes. Are they the notes - I didn't (16) get the whole question.
(17) MR. JACKSON: You broke up again, Howard.
(18) BY MR. MISHKIND:
(19) Q Are they the notes that you printed (20) or prepared in connection with your review in this (21) case?
(22) A Yes.

Page 34

(1) Q Are there any materials that you have (2) reviewed that you have not made any notes (3) concerning?
(4) MR. JACKSON: I don't -- what are you (5) asking, Howard? I don't understand that.
(6) BY MR. MISHKIND:
(7) Q Doctor, not seeing what the four (8) pages of notes are, I'm wondering whether or not (9) you've received any material from Mr. Jackson by (10) way of deposition or records that you have not (11) commented in some way on these four pages of (12) notes.
(13) A Well, it's probably safe to say that (14) I haven't commented on a lot of the things I (15) reviewed in these notes.
(16) The notes -- since you can't see (17) them, let me just quickly tell you what they (18) represent.
(19) It's basically just a chronology of (20) the medical records. These are not opinions. Two (21) of the pages are a chronology of the records. The (22) third page is a list of many of the people

---

Page 35

(1) involved in some way with this case. And the (2) fourth page is a time line of -- starting at about (3) 7:44 in the morning on 1/17/99.
(4) Q Have you -- which depositions have (5) you read, Doctor?
(6) A A deposition of Dr. John Elliot, (7) E-l-14-04; Dr. David Burkons, B-u-r-k-o-n-s; (8) Nancy Morgan, M-o-r-g-a-n, R.N.; Dr. Anthony (9) Tizzano, T-i-z-z-a-n-o; Sarah Moats, M-o-a-t-s, (10) R.N.; Joanne Zelton, Z-e-l-t-o-n, R.N.; Mary Gwin, (11) G-w-i-n, R.N.; and Plaintiff Angel Robbins, (12) R-o-b-b-i-n-s.
(13) I believe those are all the (14) depositions I've reviewed.
(15) Q Do you have a note anywhere to (16) indicate when it was that you reviewed those (17) depositions?
(18) A I have cover letters that may list (19) when I received some of the depositions. And I (20) don't know how quickly after I got them I reviewed (21) them, though.
(22) Q Did you make any notes at all were

Page 36

(1) you read any of those depositions?
(2) A No.
(3) Q Did you generate any type of memo on (4) a computer or dictate a memo when you reviewed the (5) depositions?
(6) A NO.
(7) Q What about tabbing any of the pages (8) or marking in any of the margins on any of the (9) depositions?
(10) A Yes, I did.
(11) Q Which depositions?
(12) A I believe each and every one of them.
(13) Q And what was the purpose of that?
(14) A I -- as I go through depositions, I (15) highlight extensively, and then I often also will (16) place post-it notes in the margins to help me (17) later as I'm going back and trying to answer (18) questions in my mind

so that I can find things quickly.
Q If we were to go through, for example, Dr. Burkons's deposition, do you have tabs or notes in the margins in his deposition?

Page 37

A Yes, sir.
Q And are there areas -- and this is a broad question, I understand, but are there areas in Dr. Burkons's deposition that you disagree with that you've tabbed as you read through the transcript?
A I don't know that I can answer that without actually going through his deposition.
I've got many, many tabs here, and probably three times more areas highlighted than I have tabbed.
So as I sit here right now I couldn't answer that without going through it.
Q Okay. The same thing with regard to Dr. Elliot's deposition transcript.
Are there areas that you've tabbed that you did so because you disagree with what he has said in his deposition?
A The same answer. I have hundreds of sentences underlined in Dr. Elliot's deposition.
Some of the things that I underlined -- or rather highlighted, I shouldn't say underlined --
highlighted, and some of the things I highlighted

Page 38

were just because they helped me understand what Dr. Elliot's points of view were. There may be some of them that I highlighted because I have a difference of opinion.
But there's no way from the way I've got them highlighted or tabbed that I could answer that without looking at them.
Q And you don't have any notes that would key you in to whether you agree or disagree with a particular point that Dr. Elliot made or you agree or disagree with a particular point that Dr. Burkons made, for example?
A That's correct. The only notes I have are the four pages of notes I described.
Q Okay. The same question with regard to Nurse Zelton's deposition.
Do you have things tabbed and highlighted, as well?
A Yes, I do.
Q Were you provided with any type of summary or summaries of any of the depositions by Mr. Jackson or anyone from his office?

Page 39

A No.
Q What about any time lines or summaries of the records themselves?
A No.
Q So all of the correspondence that you have from Mr. Jackson is -- are essentially cover letters indicating "Enclosed please find the following documents"?
A Yes.
Q Can you tell me, Doctor, what your assignment or area of assignments were or are as you understand it in connection with this case?
A The cover letter from back in March of this year that contained many of the records and depositions said, "Thank you for agreeing to review the matter," and to contact Mr. Jackson after I Finished reviewing the case.
There is no specific instruction that I see on here, and I don't recall receiving any specific instruction on the phone other than lust to review the case and perhaps formulate my opinions and then give a call.

Page 40

Q Did you know that Mr. Jackson was representing Dr. Tizzano in this case?
A Yes.
Q And you had a conversation with him :hen after you reviewed the material?
A Yes.
Q In fact, I take it you've had more :han one conversation with him over the

telephone in connection with this case.
A I don't recall. We've had more than one conversation but I don't know if we've had more than one over the telephone.
Q Have you met Mr. Jackson in person before this deposition?
A Yes.
Q When did you meet him?
A Yesterday.
Q Okay. Before yesterday had you ever met him before?
A No.
MR. MISHKIND: John, do you have any objection to the cover letters that you have there

---

Page 41

being marked as exhibits, since I'm not there to see them?
MR. JACKSON: I don't, Howard, with the understanding that you'll provide the same for your expert.
MR. MISHKIND: I already did, if you recall.
MR. JACKSON: I don't remember that we got all of them, but, sure, I will --
MR. MISHKIND: You got everything.
MR. JACKSON: Okay. I will be happy to have these marked.
MR. MISHKIND: Okay. How many letters are there from you that --
MR. JACKSON: Well, let me just read them into the record for you and then -- how many there are, and then we can -- we can mark them however you wish.
MR. MISHKIND: Okay.
MR. JACKSON: There's a letter of March 28, 2001. It's a -- actually it's two pages, but the second page has about five lines, six lines on it.

Page 42

There's one of September 28th, 2001, which is again a two-page letter, with the second page being literally one line.
There is a October 22, 2001 letter, one page. And there is a November 1, 2001 letter, one page.
If it will save you time, I will tell you what's in -- what was transmitted with each of these if you want it.
MR. MISHKIND: That's okay. Copies of them will be fine, otherwise we'll be on the line forever.
THE WITNESS: Mr. Mishkind?
BY MR. MISHKIND:
Q Yes, sir.
A Can I just add one thing to that, is that I don't always save all the cover letters I get. If a -- if a cover letter says, "This is the deposition of Dr. X," sometimes I just throw the cover letter away.
So there may have been other cover letters. There may have been a letter reminding

---

Page 43

me about this deposition today. But I often just throw those things away.
But I do not recall anything being other than a cover letter.
Q You believe that to be the case, that you did discard one or more cover letters in this case?
MR. JACKSON: I will tell you, Howard, that I believe that's probably the case, because the letters that I have here are all letters forwarding materials to the doctor.
So letters of scheduling -- and I'm sure we sent him scheduling letters -- are not included.
But with the exception of letters that would schedule matters, you have everything here.
BY MR. MISHKIND:
Q Doctor, is that the case, that you believe that some of these cover letters -- other than the depositions, some of the cover letters for scheduling you have, in fact, discarded?

Page 44

A Right. I just want to be quite clear, though, what I throw away is if I get a cover letter saying "You have a deposition next Tuesday" and I already

know that and it's on my (5) calendar, I've got three notes to myself, I'll (6) throw that in the trash. If it's a cover letter (7) saying "Here's another deposition," I'll throw (8) that in the trash.
(9) But if there's a letter stating (10) anything of substance, a review of a deposition (11) that you -- that you pointed out, anything at all (12) of any substance, I would keep that.
(13) And I don't have anything like that (14) here.
(15) Q Fair enough. Tell me what else you (16) have reviewed in connection with this case, (17) please, other than what you've already identified.
(18) A I've also reviewed the medical (19) records in this case. Also, I was sent along with (20) Dr. Elliot's deposition an outline for a talk he (21) gave. Also, I reviewed the Complaint, and I was (22) also sent a copy of an A.C.O.G. pamphlet on --

Page 45

(1) patient educational pamphlet on vaginal birth (2) after Caesarean delivery.
(3) And I think that's everything I've (4) reviewed.
(5) Q Did you read the outline from (6) Dr. Elliot's presentation?
(7) A Did I read that?
(8) Q Yes.
(9) A Yes, I skimmed over it.
(10) Q And in your opinion, was that of any (11) significance to you with regard to the opinions (12) you hold in this case?
(13) A It looks like it's an interesting (14) talk. I was certainly impressed or flattered that (15) my name came up on a lot of the slides. But I (16) don't know that it's significant in my (17) impression -- in my opinions, no.
(18) Q You're familiar with the A.C.O.G.
(19) pamphlet that was sent to you, correct?
(20) A Yes.
(21) Q The that was the A.C.O.G. pamphlet (22) that was being used back in 1999 and for some

Page 46

(1) period of time before that in practice throughout (2) the country, correct?
(3) A It was commonly used in -- throughout (4) the country, yes.
(5) Q Did you use it in your practice?
(6) A We have several different types of (7) pamphlets we hand out, and I think this is (8) probably one of them. In other words, some (9) patients may have gotten these over the years.
(10) Some patients may have gotten other information.
(11) Q Would you agree with me, Doctor, that (12) the A.C.O.G. pamphlet that I believe you have does (13) not substitute for an informed consent for the (14) patient in terms of deciding on the method of (15) delivery?
(16) MR. JACKSON: Objection to the form.
(17) THE WITNESS: The pamphlet itself would not (18) constitute the totality of informed consent for (19) VBAC. It's certainly an excellent pamphlet, and (20) it does go through a lot of the very important (21) issues.
(22) But also, I believe that the patient

Page 47

(1) should talk to a medical provider as part of the (2) informed consent process.
(3) BY MR. MISHKIND:
(4) Q Doctor, do you provide your services (5) as an expert witness through any expert search (6) company or companies that provide experts for (7) lawyers in medical malpractice cases?
(8) A No, I don't.
(9) Q Have you ever done so?
(10) A No. I may have to, though; not (11) because I need more cases, but because I get very (12) few cases from plaintiff experts, and that (13) probably makes me seem very biased.
(14) Q Have you ever personally had the (15) misfortune of being named as a defendant in a (16) medical malpractice case?
(17) A Unfortunately, yes, sir.
(18) Q How many times?
(19) A Over the years I've been named many (20) times peripherally; for example, if it was a (21) resident case and I may have been supervising, in (22) the extent that I was the -- the director of their

Page 48

residency program.
But there have only been two cases that I can recall where I was actually the one who was sued.
Q How many times in your career have you been named as a defendant in a medical malpractice lawsuit?
A I don't have the answer to that. I don't know.
Q All right. Are any of the cases currently pending that you're aware of?
A No.
Q Did any of those cases involve VBAC issues?
A No.
Q Have you ever testified at trial in a medical malpractice case as a defendant?
A No.
Q Your deposition has been taken, though, as a defendant, true?
A Well, let me think back on that for a moment.

