

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

KARL McELFISH, II,
Individually and as
Administrator of the
Estate of Sherry McElfish,
Plaintiff,

-vs-

No. CV 04 525188

Hon. William J. Coyne

MERIDIA MEDICAL GROUP,
L.L.C., et al,
Defendants.

PAGE 1 - 94

The Telephonic Deposition of

WILLIAM S. FLOYD, M.D.,

Taken at 3290 West Big Beaver Road,

Suite 444,

Troy, Michigan,

Commencing at 5:45 p.m.,

Monday, May 2, 2005,

Before Rhonda M. Foster, RMR, RPR, CSR-3612.

1 APPEARANCES:

2 MR. MICHAEL F. BECKER

3 (Not present)

4 Becker & Mishkind Co., L.P.A.

5 Skylight Office Tower

6 1660 West Second Street

7 Suite 660

8 Cleveland, Ohio 44113

9 (216) 241-2600

10 Co-counsel for Plaintiff.

11
12 MR. GEORGE E. LOUCAS

13 (Via telephone)

14 Emma Groethe

15 1700 Standard Building

16 Cleveland, Ohio 44113

17 (216) 241-5310

18 Appearing on behalf of the Plaintiff.

1 APPEARANCES: (Continued)

2 MS. CHRISTINE S. REID

3 (Via telephone)

4 Reminger & Reminger

5 1400 Midland Building

6 101 Prospect Avenue, West

7 Cleveland, Ohio 44115-1093

8 (216) 687-1311

9 Appearing on behalf of the Defendant Meridia

10 Euclid Hospital.

11
12 MR. ROBERT L. AUSTRIA

13 (Via telephone)

14 Moscarino & Treu

15 630 Hanna Building

16 1422 Euclid Avenue

17 Cleveland, Ohio 44115

18 (216) 621-1000

19 Appearing on behalf of the Defendant Charles

20 M. Bailin, M.D.

1 APPEARANCES: (Continued)

2 MR. ERNEST W. AUCIELLO

3 Gallagher, Sharp, Fulton & Norman

4 Sixth Floor, Bulkley Building

5 1501 Euclid Avenue

6 Cleveland, Ohio 44115

7 (216) 241-5310

8 Appearing on behalf of the Defendant Lucille

9 Stine, M.D.

10
11 MS. MARILENA DiSILVIO

12 MR. DAVID KRAUSE

13 (Via telephone)

14 Reminger & Reminger

15 1400 Midland Building

16 101 Prospect Avenue, West

17 Cleveland, Ohio 44115-1093

18 (216) 687-1311

19 Appearing on behalf of the Defendants Meridia

20 Medical Group, Gregory Karasik, M.D., and

21 Yelena Beregovskaya, R.N.

1 Troy, Michigan

2 Monday, May 2, 2005

3 About 5:45 p.m.

4 (Mr. Krause not present)

5 DEPOSITION EXHIBITS 1 - 4

6 WERE MARKED BY THE REPORTER

7 FOR IDENTIFICATION

8 WILLIAM S. FLOYD, M.D.,

9 having first been duly sworn, was examined and

10 testified on his oath as follows:

11 EXAMINATION BY MR. LOUCAS:

12 Q. Good evening, Doctor. My name is George

13 Loucas. We have briefly been introduced. I will be

14 over the telephone. I don't believe we have had the

15 pleasure of meeting in the past.

16 I take it you have had your

17 deposition taken before.

18 A. Yes.

19 Q. I am going to be asking you questions

20 relative to your review and expert opinions in this

21 case that you are going to be offering at trial,

22 understood?

23 A. Yes.

24 Q. If at any point in time I put to you a

25 question that doesn't seem to make sense, or perhaps

1 you didn't hear me, please let me know. I will be
2 happy to repeat or rephrase the question as necessary.
3 If you answer the question, I'm going to assume you
4 fully understood that which I asked. Is that fair
5 enough?
6 **A. Yes.**
7 **Q. Okay. You have had some things marked by**
8 **the court reporter.**
9 **And first of all, I am going to talk**
10 **about your CV, but you do not have a copy of that**
11 **present.**
12 **MR. AUCIELLO: Yes, we do. He found**
13 **one.**
14 **THE WITNESS: Yes, I have one, which**
15 **I gave her, and it will be part, I guess, of the**
16 **record.**
17 **BY MR. LOUCAS:**
18 **Q. All right. The one I have is three pages**
19 **long, and ends with Professional Organizations, the**
20 **last entry is Fellow, American College of Obstetrics**
21 **and Gynecology, 1963. Is that what you have?**
22 **A. No, this is 16 pages. And so you have only**
23 **got the first three pages, evidently, of my CV at some**
24 **time.**
25 **Q. All right. So I take it, then, there's some**