Page 49

I believe it has, yes.
Q Do you remember how long ago that was?
A Probably almost a decade ago.
Q Do you know Dr. Tizzano, by the way?
A I don't believe we've ever met.
Possibly again at a meeting he may have come up and said "hello." I don't -- I couldn't pick him out of a crowd.
Q Have you had occasion to talk with him in connection with any issues in this case?
A No. Not since I heard about this case, I'm sure I haven't.
Have I talked to him about VBAC, if he had come up to me at a conference ten years ago, we may have talked about VBAC, but nothing that I can recall and nothing having to do with this case.
Q Do you know any of the nurses or know any personnel that work at Wooster Community Hospital?
A I don't know anybody at Wooster Hospital, as far as I know.
Q Do you know what level obstetrical care Wooster Hospital provided back in 1999?
A No. I know there's a lot of discussion around the country about what that actually means, if you talk about level one, level two, level three. I know there's a lot of disagreement about what hospitals call themselves.
So I -- I couldn't answer that question.
Q Would you consider Wooster Hospital to be a tertiary care facility?
A No.
Q Would you consider it to be more of a rural or a community hospital?
A My understanding is it probably would be described as a community hospital.
Q Doctor, would you agree that certain patients are at greater risk for uterine rupture during a trial of labor than others?
A Yes.
Q Which patients are at greater risk?

Page 51

A Well, we know for sure that women that have a classical prior Caesarean are definitely at higher risk for uterine rupture.
There's a lot of disagreement about women that have a low vertical uteral incision. Some doctors feel that they are definitely at higher risk, other doctors believe that's not true.
And then there are many other issues where there may be a marginally increased risk or slightly increased risk.
Q Tell me based upon your review in this particular case, what risks did Angel Robbins have according to the office records and hospital records concerning a trial of labor?
A Looking through her records --
Are you talking about what risks in terms of risks of uterine rupture?
Q Correct.
A As opposed to other people attempting a VBAC?

(21) Q Correct.
(22) **A I would say her risk would be typical**

Page 52

(1) **of any woman attempting VBAC.**
(2) Q And what are those?
(3) **A Approximately 1 in 100, one percent**
(4) **risk of uterine rupture.**
(5) Q And back in 1999 was that statistic (6) of 1 in 100 known pretty much throughout the (7) nation?
(8) **A I think that's a fair statement, yes.**
(9) Q And was that 1 in 100 in terms of (10) risk of uterine rupture -- did it have the same (11) potential consequence to the mother as it did to (12) the fetus, or was the -- the risk of catastrophic (13) result greater to one versus the other?
(14) **A I think all the studies have shown (15) that the risk is greater to the baby certainly.**
(16) In terms of the risk of mortality and even the (17) risk of serious morbidity it's higher to the baby (18) than to the mother.
(19) Q In terms of the -- the magnitude of (20) the risk to the baby as compared to the mom, how (21) much greater has it been known that that (22) (inaudible comment) -- catastrophic result --

Page 53

(1) (inaudible comment) -- uterine rupture?
(2) (Off-the-record discussion.)
(3) BY MR. MISHKIND:
(4) Q I'm sorry. I'll bring it back.
(5) What percentage or what magnitude of (6) risk existed to the baby as opposed to the mom, if (7) you understand my question?
(8) **A Well, in many studies on VBAC, (9) including our own, the biggest risk to the mother, (10) if there is a uterine rupture, has been (11) hysterectomy, possibly transfusion, although these (12) are fairly rare.**
(13) We have never had a maternal death *(14)* from a -- a VBAC, and they have almost never been (15) reported in the literature.
(16) From the point of view of the baby, (17) the risks are more significant if there is a (18) uterine rupture. In the majority of cases the (19) babies will do well, but there is the risk of (20) fetal death and permanent injury to the baby.
(21) Q Would you agree that the A.C.O.G.
(22) bulletin that we just referenced and that

Page *54*

(1) Mr. Jackson sent to you doesn't comment on the (2) relative risk to the baby versus the relative risk (3) to mom in the event of a uterine rupture?
(4) **A I would agree with that, yes.**
(5) Q Would you also agree, Doctor, that *(6)* most good outcomes in VBAC cases have almost (7) universally been in hospitals where the OB/GYN, (8) anesthesia and operating nurses were immediately (9) available?
(10) MR. ROSSI: Objection.
(11) THE WITNESS: No. I would not agree with (12) that.
(13) VBACs actually have been conducted *(14)* all over the country for many years now. And for (15) the last several years there have been over (16) 100,000 VBAC's a year in this country.
(17) I would guess -- I don't have (18) statistics on this, but I would guess that the (19) majority of those actually have taken place at (20) community hospitals.
(21) And I have no data to suggest that (22) the statistics for outcome are worse at those

Page 55

(1) hospitals.
(2) BY MR. MISHKIND:
(3) Q Doctor, you would agree, would you (4) not, that there has been what I think you refer to (5) as an under-reporting bias that masked unfavorable *(6)* outcomes at rural or community hospitals as (7) opposed to large medical centers?
(8) MR. ROSSI: Objection.
(9) THE WITNESS: Well, what I believe -- and I (10) think I published this on several occasions -- is (11) that most of the VBAC studies -- not all of them, (12) but most of the studies on VBAC have come out of (13) large tertiary care centers. And for that reason, (14)

we have more data on the outcome of uterine rupture at tertiary care centers.
BY MR. MISHKIND:
Q Doctor, can you tell me back in 1999 what you considered to constitute appropriate informed consent for a mom who was contemplating a trial of labor after having undergone a C-section for failure to progress --
MR. JACKSON: Objection to form.

Page 56

BY MR. MISHKIND:
Q -- where the delivery is going to be in a community hospital setting?
MR. JACKSON: Objection to form.
THE WITNESS: I think VBAC consent basically has to include several things.
The patient needs to understand that she has an option. She can choose to have an elective repeat Caesarean, and she can choose to have a trial of labor. So that's one of the important elements of VBAC consent.
Another element is that the patient should understand that there are risks to both of those alternatives. In other words, a proper informed consent could not imply that VBAC has no risks, nor could it imply that elective repeat Caesarean have no risks.
It should really hit the major risks of both of the two options.
Do you want me to go further into that?
///

Page 57

BY MR. MISHKIND:
Q Please.
A Well, for example, for elective repeat Caesarean, the mother should understand that that is a major operation and that major operations carry certain risks, such as perhaps injury to the bowel or bladder, possibly blood loss, requiring a transfusion.
And then from this point on doctors would probably vary on what risks they wish to include, but those would be some of the main elements.
As far as VBAC, the patient should be informed that there are also risks with the trial of labor. The -- the really main risk and the really only thing that differentiates a VBAC from any other labor is that there is a much higher risk of uterine rupture with a patient with a prior Caesarean than if the patient had an unscarred uterus.
I think the patient should have an idea what uterine rupture is as part of informed

---

Page 58

consent. Not everybody understands the term "rupture." Some mothers might understand the term "tear" or "separation." And the mother should have -- the patient should have some understanding of how frequently this occurs; and that if it does occur, there could be serious consequences.
I think that's in a nutshell what VBAC consent should include.
Q When you say "serious consequences," would you agree that the mother is entitled to know that the serious consequences include death or permanent brain injury to the baby?
A Well, let me take those separately.
For example, the informed consent that I use does discuss death, but it doesn't discuss permanent brain injury.
And I think across the country physicians would agree to disagree on exactly how detailed one would get on the risks, depending on how frequent they are.
So as far as standard of care, I don't think a VBAC consent would have to specify

---

Page 59

all the potential complications if uterine rupture should occur, but the mother should understand that there could be serious sequelae.
Q Would you agree that the A.C.O.G.
bulletin does not contain any language about death or permanent brain injury as a material risk of a VBAC?
A I'mjust reading the exact phraseology. When they talk about why

you would (10) want to discuss this issue, they say -- and I'm (11) quoting from the pamphlet, (12) "This is because the main risk (13) to both you and your baby (14) during an attempted vaginal (15) birth is separation or rupture (16) of the scar left by that (17) incision."
(18) They do not specifically go beyond (19) that and discuss what the consequences of that (20) rupture or separation could be.
(21) Q Okay. And would you agree that (22) certainly a mother is entitled to know what the

Page 60

(1) consequences are in the event that there is a (2) rupture of the uterus during a trial of labor?
(3) A My feeling is that each patient is a (4) little bit different in their understanding of (5) medical affairs. To some women that would become (6) patently obvious.
(7) If you have a patient who is in the (8) medical field, for example, I think for many (9) people to say that your uterus could rupture, it (10) would be inconceivable for them to believe that (11) that could happen and nothing could go wrong or (12) that there was no -- no potential that something (13) could go wrong for either themselves or their (14) baby.
(15) There might be other patients who (16) have an eighth-grade education who would need more (17) informed consent or more information to constitute (18) an informed consent.
(19) So I think that you'd have to define (20) the informed consent by knowing more about the (21) individual situation.
(22) Q And do you have an opinion in this

Page 61

(1) case with Angel's background what knowledge should (2) have been imparted to her to provide her with an (3) adequate informed consent?
(4) A I think pretty much what -- the (5) capsule or summary that I just gave a few moments (6) ago would be a pretty fair statement of what I (7) believe informed consent should include for a (8) patient like Angel.
(9) Q In this case, Doctor, do you feel (10) that Angel was provided with an adequate informed (11) consent?
(12) MR. JACKSON: Objection to form.
(13) THE WITNESS: I believe from the testimony (14) of the physician and at least one of the nurses, (15) that she was given a proper informed consent.
(16) BY MR. MISHKIND:
(17) Q What about from the testimony of (18) Angel and --
(19) By the way, did you read the (20) deposition of the father?
(21) A I don't believe I got the father's (22) deposition, no.

Page 62

(1) Q Or the testimony of the grandmother (2) of the baby?
(3) A No. I read about that. I believe in (4) other depositions it was brought up. I did not (5) actually read their words.
(6) Q Based upon the information that you (7) obtained from reading the deposition of Angel, (8) would your opinion be different in terms of (9) whether or not she was provided with sufficient (10) information to make an informed decision about the (11) method of delivery?
(12) A I'd have to look back at exactly what (13) she said. I -- I do recall that there was (14) certainly a difference of opinion between what (15) Angel said in her deposition and what some of the (16) nurses and the doctor said in his deposition.
(17) I, of course, cannot determine (18) exactly how that should be interpreted. I (19) understand that's not my role.
(20) Q Sure. But if one were to believe (21) what Angel indicated in her testimony, would you (22) question whether or not she was provided with

Page 63

(1) adequate information to make an informed decision?
(2) A Let me quickly look at --
(3) MR. ROSSI: Objection. Are we going to
(4) ignore the medical records now, Howard, or

-- with (5) regard to this question?
(6) MR. MISHKIND: I'm not sure what -- what (7) medical records you're referring to. If you want (8) to --
(9) MR. ROSSI: I think it's document --
(10) (inaudible comment).
(11) (Off-the-record discussion.)
(12) MR. ROSSI: It's documented in the office (13) chart of Dr. Tizzano that the patient was given (14) the A.C.O.G. bulletin and provided an informed (15) consent.
(16) I'm asking you if you want him to (17) ignore that for the purposes of this question.
(18) MR. MISHKIND: Well, I'm going to object to (19) your adding on and was given an informed consent.
(20) I would certainly agree that she was (21) given the A.C.O.G. bulletin, but there has been a (22) factual dispute on the extent of the information

---

Page 64

(1) that she was provided.
(2) Q And I'm asking the doctor whether (3) based upon Angel's testimony and the providing of (4) the A.C.O.G. bulletin, whether that would raise at (5) least in your mind a request a question as to (6) whether or not she was provided with adequate (7) information in order to make an informed decision (8) about the method of delivery.
(9) MR. JACKSON: Objection.
(10) MR. ROSSI: Objection. But go ahead.
(11) THE WITNESS: Well, looking through Angel's (12) deposition, again it's clear to me that her belief (13) about what she was informed differs from the (14) belief of some of the medical care providers.
(15) But there were certain things in her (16) deposition that I had trouble comprehending or (17) agreeing with could be possible. For example, she (18) was asked on page 115 of her deposition, (19) "Was it your belief that a (20) VBAC delivery was free of any (21) potential risks or (22) complications?"

Page 65

(1) And she said, (2) "Yes."
(3) And then that question was (4) essentially rephrased, (5) "You didn't think there was (6) any risk at all or potential (7) complications with a vaginal (8) birth after having a Caesarean (9) section; is that your (10) testimony?"
(11) And she said, (12) "Yes."
(13) Well, my understanding is it would be (14) very hard for any fairly well educated person to (15) make a statement like that. So I don't understand (16) where she's coming from.
(17) BY MR. MISHKIND:
(18) Q Doctor, in your review of Angel's (19) deposition did you see any further question asked (20) by one or both of the attorneys -- and I can't (21) remember who was inquiring at that point -- about (22) her recognizing certain risks of anesthesia and

---

Page 66

(1) inspection and things of that nature which (2) followed up -- which were follow-up questions to (3) that line of inquiry?
(4) MR. JACKSON: Do you have a cite for us, (5) Howard?
(6) MR. MISHKIND: No. I'm just asking him in (7) general whether he recalls that.
(8) We can certainly go to the deposition (9) if you want to. That wasn't my purpose, John.
(10) MR. JACKSON: Well, if you want him to try (11) to find it, we can do that. But that's why I (12) asked you if you had a cite when you -- when you (13) raised a specific issue.
(14) If you don't and you want him to find (15) it, we can do that.
(16) Is that what you want to do?
(17) MR. MISHKIND: Hold on one second.
(18) MR. JACKSON: Wait -- wait till he responds (19) before you respond.
(20) BY MR. MISHKIND:
(21) Q Doctor, you brought up the issue of (22) VBAC, but you noticed on pages 116 and 117 that

---

Page 67

(1) she did acknowledge certain potential (2) complications of general anesthesia?
(3) **A Right. And that -- that exactly is (4) what I'm talking about, that it seems like she is (5) savvy enough or understanding**

enough of general concepts that she agrees -- she doesn't understand what the specific risks are of general anesthesia, but she certainly agrees that there must be risks to it.

And then it was confusing to me why someone who would understand that would believe that there are no risks -- no potential risks to VBAC.

I then had a question if she was being 100 percent candid. That is not my role to decide if she was being 100 percent candid.

That's going to be the jury's role.

Q You're not suggesting on the record that you think that Angel was being less than honest in her answers, are you?

A No. I'm suggesting that I'm confused about several things in her deposition.

Page 68

For example, in the next question she was asked, it says, "In your training as a nurse and when you were on the medical surgical floor, were there any other meds --

medical surgical procedures [sic] that you were aware of -- that you were aware of did not have any type of surgical complications?"

And she said, "I believe the only risk I think surgery has is infection."

Again I was just lost there. I'm confused. And I'm not saying that she's prevaricating. I'm just saying I'm confused here.

Q All right. Doctor, with regard to Angel's prior pregnancy, she had a Caesarean section due to failure to progress, correct?

A My understanding is that she had

Page 69

pregnancy-induced hypertension and that she did have a Caesarean section for what was termed failure to progress. I don't know if that was a failed induction, but that was the -- the gist of it, yes.

Q Did you review any of the labor and delivery records of the previous pregnancy?

A I can't recall as we sit here.

Q Do you know whether there were any hospitals in the 50-to-75-mile radius of Wooster Hospital that had centers or facilities that could perform immediate Caesarean sections for high-risk patients back in 1999?

A You mean as opposed to Wooster Hospital?

Q Yes, sir.

A Is that implying that they could not do that there? I mean is that what I would be answering in my answer?

I just want to make sure it's not a trick question.

Q No. Don't -- don't imply or don't

Page 70

infer anything.

I'm just asking you a very simple question of whether or not you're aware of any centers within the 50-to-75-mile range of Wooster Hospital that had facilities to do immediate Caesarian sections.

A Well, Wooster --

MR. ROSSI: I'll object. Go ahead.

THE WITNESS: Wooster itself may have been one of those hospitals, depending on the time of day.

And I am not familiar with the hospitals in that area. So I couldn't answer anything about hospitals within a certain number of miles, no.

BY MR. MISHKIND:

Q Okay. Do you know whether Wooster Hospital had anesthesiologists and operating room nurses that were immediately available 24 hours a day for emergency Caesarean section?

A My understanding was not 24 hours a day.

Page 71

Q And do you know whether other hospitals within a 50-to-75-mile radius of Wooster Hospital back in 1999 had such centers?

MR. JACKSON: I'll object, Howard. He told you he didn't know the geography.

If you want to explain to him the cities

that are within that 75 --
MR. MISHKIND: No. That's not my question.
If he doesn't know, then "No" will be sufficient.
MR. JACKSON: He answered that before, didn't he, that he didn't know the geography.
BY MR. MISHKIND:
Q Doctor?
A Right. I've been to Cleveland at least one time. I have a general feeling for the Cleveland area. I know where Euclid is. I've driven around the area. But I do not know the exact locations of the hospitals in that area, so I couldn't answer that question.
Q Okay. I take it it's your opinion -- you accepted the testimony of Dr. Tizzano and the

---

Page 72

nurse practitioner that Angel was provided with sufficient information to provide her with an ability to make an informed decision on the method of delivery?
MR. JACKSON: Objection.
BY MR. MISHKIND:
Q Is that correct?
A When you say accept the testimony, all I have to go by are the medical records and the testimony.
These cases would be easy if we could be a fly on the wall and hear exactly what went on at all these discussions, but that is all we have to go on.
And as I read through the depositions and put everything together and tried to come to some decision on that, it was eventually my belief that she did have standard of care informed consent for VBAC.
Q Okay. Now, certainly if we had the VBAC pamphlet given and no further explanation to the patient of the material risks and

---

Page 73

complications and the alternatives, that in and of itself would not be adequate information for a patient to make an informed decision, correct?
A Well, first of all I should point out that in many medical centers the patient never gets this A.C.O.G. VBAC pamphlet. There is certainly no requirement across America that --
that people get it.
So some people might feel that giving that pamphlet goes above and beyond the standard of care.
But I would agree with you -- and I think I've already agreed at least once or twice on this point -- that simply handing the patient that pamphlet would not fulfill the totality of a VBAC informed consent.
Q Okay. Doctor, what is the Friedman labor curve?
A The Friedman labor curve is a chart that was developed by Dr. Emanual Friedman decades and decades ago which plotted the cervical dilatation against time. And also some people

---

Page 74

will also plot the descent of the baby versus time.
Q Would you agree it's important to follow the Friedman labor curve during a VBAC?
A No. Not at all. I have not personally plotted a Friedman curve in probably over -- in over a decade.
When I was in my residency 20 years ago, we generally did make Friedman curves for most patients in labor. Most doctors around the country, though, no longer use Friedman curves.
Q Is it important to follow certain parameters during labor to adequately assess the progress of -- of a trial of labor in a VBAC case?
A Yes.
Q And what are you attempting to do while you're monitoring the labor in a -- in a trial of labor?
What are you looking for that would cause you to reconsider the delivery method?
A Well, I may have missed something

in your question.

Page 75

When you said when you were monitoring, we started out our conversation on this issue talking about progress. But, of course, I would not want to neglect to mention that you're monitoring the baby's heartbeat, you're monitoring the mother's vital signs.

Did you want me to confine this just to progress?

Q I believe that was what my question was directed toward.

A In a patient having a trial of labor, you want to make sure that the patient is progressing. That does not necessarily mean sticking to any particular curve, but the patient should be making progress in her labor. Progress is the definition of labor -- or is a definition of labor.

Q Okay. All right. And we'll get to that in a moment.

Let me ask you this, Doctor: Would you agree that a trial of labor should not be managed in a cavalier manner?

Page 76

A Yes. I would agree with that. I may have even published that.

Q Would you agree that a trial of labor should not be managed in a superficial manner?

A That sounds very similar to me, but I would also agree with that statement.

Q In 1999 were uterine ruptures more or less common in a trial of labor as opposed to a planned Caesarean section following a previous C-section?

A Uterine rupture is more common during a trial of labor than it is with a planned repeat Caesarean.

Q Doctor, in looking over a number of the articles that you've written, you believe in recommending that women attempt a vaginal birth after they've had a Caesarean section, correct?

A I believe in appropriate candidates that they be offered that option, yes.

Q And is it fair to say that you're an advocate of what has been referred to as vaginal birth after Caesarean or VBAC?

Page 77

A The word "advocate" I think probably has different connotations, different meanings to different people.

I think in the medical-legal arena, particularly in the legal arena, advocate is someone who fights strongly for an issue, as if you were a -- a advocate for your client and you're an attorney. So I would not say I'm an advocate in that sense.

I have long believed that VBAC should be an option open to many women.

If that's your definition of advocate, then -- then I would agree.

Q Well, Doctor, I'm just asking you a question that perhaps may have been asked of you previously as to whether or not you're an advocate of what has been referred to as VBAC.

And you're telling me that you don't use the term "advocate"?

A I'm telling you that I have been asked that question before, and my understanding is that many attorneys use the word "advocate"

Page 78

very differently than my understanding of the word.

I know many attorneys have explained to me that the word "advocate" means you will fight for this to happen. If a patient -- or a client is your client and you're that client's attorney, the word "advocate" might mean you're going to -- to go all the way as far as you can possibly go to fight for that patient.

I certainly don't feel that way about VBAC. If a patient comes to me and says, "You know, I really would rather have a repeat Caesarean section," I don't say, "Oh, no, no, no.

I'm an advocate for VBAC. We're going to have to -- we're going to have to have a

long discussion."
I say, "Fine. You have your choice of whatever you want to do."
I am an advocate in any sense of the word that the option be kept open for women who are appropriate candidates. I would hate to see the option taken away.

Page 79

Q You've written a number of articles encouraging physicians to encourage their patients to attempt VBAC, true?
A I have written many articles talking about the VBAC option, and many of my articles have concluded that it's a very reasonable and safe option.
I don't think I've ever written an article that would fit into me being an advocate in the connotation of the word I just described.
Q (Inaudible comment) -- of VBAC in the United States?
MR. JACKSON: We lost you there, Howard.
You broke up. We did not get your question.
BY MR. MISHKIND:
Q Okay. Doctor, would you agree that if Dr. Tizzano set out to find perhaps the number one proponent of VBAC in the United -- United States, you would be if not the number one, certainly one of the major proponents?
MR. JACKSON: Objection.
THE WITNESS: Well, I think -- I think

Page 80

that's probably not the case at all. I know that there are many people in the country who feel --
who feel very strongly about vaginal birth.
They're into the natural birth movement. They are associated with groups that are in the national --
the natural birth movement.
That's certainly not where I'm coming from at all. If -- if Dr. Tizzano were to say that I'm perhaps one of the experts in the world on the subject of VBAC or that I've studied VBAC more than perhaps anybody else in the world, that might be a fair statement. I'd at least be up there somewhere near the top.
But as far as someone who is an advocate for suggesting that option as opposed to another option, I would hope that nobody would think that I'm that way.
BY MR. MISHKIND:
Q My last question to you, I didn't use the term "advocate." I used very specifically and intentionally the term "proponent of VBAC."
And I asked you again would you be,

Page 81

if not the number one, certainly one of the major proponents of VBAC in the United States?
MR. JACKSON: Objection. Asked and answered.
THE WITNESS: I don't mean to imply that you're playing a semantics game here, but I know that attorneys often are experts in words. And unfortunately, doctors often are not experts in words.
If someone could take the time to explain to me the clear distinctions between the word "proponent" and "advocate," then maybe I could see the difference in what you're asking me.
But I've tried twice, and I'll try more times if you want me, to explain my feelings about VBAC.
Basically I have always felt that the safe thing should be alternatives. Women should have safe options, as long as they're safe.
No, I don't consider myself to be an advocate. If "proponent" could be considered a synonym for "advocate," then I would say the same

Page 82

thing.
BY MR. MISHKIND:
Q Okay. Very good, Doctor. Thank you.
Is it fair to say that no one has published more articles in favor of VBAC than you have?