1 -- what would the remaining 13 pages consist of?
2 **A. Okay. Just let me summarize it as I go**
3 **through, okay?**
4 **Q. Go ahead.**
5 **A. Yeah. You know, the first page really deals**
6 **with my education, you know, Cass Technical High School**
7 **in Detroit, MIT for biophysics, biochemistry.**
8 **Q. First three pages. If you will go to the**
9 **fourth?**
10 **A. Okay. And then you have the teaching**
11 **appointments and the third page are hospital**
12 **appointments, professional organizations. The fourth**
13 **page is professional organizations. The fifth page is**
14 **honors, awards, licensure. The sixth page is honors**
15 **and awards. The seventh page are national/**
16 **international boards and committees, and state boards**
17 **and committees, and grants. The eighth page are grant**
18 **supports, and it starts publications. There are**
19 **roughly I have about 80 publications. And that really**
20 **is the rest of the, you know, 16 pages.**
21 **Q. All right. And the publications, do you**
22 **have a specialty interest within the field of**
23 **obstetrics and gynecology?**
24 **A. It's varied. Most of the publications**
25 **either deal with ovarian cancer, more lately**

1 **reproductive endocrinology and infertility. There are**
2 **essentially no articles that deal with the subject**
3 **matter of either preeclampsia, HELLP syndrome, or**
4 **things of that type.**
5 **Q. Or DIC I take it?**
6 **A. Or DIC.**
7 **Q. How about complications that occur during**
8 **pregnancy such as, say, hypertension or chronic**
9 **hypertension?**
10 **A. No, there are no articles dealing with that.**
11 **Q. Can you go ahead and tell me about your**
12 **practice as it exists today, if you will give me what**
13 **your typical work week is like.**
14 **A. I spend three full days in the office,**
15 **Monday, Wednesday, and Thursday. I cover the hospital**
16 **all day on Tuesday, do my major, you know, surgical**
17 **cases. And on Friday I do my minor surgical cases. I**
18 **have four Board Certified, you know, partners or**
19 **associates. We each take a 24-hour segment at the**
20 **hospital as far as coverage. I am the senior**
21 **physician, so as of the last two years, I do not work**
22 **weekends. And I am on a number of administrative**
23 **committees, but those fill in usually on, you know, my**
24 **surgical days, Friday or Tuesday.**
25 **Q. What type of major surgical procedures do**

1 you do on Tuesdays?
2 **A. Mostly hysterectomies, bladder repairs and**
3 **suspensions, and, you know, laparoscopy.**
4 **Q. What about minor surgeries on Friday?**
5 **A. Usually they're going to be D and C's,**
6 **laparoscopies. That's primarily it. They're all**
7 **outpatient.**
8 **Q. Do you see, then, general obstetrical**
9 **patients?**
10 **A. Yes.**
11 **Q. What part of your practice is so comprised?**
12 **A. It's really hard to divide it up. You know,**
13 **I see more gynecology in the office, but you end up on**
14 **the rotation, obstetrics, as a group of, you know, five**
15 **people, we are doing between 6 and 700 deliveries a**
16 **year. I probably do at least a hundred to 125 a year.**
17 **Q. Are those your patients or are those that**
18 **you see from day one of their prenatal care through**
19 **delivery or otherwise?**
20 **A. No, all obstetrical patients are patients of**
21 **the practice and rotate through the physicians here.**
22 **Q. Of the 100 to 125 that you deliver, how is**
23 **it you come to deliver them? Are they your assigned**
24 **patients that you see from beginning of patient to end**
25 **or otherwise?**