A Again in favor of, that's -- that's an amazing terminology. The articles I've published have given the statistics, have discussed the results of large multi-center studies evaluating VBAC, in some cases evaluating VBAC as opposed to elective repeat Caesarean. And the data speaks for itself.

Q Okay. So when I state to you very specifically that no one has published more articles in favor of VBAC than you, what you're telling me is that that statement is not accurate?

MR. JACKSON: Objection.

BY MR. MISHKIND:

Q Correct?

A I would need you to explain to me -- I would ask you to please explain to me what you

---

Page 83

mean by "in favor of."

My understanding of research papers is you do a study, you present your data, you reach conclusions. You don't advocate things.

So I'm perhaps confused by what you're asking me.

Q Okay. Very good. We'll leave that for another time.

Doctor, let me ask you this: Can we agree that the success rate is not the same for all women who attempt VBACs?

A That is correct.

Q And, in fact, your research suggests that women with a previous Caesarean section for failure to progress has the lowest success rate on a VBAC, true?

A I believe in the studies where we specifically looked at that, the majority of women with a previous C-section for failure to progress will have a successful VBAC, but the rate was lower than for categories such as previous Caesarean for breech or twins.

Page 84

Q In fact your research showed -- and correct me if I'm wrong -- that roughly one third of women who attempted VBAC with a history of failure to progress eventually failed to deliver vaginally, true?

A I don't know the statistics offhand.

I haven't looked at that data in a long time. But that sounds approximately correct, yes.

Q And there's nothing in any of the medical literature in this case -- when I say medical literature, I mean medical record or hospital records or depositions, that you've seen that Angel Robbins was told statistically that approximately one third of patients that have had a prior Caesarean for failure to progress will also fail to deliver vaginally, true?

A No. But I would certainly point out that I don't tell patients that either.

Q Okay. But I'm just asking you, there's no indication in this case that that information was provided to the patient, correct?

A Right. I did not see that.

Page 85

Q Okay. What does the standard of care require of a physician when the woman indicates during the course of labor, "Doctor, I want a Caesarean section right now" or she tells a nurse, "I want a Caesarean section right now"?

MR. JACKSON: Let me -- you asked two questions there, Howard.

MR. MISHKIND: I'll break it down, John.

MR. JACKSON: But let me just clarify one point, that the doctor is here for opinions regarding the standard of care of Dr. Tizzano and the Wooster Clinic, not of nurses.

MR. MISHKIND: Well, I understand that, but I'm taking his discover deposition. And you can certainly object.

MR. JACKSON: Well, I'm saying to you that he's not offered as an expert on nursing care.

MR. MISHKIND: I understand that. I understand that.

MR. JACKSON: So if you want to ask him about doctor's, he will answer those.

MR. MISHKIND: I'm going to ask him

Page 86

questions that I feel to be appropriate for a discovery deposition. If you want to object, if you feel that I'm going outside of what would be appropriate, that's fine.

But I'm going to continuing to ask the questions, and I hope that the doctor will answer the questions.

MR. JACKSON: He'll answer appropriate questions.

MR. MISHKIND: Well, I only ask appropriate questions. And we've had that discussion in the past.

MR. JACKSON: How did we resolve it in the past?

MR. MISHKIND: You expect me to remember?

MR. JACKSON: Well, you raised the issue.

MR. MISHKIND: We'll save that for another conversation.

Q Let's go back to my question.

If a mother indicates during the course of labor that she wants a Caesarean section, what does the standard of care require of

---

Page 87

a physician when that information is imparted to the physician?

A I think there is a very wide spectrum of scenarios. I've lectured on this before, and I've thought about this quite a bit over -- over numerous years.

if the patient were to say "Doctor, you know, I'm tired of this. You know, I don't like this anymore," what she often, more often than not, is saying "I don't like labor. I'm uncomfortable."

And a reasonable doctor wouldn't just say, "Okay. Then we'll open the operating room."

The doctor would try to find out why the patient was feeling that way. Perhaps she didn't have an epidural. Maybe an epidural would help her.

Maybe if she had an epidural, it could be re-dosed.

There are other occasions, for example, a woman had very good pain relief, but there are other reasons why she said she wanted a Caesarean, and she was very adamant about it.

Page 88

So the spectrum -- an individual case could fit anywhere from one end of that spectrum to the other.

And my answer about what the standard of care would require would depend on where the particular case fell on the spectrum.

Q Let's see if you agree with this.

A Sorry for such a long winded answer.

Q I'm sorry?

A I just said sorry for such a long-winded answer.

Q That's all right. I hope I didn't cut you off.

A No, sir.

Q Okay. I want to see if we can agree that certainly an obstetrician has an obligation to determine why the patient is asking for a Caesarean section and then put that data along with all the medical facts that are available at the time to help to come to a decision.

A Yes, I would agree with that.

Q And certainly if there is no

Page 89

contraindication to the patient wanting to have a Caesarean section, the obstetrician shouldn't simply decline to do the Caesarean section because of the hour of day or the preference on the doctor's part to deliver vaginally, true?

A Yes. You can't just dismiss a request like that offhand or out of hand. You would have to put all of the data for that particular case into the equation. And there might be times after reflection that that, indeed, was a reasonable request on the part of the patient.

There may be other kind -- times after pondering over all the issues that really there are other things you could offer the patient.

(17) Q Did you determine based upon (18) everything that you've reviewed in this case, (19) Dr. Tizzano's testimony, the records, the nurse's (20) testimony, whether or not Dr. Tizzano determined (21) from the patient why it is that she had expressed (22) on at least one occasion, if not more, to the

---

Page 90

(1) nurses that she wanted to abandon the trial of (2) labor and wanted to proceed with C-section?

(3) **A My understanding is there is (4) disagreement on this issue among the parties (5) involved. I saw what I believe to be different (6) takes on this issue perhaps in some of the (7) depositions.**

(8) My understanding was that I believe (9) it was Nurse Moats felt that the patient was (10) getting tired, and that was her impression of why (11) the patient had mentioned Caesarean section.

(12) I don't know how much of that, if any (13) of that, was actually conveyed -- conveyed to (14) Dr. Tizzano.

(15) Q Well, let me ask you this: If the (16) patient had expressed on one or more occasions to (17) the nurse that she wanted to have a C-section and (18) then the doctor arrived at the hospital at (19) sometime thereafter, does the doctor have an (20) obligation to determine either from the patient or (21) from the nurse or a combination what it was that (22) was factoring into that decision-making process?

Page 91

(1) **A No. A couple of things I would say.**

(2) First of all, unless the doctor knew, I don't (3) think there could be any obligation to inquire (4) about it.

(5) If I -- for example, if I came to the (6) hospital in the morning and I did not know that (7) one of my patients was talking about a Caesarean (8) section, I don't think I'd have any obligation to (9) find out about it. I'd have no reason to believe (10) that that was an issue.

(11) And the second part of that has to do (12) with what happens between a patient and a nurse.

(13) No, it is not true, in my opinion, (14) that whenever a patient says, "I want a C-section" (15) that the nurse has to pick up the phone and call (16) the doctor. I think that would probably occur in (17) an extraordinary -- extraordinary number of (18) labors. And I don't think that would necessarily (19) be good patient care.

(20) In fact, in my experience over the (21) years, many, if not most, patients at some point (22) in their labor say something like maybe "Take the

---

Page 92

(1) baby now" or "Take it," which at five centimeters (2) could mean nothing other than Caesarean, because (3) you couldn't do forceps at five centimeters.

(4) And nurses generally don't say, "Oh, (5) okay, now I'm calling the doctor, because you have (6) pretty much said you want the baby out now, you (7) want a Caesarean."

(8) Now, certainly I'm not going to go on (9) record saying there is not a time when a nurse (10) wouldn't have an obligation to call the physician.

(11) If the patient seemed to be thinking quite (12) rationally and said to a nurse, "Look, I've (13) thought this over, and -- and I have pondered this (14) over, and I don't want to do what I'm doing (15) anymore. I want to talk to my doctor. I want a (16) Caesarean section," in a case like that I think (17) the nurse would have an obligation to contact the (18) doctor.

(19) Q Well, if, in fact, the nurse does (20) notify the doctor, whether she had an obligation (21) or not, and tells the doctor that the patient (22) wanted a C-section, what responsibility is there

---

Page 93

(1) on the part of the physician to act upon that (2) information?

(3) **A I don't have enough information from (4) the hypothetical you gave me to answer that (5) question. Very similarly -- so there's a (6) spectrum of the way patients might mention (7) Caesarean all the way from**

kind of half kidding to (8) demanding.
(9) The conversation between a nurse and (10) a doctor has an entire spectrum. A nurse might (11) mention in passing in the course of a conversation (12) that "Mrs. X, you know, is kind of hinting a (13) little bit that she's getting tired of this," or (14) the nurse might say, "Mrs. Jones is demanding, as (15) is her husband, that you get over here now and do (16) a C-section."
(17) The standard of care would demand (18) totally different things in those two scenarios.
(19) Q Doctor, in your experience have you (20) had catastrophic results with regard to babies as (21) a result of uterine ruptures?
(22) A Could you clarify, by my experience

page 94

(1) do you mean in my research studies or in my (2) personal practice?
(3) Q Your personal practice.
(4) A I have not personally had a (5) catastrophic event with a uterine rupture, no.
(6) Q And by catastrophic, just so that (7) we're on the same wavelength, that would include (8) death and neuro- -- permanent neurological damage, (9) correct?
(10) A Correct.
(11) Q Okay. According to your review in (12) this case, when was Dr. Tizzano first contacted by (13) the nurses at Wooster Hospital?
(14) A Clearly there's a -- a difference of (15) opinion or disagreement in the testimony in this (16) case. And I don't know that I can be the one (17) that's going to be able to answer that (18) controversy.
(19) Q Well, do you recall Dr. Tizzano's (20) testimony concerning when he believes he first had (21) communication with the hospital on Angel?
(22) A Yes.

Page 95

(1) Q And what's your recollection?
(2) A My understanding is that Dr. Tizzano (3) believes that he woke up somewhere around (4) 6 o'clock in the morning on January 17, 1999 and (5) called the hospital, and then at that time learned (6) that this patient was in labor.
(7) Q And you recognize the nurses -- at (8) least Nurse Moats, has a different recollection (9) of -- when she had first communication with (10) Dr. Tizzano?
(11) A Yes.
(12) Q -- correct?
(13) A Yes, correct.
(14) Q In looking at the record -- (15) forgetting about the testimony, but looking at the (16) medical record, are you able to conclude more (17) likely than not who has a better recollection of (18) the events in terms of when Dr. Tizzano was first (19) contacted?
(20) A No, I don't believe I can do that (21) from the medical record, no.
(22) Q From your review of the testimony in

Page 96

(1) this case, how many times did Angel express a (2) desire to have a Caesarean section and to (3) discontinue the trial of labor?
(4) A I don't know that I could say how (5) many times. I read her deposition and her (6) testimony and I read Nurse Moats's testimony. I (7) think I have a pretty good flavor for their (8) opinions about this.
(9) But I don't -- I couldn't give you a (10) number of times.
(11) Q When was it, according to your (12) review, that Angel first expressed a desire to (13) have a Caesarean section and to abandon the trial (14) of labor based upon what you read?
(15) A In her point of view or in the (16) nurse's point of view?
(17) Q Both.
(18) A I'm reading from Angel Robbins's (19) deposition on page 43 and kind of jumping right to (20) the -- to the sentence on line nine, which is a (21) question -- or statement, it says, (22) "Probably around 4 o'clock is

Page 97

(1) the first time that I told her (2) I wanted to have a C-section."
(3) Q And you recognize Nurse Moats's (4)

testimony was that before calling Dr. Tizzano at 6:00 A.M., Angel expressed that to her, correct?

A She did, I believe, in her deposition agree that Angel had requested Caesarean section.

Q I'm sorry, Doctor. Could you repeat your answer? I lost you on that.

A Yes. My understanding from reading Nurse Moats's deposition is that she did agree that Angel Robbins had requested Caesarean delivery.

Q And without going line and verse through Angel's testimony, would you agree that according to her testimony that you've read, she expressed on more than one occasion to Nurse Moats a desire to have a C-section?

A That -- from Angel's testimony that she said that?

Q Yes, sir.

A Yes. She did say that in her

Page 98

deposition.

Q Now, Angel had been seen by Dr. Tizzano on the 16th in the office, correct?

A Yes.

Q And would it have been reasonable for the nurse to contact Dr. Tizzano at or around midnight when she arrived at the hospital to let him know that his patient, who was a trial of labor, had arrived at -- in labor and delivery?

A Yes.

Q And do you recall Dr. Tizzano's testimony that had he been contracted at or around midnight, that he more likely than not would have come to the hospital to evaluate the patient, because he normally is not asleep at that time?

A Yes, I do recall that.

Q Would that have been the approach that you would have taken in this case, as well?

MR. JACKSON: What do you mean, Howard?

BY MR. MISHKIND:

Q Come to the hospital to evaluate the patient given that she was a trial of labor?

Page 99

MR. JACKSON: You want to know if this doctor, Dr. Flamm, would have done that?

MR. MISHKIND: Correct.

MR. JACKSON: Or are you asking is that standard of care?

MR. MISHKIND: No. You -- you heard my question.

MR. JACKSON: Okay.

MR. MISHKIND: I asked him specifically.

MR. JACKSON: Well, I'll object as -- But go ahead, Doctor.

THE WITNESS: I would have to be in Dr. Tizzano's setting with all the factors being the same. I think it's certainly a reasonable choice to do. And certainly if you live quite a ways from the hospital, that might be a real good idea to do.

If a doctor lived five minutes away from the hospital, I think probably some doctors would choose to come in in the middle of the night; other doctors, depending on their relationships with the nurses, might not choose to

Page 100

come in in the middle of the night if somebody is in early labor.

Q So it would have been a reasonable thing for Dr. Tizzano to have done based upon what he testified to that had he been notified by the nurse that he more likely than not would have come to the hospital to see his patient?

MR. JACKSON: Objection.

MR. ROSSI: Objection.

THE WITNESS: Would it have been reasonable for him to come to the hospital wound midnight if he was notified?

BY MR. MISHKIND:

Q Correct.

A Sure.

Q Okay. And certainly would it have been reasonable for Dr. Tizzano to have been notified by the nurses if Angel was complete with minus three station and was expressing a desire not to proceed with a

vaginal birth -- would it (21) have been reasonable for Dr. Tizzano to have been (22) notified of those facts and statements?

Page 101

(1) **A Yes.**
(2) **Q** And what would a reasonable physician (3) have been required to do if they're notified where (4) the patient is complete minus three station and (5) the patient is expressing a desire to abandon the (6) trial of labor and to proceed to a C-section?
(7) MR. ROSSI: Objection.
(8) MR. JACKSON: Objection.
(9) THE WITNESS: There are three parameters in (10) that question. And let me break it down just a (11) little bit.
(12) With the first two parameters, if a (13) patient -- if a doctor was informed that your (14) patient is complete and minus three, the doctor (15) may choose to come in. He may choose to say, (16) "Well, let's let her push a little bit and see if (17) the head comes down."
(18) Now, the third parameter, though, (19) kind of changes things. And this goes back to our (20) discussion again about the spectrum. If the nurse (21) said, you know, "Your patient is complete and (22) she's minus three" and maybe they chatted about

Page 102

(1) some things and she says, "Oh, by the way, she (2) kind of mentioned Caesarean," I don't know that (3) that would change the requirement or obligation of (4) the doctor either way.
(5) If the patient -- if the nurse, on (6) the other hand, said, "In addition to the fact (7) that she's complete and minus three she is saying, (8) 'Look, I want a C-section and I want my doctor (9) now,'" then I think the doctor would have an (10) obligation to come and see the patient.
(11) Q And if the patient expressed a desire (12) for the nurse to indicate with the doctor and the (13) nurse does, in fact, communicate to the doctor (14) that the patient wants a C-section, that the (15) patient is complete, that the patient is minus (16) three station, does the physician then have an (17) obligation to come to see the patient?
(18) MR. JACKSON: Objection. I think he just (19) answered that question, Howard.
(20) THE WITNESS: And I'm just having trouble, (21) because that broke up a little bit, and I couldn't (22) get every bit of it. I'm a little -- I couldn't

Page 103

(1) hear all the words.
(2) BY MR. MISHKIND:
(3) Q Sure. If the -- if the patient (4) expresses a desire to have a C-section and (5) requests that the nurse notify the doctor and if, (6) in fact, the nurse notifies the doctor that the (7) patient is complete, minus three station and is (8) desirous of having a C-section, would the standard (9) of care then require the physician to come and (10) evaluate the patient?
(11) MR. JACKSON: Objection. Asked and (12) answered. He answered that just a moment ago.
(13) BY MR. MISHKIND:
(14) Q Okay. Go ahead, Doctor.
(15) **A Maybe I didn't make myself clear, but** (16) **I thought I had asked -- I had answered that exact** (17) **question.**
(18) MR. JACKSON: You did.
(19) THE WITNESS: And I explained that there (20) would be times when there would be an obligation (21) for the physician to come to the hospital. There (22) would be other times when there would not be an

Page 104

(1) obligation under the standard of care for the (2) physician to come in based on exactly what was (3) conveyed in that discussion.
(4) BY MR. MISHKIND:
(5) Q All right, Doctor. When, according (6) to your review in this case, did Angel become (7) complete?
(8) **A At approximately 4:15 in the morning.**
(9) Q And at that time she was minus three (10) station, 100 percent effaced; is that correct?
(11) **A Yes, sir.**

(12) Q And at that time would it have been (13) reasonable for the nurse to contact Dr. Tizzano to (14) notify him as to the status of his patient?
(15) MR. ROSSI: Objection.
(16) THE WITNESS: Yes.
(17) BY MR. MISHKIND:
(18) Q According to the hospital record, is (19) there any indication that the nurse contacted (20) Dr. Tizzano at that time?
(21) **A I'm sorry. According to what?**
(22) Q According to the hospital record is

Page 105

(1) there any indication that Dr. Tizzano was (2) contacted at that time?
(3) **A I don't recall seeing that.**
(4) Q And, in fact, according to the (5) testimony of the nurse, can we agree that they (6) that she did not contact the doctor at 4:00 A.M.
(7) when -- (Inaudible comment) -- was complete?
(8) **A Yes, that's my understanding.**
(9) (Off-the-record discussion.)
(10) BY MR. MISHKIND:
(11) Q -- when Angel was complete?
(12) **A Yes, that is my understanding.**
(13) Q Now, at 6:00 A.M., assuming that (14) Dr. Tizzano had not been contacted at 4:00 A.M., (15) would you expect that a reasonable and prudent (16) nurse would notify Dr. Tizzano at 6:00 A.M. when (17) they had this conversation that the patient was (18) complete and had been complete for approximately (19) two hours when she gave a report to the doctor?
(20) MR. JACKSON: Howard, are you asking the (21) standard of care of a nurse under those (22) circumstances?

Page 106

(1) MR. MISHKIND: I'm asking him whether it (2) would have been reasonable for a labor and (3) delivery nurse under the circumstances to notify (4) the doctor not only that she is complete, but that (5) she had been complete for two hours.
(6) MR. JACKSON: That's a different question (7) than standard of care. And if that's your (8) question, he can answer that.
(9) But he's not going to answer (10) questions about standard of care of a nurse.
(11) MR. MISHKIND: Your objection's noted. And (12) my question is very specific. And he can go ahead (13) and answer the question.
(14) THE WITNESS: Mr. Mishkind, I just want to (15) clarify something, because a chill went down my (16) back when you said "reasonable and prudent."
(17) Because I guess maybe I have the same feeling that (18) some other people had that it sounded very much (19) like it was leaning towards the definition of (20) standard of care.
(21) And I hope you didn't misconstrue any (22) of my previous answers over the past half hour

---

Page 107

(1) when you asked would it be reasonable to do this (2) or reasonable to do that, I was agreeing every (3) time I agreed that sure, it would be reasonable, (4) but I was not talking about standard of care.
(5) BY MR. MISHKIND:
(6) Q Doctor, what is your definition of (7) standard of care?
(8) **A Well, I'm sorry, are you then (9) implying that I was agreeing that all those (10) things --**
(11) MR. JACKSON: No. You've answered that, (12) Doctor.
(13) BY MR. MISHKIND:
(14) Q Doctor, answer my question. What's (15) your definition of standard of care?
(16) **A It's the -- that level of care that (17) would be rendered under the same or similar (18) circumstances by a reasonable or prudent nurse or (19) physician or other medical care provider.**
(20) Q Doctor, do you as an OB, as an (21) obstetrician, rely upon labor and delivery nurses (22) to convey information to you when you aren't

---

Page 108

(1) physically present at the hospital? True?
(2) **A That is true.**
(3) **Q** And certainly there are certain (4) stages in labor that are important for the (5) obstetrician to be notified of so that decisions

and orders can be given, true?
A That varies around the country, depending upon the arrangements that exist between physicians and nurses.
Some doctors would want to be notified when any of their patients are completely dilated. Some doctors have certain things that they want to be notified about. Other doctors have other arrangements with nurses.
So I don't think there's an universal standard of care about exactly what doctors want to be notified about. But I would agree that there is an obligation to -- for a nurse to keep doctors appraised of relevant information.
Q Okay. Well, in a patient that is a trial of labor that becomes complete that is minus three station that has an unengaged presenting

---

Page 109

part, is that information that's important for the obstetrician to be apprised of?
A Again I think it would depend on the relationship between that doctor and that nurse.
There may be a doctor in -- in a certain community that would say, "Yes, definitely, anytime one of my patients becomes complete, I don't care if it's 3:00 in the morning, I want that phone call." Other doctors say, "No. I mean you're a good nurse. You've been practicing for many years. When a patient becomes complete, fine, let her start pushing. If then the strip starts looking suspicious or she's not bringing the baby down, then give me a call."
Both of those physicians would be meeting the standard of care.
Q Doctor, I want you to assume hypothetically that Dr. Tizzano had come to the hospital earlier than 6:00 A.M. and was told that Angel wanted to have a Caesarean section any time after 4:00 A.M. and 6:00 A.M., would there have been any contraindication for proceeding to a