1 A. No, my night or day on rotation.
2 Q. You said you have -- that day of rotation
3 would be your 24-hour coverage at the hospital?
4 A. That's right.
5 Q. And how often does that occur?
6 A. Every Tuesday.
7 Q. You spend --
8 A. I live at the hospital on Tuesday.
9 Q. -- or how does that work?
10 MR. AUCIELLO: I think you were both
11 talking at the same time, so why don't you repeat it?
12 THE WITNESS: I go in the hospital
13 at 7:00 in the morning on Tuesday, and I stay there and
14 finish my surgery, do any deliveries, and then I am on
15 call after until Wednesday morning.
16 BY MR. LOUCAS:
17 Q. Now what happens if you have a high risk
18 delivery in the hospital while you are on 24-hour
19 coverage?
20 A. I am the person that manages it.
21 Q. When, if ever, do you call in a Maternal
22 Fetal specialist in that -- for a high risk delivery?
23 A. For the most part, Maternal Fetal medicine
24 we use for -- in the prenatal period of time for our
25 diabetics and other, you know, problems. Once we have

1 a surgical problem, we pretty much manage it ourselves.
2 Q. All right. So if a complication such as
3 diabetes or gestational diabetes develops then you go
4 ahead and refer over to a Maternal Fetal in your
5 practice?
6 A. Yes.
7 Q. How about preeclampsia?
8 A. No, we manage all our preeclamptics.
9 Q. And how about if the preeclamptic progresses
10 on to severe preeclampsia, do you refer them out or do
11 you continue to see them?
12 A. We continue to manage them, but the hospital
13 has a rule, though, any time that you have a, you know,
14 complication of pregnancy of that type, then Maternal
15 Fetal medicine is notified.
16 Q. For what purpose?
17 A. They are always available.
18 Q. So when you say they're notified, how are
19 they notified?
20 A. By the resident.
21 Q. But I mean is there a communication, is
22 there a copy of the chart sent over, or how does that
23 work?
24 A. Primarily resident notification to Maternal
25 Fetal medicine. More often it's a large group.

1 They're in house most of the time.
2 Q. But do they see the patient after that or do
3 they open a chart on the patient?
4 A. No. Only if we request it.
5 Q. The notification is by the resident, what,
6 verbally or through written form?
7 A. Verbally.
8 Q. Do they have to do anything on their end to
9 document the verbal communication of the high risk
10 patient?
11 A. No.
12 Q. Have you ever delivered a severely
13 preeclamptic patient?
14 A. Yes.
15 Q. When was the last time?
16 A. Within the year.
17 Q. How many over the course of your career?
18 A. Well, I can tell you it's a lot. You know,
19 I have -- I had one partner who retired about four
20 years ago. When he retired they had calculated the two
21 of us had done 15,000 deliveries. I have been in
22 practice for 44 years.
23 Q. And how about -- have you delivered patients
24 with HELLP syndrome?
25 A. Yes.

1 Q. About how many?
2 A. I don't know.
3 Q. And when did you last deliver such a
4 patient?
5 A. Oh, probably within the last two years. I
6 can't really recall. You know, there's all kinds of
7 modification of what you call HELLP syndrome. And
8 essentially if you have an individual who has, you
9 know, elevated enzymes and low platelets, you have
10 defined HELLP syndrome, but not all of them have the
11 severity that, you know, or bad outcomes.
12 Q. And have you ever lost a patient to
13 preeclampsia?
14 A. No.
15 Q. Ever lost a patient to HELLP syndrome?
16 A. No.
17 Q. Have you lost a patient to DIC from HELLP
18 syndrome?
19 A. No.
20 Q. Has your practice ever lost a patient to
21 preeclampsia?
22 A. Not that I can recall.
23 Q. How about from HELLP syndrome?
24 A. Not that I recall.
25 Q. How about -- you know, I have seen the term

1 "superimposed preeclampsia." What does that mean to
2 you?
3 A. Essentially superimposed preeclampsia means
4 that it's an individual who has chronic hypertension,
5 meaning that they are -- have had hypertension, either
6 prior to the pregnancy or during the pregnancy, and
7 then develop exacerbation to define, you know,
8 preeclampsia where they develop Albuminuria, increased
9 hypertension, and/or edema on top of that. And it has
10 to be, by definition, after the 26th week of pregnancy.
11 Q. So was Sherry McElfish -- did she have the
12 diagnosis of superimposed preeclampsia?
13 A. I don't know.
14 Q. And why is it you do not know that?
15 A. My -- all of my opinions in this case are
16 going to be relative to her admission to the hospital,
17 9-16, 11:30 through to the end of delivery, and the
18 entire period of time that Dr. Stine managed this
19 patient.
20 I have not reviewed the records as
21 to her -- as to other people's care, either prenatally,
22 or to her postoperative, you know, care.
23 Q. But I take it you did review, then, the
24 medical records from Euclid Meridia Hospital, correct?
25 A. Yes.