---

Page 110

C-section in this case?
MR. ROSSI: Objection to the hypothetical.
Go ahead.
MR. JACKSON: Objection. Go ahead, Doctor.
THE WITNESS: Again it would -- it would bring into play all the things that I discussed and I'm not going to bore you with that whole discussion spectrum again. But one -- one thing that would interfere with the -- with going ahead with a Caesarean might be that there might be no need for one. In other words, maybe the patient was just uncomfortable, maybe the doctor would mention a few things to the patient and they'd say, "Oh, sure, we'll just bump up that epidural a little bit."
And now that you've said that -- you've clarified that for me, I really don't want a C-section. I want to give it some more time."
So I'm not sure if that's answering your question.
BY MR. MISHKIND:
Q It really doesn't, though. Because

Page 111

specifically when I asked you about contraindication based upon a patient being complete, being minus three station -- minus three station with a floating presenting part, 100 percent effaced, would there be any medical contraindication that would prevent the obstetrician from proceeding to a C-section if that decision was made?
MR. JACKSON: Objection.
MR. ROSSI: Objection.
THE WITNESS: Maybe I'm just not clear on where you're going with it, but there would very rarely ever be a medical contraindication which would dictate the inability to do a C-section if it was indicated.
BY MR. MISHKIND:
Q And certainly in this case there is -- there is no medical contraindication if a decision had been made to proceed with a C-section during labor at any time after it becomes complete -- there would be no

medical (22) contraindication for proceeding with a C-section,

Page 112

(1) true?
(2) **A Right. If I understand your (3) question, I would agree with you, yes.**
(4) Q Okay. Can we also agree that if a (5) C-section had been performed prior to the uterine (6) rupture, that more likely than not Alexis Robbins (7) would have survived and would be fine today?
(8) MR. ROSSI: Objection.
(9) THE WITNESS: More likely than not that is (10) true.
(11) BY MR. MISHKIND:
(12) Q Now, at 6:00 A.M. you understand that (13) there was a conversation that took place between (14) Nurse Moats and Dr. Tizzano, true?
(15) **A Yes.**
(16) Q Did you also recognize that there is (17) some controversy between the two as to what Nurse (18) Moats told Dr. Tizzano and what Dr. Tizzano (19) believes he was advised of?
(20) **A Yes, I understand that.**
(21) MR. JACKSON: Howard, the -- your (22) videographer just indicated to me a note that

Page 113

(1) there are three minutes left to the end of his (2) tape.
(3) MR. MISHKIND: Okay.
(4) MR. JACKSON: So I think you have to (5) conclude the depo within three minutes.
(6) MR. MISHKIND: 2 minutes and 59 seconds, (7) John.
(8) MR. JACKSON: That would be good.
(9) MR. MISHKIND: Uh-huh. Wishful thinking, (10) right?
(11) MR. JACKSON: No. I think that's a fact.
(12) He's out of tape, so --
(13) MR. MISHKIND: Yeah. He brought along an (14) extra cassette, I'm sure.
(15) Q Based upon the fact that Dr. Tizzano (16) was -- in his way of thinking, was advised about (17) Angel for the very first time at 6:00 A.M., (18) assuming he was told that the patient was (19) complete, was minus three, minus four station at (20) 6:00 A.M., but was not told how long she had been (21) complete, nor was he told that she was desirous of (22) having a C-section, how soon would you expect a

Page 114

(1) reasonable and prudent obstetrician to come to the (2) hospital to evaluate this patient?
(3) **A That would -- the answer to that (4) question would depend on many things.**
(5) Is this a hypothetical or are we *(6)* assuming facts that might be in evidence in this (7) case?
(8) Q Well, there's -- there's dispute in (9) the facts in this case, so I'm giving you one (10) scenario. And that is based upon Dr. Tizzano (11) saying that he had this conversation at 6:00 A.M., (12) learned about Angel being in labor and delivery (13) for the first time, was told by the nurse that the (14) patient was complete, minus three, minus four (15) station, and that's the extent of the information (16) that he was provided.
(17) At that point membranes were intact, (18) a reactive fetal heart rate tracing was present, (19) but that's the extent of the information.
(20) He was not told that she had been (21) complete since 4:00 A.M. He was not told that she (22) was desirous of a C-section. And according to

Page 115

(1) Dr. Tizzano, he had not had any information about (2) the patient prior to 6:00 A.M.
(3) How soon under those circumstances (4) would a reasonable and prudent obstetrician have (5) been required to come and evaluate this patient?
(6) **A By what I meant in the question I (7) asked was where is the physician?**
(8) And in this case my understanding is (9) Dr. Tizzano is five minutes away from labor and (10) delivery. In that situation Dr. Tizzano is (11) essentially in the medical center complex. I (12) don't mean that literally, so -- I of course (13) understand his house is not on the campus of the (14) hospital.

(15) But many medical centers, such as the (16) one I work in, sprawl over many acres. And I (17) could be somewhere on the medical campus -- and by (18) the way there are certainly bigger medical centers (19) than the one I work at -- and you could (20) theoretically be more than five minutes away from (21) the labor and delivery area even though you're (22) on -- you're at the Medical Center.

Page 116

(1) So when does the standard of care (2) require Dr. Tizzano to come in? Well, I feel if (3) he's five minutes away, he essentially is in in (4) respect to where you would be in a medical center.

(5) So if all Dr. Tizzano had been told (6) is what you just described, then it might be (7) reasonable for a doctor to say, "All right. I'm (8) going to wait until I get the next call saying (9) that something else has happened, that the patient (10) perhaps is starting to crown now or that there's (11) something on the monitor strip that I don't like (12) now."

(13) Otherwise the doctor might then just (14) decide to take a shower and mosey on into labor (15) and delivery in an un-rushed fashion.

(16) Q Doctor, in this case --

(17) MR. JACKSON: Howard, you might want to (18) wait, because you're going to run out of tape (19) here.

(20) MR. MISHKIND: Okay. That's fine. You (21) want to change the tape now?

(22) VIDEOTAPE OPERATOR: Yeah.

Page 117

(1) This is the end of videotape number (2) one. We are off the record at 3:40.

(3) (Brief recess.)

(4) VIDEOTAPE OPERATOR: This is the start of (5) videotape number two. We are back on the record (6) at 3:47.

(7) BY MR. MISHKIND:

(8) Q Doctor, tell me based upon your (9) review in the case the time Dr. Tizzano spoke with (10) Nurse Moats, how long was it before he arrived in (11) labor and delivery to see Angel?

(12) **A Something on the order about an hour (13) and 40 and an hour and 45 minutes.**

(14) Q Do you have an opinion in this case (15) whether that time period from the report at (16) 6:00 A.M. until his arrival at 7:40 -- whether (17) that was a reasonable period of time to have (18) elapsed before he arrived or not?

(19) **A Just to clarify again, since we got (20) into just a bit of a discussion a few minutes ago, (21) are we talking about reasonable, like, you know, a (22) reasonable guy might have done it, a reasonable**

Page 118

(1) **doctor might not have done it, or are you saying (2) standard of care of a reasonable and prudent (3) physician?**

(4) Q Well, let's start with if you had had (5) the conversation with the nurse, would you have (6) felt that an hour and 40 minutes for you to arrive (7) to the patient would have been reasonable?

(8) MR. JACKSON: Under these circumstances, (9) Howard?

(10) MR. MISHKIND: Yes.

(11) MR. JACKSON: Your answer was yes?

(12) MR. MISHKIND: My answer to your question, (13) John, was yes.

(14) MR. JACKSON: Okay. I didn't catch that.

(15) Thank you. Go ahead.

(16) THE WITNESS: I don't know. I'd have to (17) think about that.

(18) If I was five minutes away, I (19) might -- I might do exactly the same thing. I (20) might be thinking, well, again, I don't -- I being (21) Bruce Flamm don't know this nurse, so I don't know (22) what type of relationship they had.

Page 119

(1) But if hypothetically I was working (2) with a nurse I trusted very much or with a nurse (3) midwife, as we often work in our practice, and I (4) was told the patient was complete but the baby was (5) still like minus two, minus three, I might not (6) come in until I was told something else if I was (7) just five minutes away. I might just wait until (8) someone called me and said, "Now we'd like you to (9)

come over because, A, the strip doesn't look good; (10) B, she's starting to crown" or any other number of (11) things.
(12) So I can't say for sure what I would (13) do in this situation without knowing more details.
(14) BY MR. MISHKIND:
(15) Q Doctor, let's assume that according (16) to the nurse, Nurse Moats, that whatever (17) information she conveyed to the doctor, her (18) testimony will be that Dr. Tizzano indicated that (19) he would be over shortly to see the patient. (20) Adding that statement by Nurse Moats (21) to what Dr. Tizzano said, is an hour and (22) 40 minutes a reasonable period of time to respond

Page 120

(1) when the doctor says that he'll be over shortly to (2) see the patient?
(3) MR. JACKSON: Objection.
(4) Go ahead.
(5) THE WITNESS: I think we're getting into (6) gray areas, like what do we mean by "shortly."
(7) But to continue our hypothetical, if (8) I was on the phone with a nurse and she told me my (9) patient was complete and I said I'd be over (10) shortly, I would assume my -- my meaning in that (11) would be less than an hour and 45 minutes, if, (12) indeed, that was said in this hypothetical.
(13) BY MR. MISHKIND:
(14) Q Do you know why in this case (15) Dr. Tizzano did not arrive sooner than an hour and (16) 40 minutes?
(17) **A No.**
(18) Q Do you know of any reason why (19) Dr. Tizzano couldn't have come to see the patient (20) sooner than an hour and 40 minutes?
(21) **A No.**
(22) Q Would the urgency of the visit by

Page 121

(1) Dr. Tizzano, in your opinion, have been increased (2) if Dr. Tizzano was told not only was she complete (3) and minus three, minus four station, but had also (4) been complete for the last two hours?
(5) MR. ROSSI: Objection.
(6) THE WITNESS: Yes. I think that would (7) change the situation.
(8) BY MR. MISHKIND:
(9) Q Tell me why, Doctor.
(10) MR. ROSSI: Objection.
(11) THE WITNESS: Well, when the patient is (12) pushing, we like to see them make some degree of (13) progress.
(14) There are different parameters that (15) have been voiced over the years for what adequate (16) progress is, and we've amended those parameters (17) particularly in the last decade or so since (18) epidurals have become quite popular, because often (19) progress in the second stage is much slower with (20) an epidural.
(21) But if I had a VBAC patient who has (22) been complete for two hours and pushing for two

Page 122

(1) hours and still at a minus two or minus three (2) station, yes, I think that would mean something (3) very different to me than a call just saying my (4) patient was complete.
(5) BY MR. MISHKIND:
(6) Q If you add to that also the statement (7) by the nurse to the physician that the patient (8) wanted to have a C-section, how would that impact (9) your decision in terms of the timing of arrival?
(10) MR. JACKSON: Objection.
(11) Go ahead.
(12) THE WITNESS: If hypothetically I was told (13) I had a VBAC patient who has been complete and (14) pushing for two hours and she wants a C-section, (15) of course it would depend a little bit on what was (16) conveyed about what she actually said about (17) wanting a C-section, but certainly that would make (18) me want to come over sooner rather than later.
(19) BY MR. MISHKIND:
(20) Q When Dr. Tizzano arrived, one of the (21) first things that he did was to rupture the (22) membrane?

Page 123

(1) Is that your recollection, as well?
(2) **A Yes, sir.**
(3) Q Do you believe that that was an (4)

appropriate thing for him to do?
A Sure.
Q Tell me why.
A Very often when somebody has been pushing and the baby's head is still a bit high, rupturing the membranes will help the head descend.
Q If a decision had been made to proceed with a C-section, would rupturing the membranes have been an appropriate thing to have done at that time?
A It would not have been needed. If the decision -- in other words, before the rupture of membranes was done, if Dr. Tizzano had talked to the patient and they decided jointly to proceed with the Caesarean, there would be no need to rupture the membranes, that's correct.
Q Okay. Now, can rupturing the membranes precipitate or be the catalyst to cause

---

Page 124

the uterus to rupture?
A I have never heard of that. And we've probably looked at more uterine ruptures than anybody in the world. And I certainly have thought about that in this case because the strip changed so quickly in relationship to when the rupture of membranes was done.
But I don't recall a single case in our series of probably over 60 uterine ruptures where there was any link between rupture of membranes and ruptured uterus.
Q Do you have any opinion in this case what caused the uterine rupture?
A Almost certainly it was related to the previous C-section. But specifically what caused it, I don't think anybody can answer that question.
Q And in this particular case again had the baby been delivered at any time prior to the uterine rupture, we can agree that the baby would have lived and would be neurologically fine?
A I believe that's --

Page 125

MR. JACKSON: Objection.
Go ahead.
THE WITNESS: I believe more likely than not that's true.
BY MR. MISHKIND:
Q Now, at what point in time do you believe that there was clinical evidence of a uterine rupture?
A This question has to be answered two different ways; one is in hindsight, and the other is as if I were a doctor or a nurse in the trenches taking care of Angel. Because often you get more information in hindsight that helps you try to localize when a uterine rupture may have occurred.
Do you want me to do it both ways or do you just want me to do one of those?
Q Go ahead, Doctor, do it both ways.
Perhaps that will cut things along.
A Doing it first as if I were in the room taking care of this patient, the rupture of membranes occurred at about 7:44 in the morning.

Page 126

And then a few minutes after that there is loss of signal. This is starting around 7:50 or so. And there's several minutes where it looks like you can pick up the baby's heart rate in the same range it has been, but it's kind of intermittent.
And we call that loss of signal.
That in itself is not a particularly worrisome thing, particularly when an intervention has just been done. You suspect the baby may have moved.
So often what we will do at this point is either to try to move the external monitor to get the baby back on the monitor more clearly or put a fetal scalp stick -- a fetal scalp clip on to confirm what the baby's heart rate is.
Then at just before 8 o'clock, approximately 7:59, you can clearly see that this is not loss of signal. You are seeing the baby's heart rate, and it's a bottom of a deceleration down to about 80 and then starting to come up.

(21) At that point something has changed.
(22) And it's possible that that could represent

Page 127
(1) uterine rupture. Although I think in the trenches (2) I don't think I would suspect that right at that (3) moment, nor would I expect a reasonable and (4) prudent physician or nurse to.
(5) The baby's heart rate then comes back (6) up to baseline. And then there are a series of (7) variable decelerations occurring from about (8) 8:03 or 8:04 until about 8:10, where they become (9) more concerning in my mind.
(10) To me, when we get about to 8:10 or (11) so and for the next few minutes the strip is (12) starting to look very worrisome to me. And I (13) think at this point a reasonable physician would (14) look at this strip in the context of a patient (15) with a prior Caesarean and say, "On my (16) differential is uterine rupture, and it probably (17) should be high on the list of differential (18) diagnoses."
(19) Now, in hindsight, knowing that there (20) was a uterine rupture, to try and answer the same (21) question, when is it likely that the uterine (22) rupture occurred, it's possible that it occurred

Page 128
(1) during the period of loss of signal somewhere (2) around 7:55, although I couldn't say that with any (3) reasonable degree of medical certainty.
(4) I still would think that more likely, (5) looking at this monitor strip, the actual uterine (6) rupture occurred probably somewhere more like (7) 8 o'clock and 8:10. That would probably be the (8) best I could estimate it.
(9) Q Do you recall Dr. Tizzano's testimony (10) that had the baby been delivered at or before (11) 8:15 A.M., that in his opinion Alexis would have (12) survived and would have been fine?
(13) **A I recall him saying something to that (14) effect. I don't recommend - I don't recall the (15) exact phraseology.**
(16) Q Basically are you -- do you take (17) issue at all with Dr. Tizzano's testimony in terms (18) of had the baby been delivered at or prior to (19) 8:15, that she would have lived and would be fine, (20) or do you agree with that?
(21) **A Well, your -- your introductory (22) phraseology is certainly interesting, do I take**

Page 129
(1) **issue with. I certainly don't like to argue or (2) take issue with anyone.**
(3) But I would say that in light of what (4) the monitor strip looks like at 8:10 and 8:15, I (5) don't think you can say within a reasonable degree (6) of medical certainty at this point that this baby (7) would have been alive, healthy and well, no.
(8) That's very different than saying the baby would (9) have been more likely than not alive, healthy and (10) well at 7:30.
(11) Q 7:30?
(12) **A Right. Before we believe that the (13) uterine rupture occurred.**
(14) Q Okay. Tell me in your opinion when (15) you believe the window of opportunity closed in (16) terms of delivering this baby without any (17) neurological sequelae.
(18) **A Many doctors talk about fetal reserve (19) and lack of fetal reserve. But it seems to me (20) that when the rupture of membranes was performed, (21) the monitor strip looked to me what I would call (22) fairly reassuring. And it would depend on what**

Page 130
(1) **was happening in the interval from 7:50 to (2) 8 o'clock. The answer to that question would (3) depend on what was happening in the interval (4) between 7:50 and 8 o'clock.**
(5) As I pointed out in my description of (6) when I think the rupture occurred, I came up with (7) two different concepts depending on whether I was (8) looking at it as a doctor in the trenches or (9) looking at on it -- looking at it as a doctor who (10) now had seen the outcome and knew that a uterine (11) rupture had occurred and looking back on it. So (12) those windows would be different.
(13) Even in hindsight I can't say for (14) sure,

and I don't believe anybody can say for (15) sure, exactly when the uterine rupture occurred.
(16) If we believe that the uterine (17) rupture occurred somewhere around 8 o'clock as a (18) ballpark starting point, even then nobody can (19) answer the question when is the last moment when (20) this baby could have been born alive, healthy and (21) well.
(22) The reason nobody can answer that

Page 131

(1) question is because we never know in an individual (2) case what happened in that particular uterine (3) rupture. In other words, if we knew for a fact (4) that there was total anoxia at 8 o'clock, that (5) something happened with this uterine rupture that (6) caused for some reason the cord to be totally (7) clamped off, for some reason oxygen flow to the (8) baby to totally stop, then we could kind of give (9) some guesstimates that would answer your question, (10) when is -- when is the last moment the baby could (11) be born alive healthy and well.
(12) Unfortunately we never know the (13) answer to that question, because there could be (14) partial asphyxia occurring. That could go on for (15) three minutes or eight minutes, and then it could (16) turn into total anoxia. The baby may -- the baby (17) may be getting no oxygen whatsoever. And that (18) would very quickly change how long the baby could (19) survive or survive neurologically intact.
(20) The only other way I can think to (21) approach this is to look at what actually happened (22) with the baby's condition. In this case we do

Page 132

(1) have information that helps us somewhat. We know (2) that this baby was born in very bad shape. The (3) Apgars were one, one, one and one. In fact, the (4) baby died at about three weeks of age.
(5) So we know that at some point after (6) the rupture occurred there must have been either (7) severe hypoxia or total anoxia.
(8) I'm sorry. Did I put you to sleep?
(9) Q No. No. I was waiting for you to (10) finish, because I'm obviously dealing with -- when (11) I'm asking about the window of opportunity, I'm (12) asking you based upon the evidence that we have.
(13) And looking at it from that vantage (14) point you are relying on all information that you (15) have including any lab values at the time of (16) delivery.
(17) So I would like to determine from you (18) whether you have an opinion that you're going to (19) be expressing at the time of trial to a reasonable (20) degree of medical probability as to when this baby (21) needed to be delivered in order to have survived (22) and in order to have avoided any permanent

Page 133

(1) neurological injury.
(2) **A Let me do my best to try to answer (3) both of those questions. And again, these are (4) only going to be estimates to the -- to the best (5) of my ability, and these are going to be estimates (6) being made by somebody who may have looked at more (7) uterine ruptures than anybody in the world. There (8) may be some people at U.S.C. that have looked at (9) more than me, but there can't be many people that (10) have.**
(11) And I would say that looking at the (12) monitor strip at around 7:50 when we start to see (13) the loss of signal, I believe if that baby was (14) delivered at 8 o'clock, it almost certainly would (15) have survived. Whether the baby would have (16) survived neurologically intact, I cannot answer (17) that question.
(18) If we take it out to maybe ten (19) minutes after 8:00, I still believe that that baby (20) probably would have survived, who have lived. But (21) the likelihood that the baby would have survived (22) neurologically intact begins to fall off.

Page 134

(1) And then if we go much beyond 8:10, (2) if we're talking about if the baby had been (3) delivered at 8:20, I think all bets are off. The (4) baby may not have even survived if

delivered at (5) 8:20, and certainly there is a good chance that (6) the baby would have been neurologically impaired (7) if delivered at 8:20.

(8) Q Are you able to quantify the amount (9) of neurological impairment at any of those periods (10) of time from 8:00 to 8:20?

(11) **A I cannot do that. And I would be (12) skeptical of anybody who said they could.**

(13) **Q** Your testimony will not be -- you (14) won't be quantifying the neurologic injury, (15) correct?

(16) **A As far as at any given moment could I (17) predict what degree of brain damage this baby (18) would have had? Is that what you're asking me?**

(19) **Q** I didn't exactly word it that way, (20) but, Doctor, but since it's a lot later here in (21) Cleveland than it is in California, I'll accept (22) your definition.

Page 135

(1) **A Right. I just wanted to understand (2) what I -- what you meant by quantifying.**

(3) If that's what you mean, no, I don't (4) think anybody can go much further than I've just (5) gone in quantifying the baby's long-term (6) neurologic status if it had been delivered at any (7) of those moments we were just talking about.

(8) Q How would intrauterine resuscitation (9) at the point in time when the baby became (10) bradycardic have impacted the window of (11) opportunity to deliver the baby neurologically (12) intact?

(13) MR. ROSSI: Objection.

(14) THE WITNESS: I think it would have in this (15) case impacted it little or -- little, if at all.

(16) BY MR. MISHKIND:

(17) **Q** Was there any -- was there a delay in (18) your opinion in terms of providing intrauterine (19) resuscitation?

(20) **A I don't believe so. And the reason I (21) say that, I know there are issues about a few (22) minutes before oxygen was put on the mother and**

Page 136

(1) **whether she was turned to her side quickly.**

(2) These are the typical nursing (3) interventions that are do -- that done for, quote, (4) intrauterine resuscitation. And certainly they (5) may be extremely helpful. For example, if the (6) baby is laying on its umbilical cord, turning the (7) mother to the side could have a world of (8) difference.

(9) If the uterus has just ruptured, you (10) could turn this woman on her side, have her get a (11) knee-chest, you could give her all the oxygen in (12) the world, and I don't think that's going to (13) materially change the outcome.

(14) Q Doctor, would you as the OB/GYN for (15) this mom have wanted to know how long she had been (16) complete when you had the conversation at (17) 6:00 A.M.?

(18) MR. JACKSON: Objection.

(19) MR. ROSSI: Objection. Howard, with all (20) due respect, this may be the fourth time you've (21) wanted him to answer this question.

(22) ///

Page 137

(1) BY MR. MISHKIND:

(2) Q Go ahead, Doctor.

(3) **A I think you phrased that saying would (4) I wanted to have known that.**

(5) I think in my own practice I would (6) leave that to the discretion of the nurse or the (7) midwife taking care of the patient.

(8) If they told me, "Dr. Flamm, this (9) patient is complete. The strip looks pretty (10) good," I don't know that I would ask any more than (11) that.

(12) The nurse or the midwife might say, (13) "Well, Doctor Flamm, this patient is complete, and (14) she's been pushing for two hours." If I was told (15) that, I would certainly interpret those two things (16) very differently. But if I wasn't told that, I (17) don't suspect I would ask that.

(18) Q Well, let me ask you this way, (19) Doctor: Would you see any reason why a nurse (20) would not tell Dr. Tizzano at 6:00 A.M. that she (21) was complete, had been complete since 4:15 A.M.?

(22) MR. JACKSON: Objection.

Page 138

MR. ROSSI: Objection.
THE WITNESS: Do I see any reason why a nurse would not say that?
BY MR. MISHKIND:
Q Yes.
A No. That would be a very reasonable thing to say.
Q Okay. Doctor, I take it you're going to take the stand and indicate that Dr. Tizzano met the standard of care in this case. Correct?
A Yes, sir.
Q And that's based upon issues with regard to informed consent, as well as issues with regard to the -- his management of the labor and delivery of this baby?
A Yes.
Q And certainly there is a factual issue as to whether or not the patient rescinded her decision to have a trial of labor, correct?
A Yes, I understand that's an issue in this case.
Q And certainly a patient has the right

Page 139

under appropriate circumstances to rescind that decision, and in this case I think you told me that there would be no contraindication to proceed with a Caesarean if that was reasonable under the circumstances, true?
A True to both of those points.
Q Okay. And under any set of circumstances, the time period that we're going to be talking about at the time of trial for your testimony -- we can certainly agree that if this baby had been delivered for whatever reason prior to 8 o'clock by Caesarean, that mom and baby would be fine today, true?
MR. JACKSON: Objection.
Go ahead.
THE WITNESS: I believe that's true, yes, within a reasonable --
BY MR. MISHKIND:
Q I wanted to know from you, Doctor, because I don't have the benefit of a report, which sometimes occurs in these cases, but are there any other reasons that you believe

Page 140

Dr. Tizzano met the standard of care other than those which we've talked about during the course of this deposition?
MR. JACKSON: Objection, Howard. How can anybody answer a question like that?
MR. MISHKIND: Well --
MR. JACKSON: I mean --
BY MR. MISHKIND:
Q Tell me all the bases upon which you believe that Dr. Tizzano met the standard of care in this case other than what you've already expressed.
MR. JACKSON: Howard, I object. That's an unanswerable question.
If you wanted to know, for example, how they didn't do something and all the bases for criticizing things, that's one thing. That's easy to answer.
But to ask somebody a kind of a negative question like that makes no sense.
MR. MISHKIND: Well --
MR. JACKSON: So, I object.

Page 141

MR. MISHKIND: Okay.
MR. JACKSON: You've explored the doctor's opinions. And to ask a question like that's improper.
BY MR. MISHKIND:
Q Well, Doctor, I want to find out whether or not there are any other opinions that you hold in this case that we have not explored during the course of this deposition.
MR. JACKSON: I think you've explored those -- the opinions he's going to render.
MR. MISHKIND: I appreciate that, John. I very much appreciate your confirmation of that.
BY MR. MISHKIND:
Q But I want to find out from the doctor whether we've explored the opinions that you hold and the opinions that you believe you will be testifying to at the time of trial of

this (19) matter.
(20) MR. JACKSON: Howard, I will represent to (21) you that you've explored the opinions that the (22) doctor is going to be asked to render at this

Page 142
(1) trial.
(2) MR. MISHKIND: John, I very --
(3) MR. JACKSON: And that's what you're (4) entitled to.
(5) MR. MISHKIND: And I'm entitled to get the (6) answers from the doctor. And that's what I'd (7) like --
(8) MR. JACKSON: Okay. You are. But that --
(9) you know, that's what you're --
(10) Go ahead, Doctor.
(11) I'm not going to dance on the head of (12) a pin with you, Howard.
(13) MR. MISHKIND: Well, I'm not asking you to (14) do that. And I don't know why you're jumping in (15) and not letting the doctor answer the question.
(16) MR. JACKSON: Because he's answered your (17) question.
(18) BY MR. MISHKIND:
(19) Q Go ahead, Doctor, and answer my (20) question, please.
(21) Have we explored the opinions that (22) you've arrived at in connection with Dr. Tizzano

Page 143
(1) in this case?
(2) **A I've been asked that question before**
(3) **in other cases. And I'm not an attorney, so it (4) often confuses me a bit.**
(5) I probably came up with, you know, (6) dozens of opinions in reading through all these (7) depositions and medical records. But I think (8) basically we've probably explored all the key (9) areas.
(10) There may be something that if you (11) were to ask me a question at trial that you didn't (12) ask me today that I might actually have an opinion (13) on. I couldn't say that I -- I have a lot of (14) opinions.
(15) Q Okay. Well, I'll accept that, and (16) I'll accept what Mr. Jackson has said previously (17) so that we can move to a -- to a conclusion on (18) this.
(19) I need to check my notes, Doctor, and (20) I may be done.
(21) MR. MISHKIND: Doctor, I have no further (22) questions for you.

Page 144
(1) THE WITNESS: Thank you very much.
(3) EXAMINATION (4) BY MR. ROSSI:
(5) Q Doctor, this is Greg Rossi. I've got (6) two quick questions for you. I represent the (7) hospital, as you know.
(8) As I understand it, you've been (9) retained by Mr. Jackson to comment on the care and (10) treatment provided by Dr. Tizzano in this case.
(11) Is that true?
(12) **A Yes, sir.**
(13) Q So I take it, then, that it is not (14) your intention to criticize my nurses at the time (15) of trial. Is that fair?
(16) **A Correct. I wasn't asked to do that.**
(17) MR. ROSSI: Okay. Thank you. That's all I (18) have for you, then.
(19) THE WITNESS: Thank you.
(20) MR. MISHKIND: Doctor, let me just ask you (21) a follow-up question to that.
(22) ///

Page 145
(1) FURTHER EXAMINATION (2) BY MR. MISHKIND:
(3) Q You are familiar with labor and (4) delivery nurses, correct?
(5) **A Yes, sir.**
(6) Q And you work with them on a (7) day-to-day basis, correct?
(8) **A Yes.**
(9) Q And you rely on them to provide you (10) with information when you're not at the hospital, (11) correct?
(12) MR. JACKSON: Asked and answered, Howard.
(13) You've been through this.
(14) MR. ROSSI: Twice, Howard, asked and (15) answered. I object.
(16) MR. MISHKIND: You can object. That's (17) fine.

MR. JACKSON: Howard, you can't keep asking the same question over and over again.
MR. MISHKIND: I just want to clarify the record based upon Mr. Rossi's statement. I'm almost done.

Page 146

THE WITNESS: Yes. The answer to your last question was yes.
MR. MISHKIND: Okay. I have no further questions.
MR. ROSSI: That's it. Can I -- the court reporter, Patricia, I'd like to get a copy of that, please. This is Greg Rossi.
THE REPORTER: Do you want a copy, Counsel?
MR. JACKSON: Yes.
MR. ROSSI: Doctor, can I make a request of you?
Can we get a current copy of his curriculum vitae, John?
MR. JACKSON: Yes.
MR. MISHKIND: I think it was marked as an exhibit.
MR. ROSSI: Was it, the current one?
MR. JACKSON: Yes.
MR. MISHKIND: The current one was marked.
MR. ROSSI: And, Patricia, will you copy that and attach it to my transcript?
THE REPORTER: I will.

Page 147

(Off-the-record discussion.)
MR. JACKSON: Let him say on the record whether he's going to waive his signature. And I think he is not going to waive it, but --
MR. MISHKIND: Okay. That's fine.
MR. JACKSON: So that everyone's aware, he'll read it.
MR. MISHKIND: Okay.
THE WITNESS: I will read it, yes.
(Off-the-record discussion.)
MR. JACKSON: Everybody is ordering copies.
Why don't you send the original directly to the doctor?
Do you have any objection to that, anybody?
MR. ROSSI: No.
MR. JACKSON: Howard?
MR. MISHKIND: Well, I'm ordering -- I'm ordering the original. So --
MR. JACKSON: Send the copy to the doctor, then. Is that --
MR. MISHKIND: If you want to send your

Page 148

copy to the doctor, whatever -- I'm ordering and paying for an original. And certainly I will accommodate the doctor in whatever way so he can read the transcript.
In fact, what is today's date?
THE WITNESS: The 12th.
MR. MISHKIND: We can even reflect on the record that the doctor can have 28 days rather than 7 days, which is under our rules to read the depo. And you can reflect that on the transcript.
MR. JACKSON: 28 days from when he receives it, you mean?
MR. MISHKIND: 28 days, yeah.
(Off-the-record discussion.)
MR. MISHKIND: Let's use 28 days from -- it's going to be two weeks -- or maybe 21 days so we don't get too close to the trial with the transcript rather than the ridiculous 7-day rule.
I want to be fair to the doctor. It's hard enough to read something in seven days when you have a practice.
THE WITNESS: Thank you, Mr. Mishkind. I

Page 149

appreciate that.
MR. MISHKIND: Okay.
(Off-the-record discussion.)
MR. JACKSON: She's going to make an original and a copy for you, a copy for me, a copy for Greg. She'll send the original to you, the copy to the doctor directly for his review.
Everybody else will get a copy directly. Fair enough?
MR. ROSSI: Fair enough.

(11) MR. JACKSON: Okay, guys.
(12) MR. MISHKIND: Okay. So long.
(13) VIDEOTAPE OPERATOR: This concludes today's (14) proceedings. Total number of videotapes used was (15) two.
(16) We're going off the record. The time (17) is 4:21.
(19) (Whereupon the documents referred (20) to were marked Plaintiff's (21) Exhibits 6 through 9 by the (22) Certified Shorthand Reporter for

Page 150

(1) identification and are attached (2) hereto.)
(4) (Whereupon at 4:21 o'clock, p.m., (5) the above deposition proceedings (6) were concluded.)

Page 151

(7) * * * * * (1) I, BRUCE FLAMM, M.D., say I have read the (2) foregoing deposition and declare under penalty of (3) perjury under the laws of the State of California:
(4) That the foregoing is my deposition under (5) oath; (6) That I have read same and have made the (7) necessary corrections, additions or changes to my (8) answers that I deem necessary; (9) That my answers as indicated are true and (10) correct.
(12) Executed at _____, California, (13) this _____ day of _____, 20_____.
(15) _____
BRUCE FLAMM, M.D.

Page 152

(1) REPORTER'S CERTIFICATE (3) I, PATRICIA L. HUBBARD, CSR #3400, a (4) Certified Shorthand Reporter in and for the State (5) of California, do hereby certify:
(6) That, prior to being examined, the witness (7) named in the foregoing deposition, to wit, BRUCE (8) FLAMM, M.D., was by me duly sworn to testify the (9) truth, the whole truth, and nothing but the truth; (10) That said deposition was taken down by me (11) in shorthand at the time and place therein named (12) and thereafter reduced to typewriting under my (13) direction.
(14) I further certify that I am not interested (15) in the event of the action.
(16) WITNESS my hand this 19th day of November, (17) 2001.

D

E

N

O

P

Q

R

U

V

W