1 Q. And I take it you reviewed them thoroughly
2 in arriving at your opinions, true?
3 A. Yes.
4 Q. And you did review, then, her prenatal flow
5 sheet that was in the Euclid Meridia Hospital chart?
6 A. Yes.
7 Q. So in reviewing those records, you were able
8 to see exactly what had transpired with regard to her
9 vitals and laboratory testing, etcetera, just as
10 Dr. Stine had available to her on the evening she
11 presented, correct?
12 A. Yes.
13 Q. And so in doing that, did you arrive at the
14 opinion as to whether or not -- strike that.
15 You would agree with Dr. Bailin and
16 others who took care of her, that she was a chronic
17 hypertensive, true?
18 A. I didn't arrive at those opinions because I
19 didn't make opinions relative to that issue.
20 Q. Well, what would you need to make that
21 opinion?
22 A. Oh, I could look at this and see if she is
23 hypertensive. I have got the flow sheet in front of
24 me, and --
25 Q. All right. Let's do that, please.

1 A. Yeah, and her blood pressures were normal,
2 that I can see, until 8-21.
3 Q. Okay.
4 A. So -- and she was already, you know, 30
5 weeks pregnant or 34 weeks, you know, pregnant when she
6 has hypertension. So I don't know that, you know,
7 fulfills any criteria of chronic hypertension.
8 Q. It does not?
9 A. Not reviewing what I have. I have no
10 additional history, but if her blood pressures are
11 normal for the first, you know, 30 some weeks of
12 pregnancy, then she is not a chronic hypertensive.
13 Q. Okay. And then if her hypertension does
14 elevate as of August 21, is there a medical term for
15 that other than chronic hypertension?
16 A. It would, you know, fall into the
17 probability of, you know, pregnancy-induced
18 hypertension.
19 Q. And is pregnancy-induced hypertension the
20 same as preeclampsia?
21 A. Yes.
22 Q. As of 8-21, is it fair to say, then, she has
23 preeclampsia?
24 A. I didn't review it from that point of view,
25 but she is hypertensive at that particular time, yes.

1 Q. Going back to your CV, where is it that you
2 are -- that you have privileges? Where do you have
3 privileges?
4 A. Where do I have at the present time?
5 Q. Yes. Thank you.
6 A. The only hospitals I am working out of --
7 only hospital I am working at the present time is
8 William Beaumont Hospital in Royal Oak, Michigan.
9 Q. And when it says adjunct associate professor
10 on your CV, is that clinical?
11 A. It has been -- it was actually a salaried
12 university position.
13 Q. And I guess what I am getting at is was
14 there didactic teaching involved or --
15 A. Yes.
16 Q. -- is it clinical where you would supervise
17 residents that would come through?
18 A. Both.
19 Q. Where would you do your didactic
20 instruction?
21 A. The lectures were at Wayne State University
22 School of Medicine.
23 Q. And when you say "were" as in past tense, do
24 you still presently do that or no?
25 A. No, I give my lectures now at William

1 **Beaumont Hospital and we rotate the students through**
2 **the hospital both from Wayne State University and the**
3 **University of Michigan.**
4 Q. All right. Do you still, then, draw a
5 salary --
6 A. No.
7 Q. -- at Wayne State?
8 A. No.
9 Q. When did you last do so?
10 A. **It's probably been about four or five years.**
11 Q. Is it fair to say that's about when you last
12 would have done a didactic lecture?
13 A. No.
14 Q. I'm sorry. At Wayne State.
15 A. Yes.
16 Q. Okay. What would the subject matter be for
17 your lectures?
18 A. **Over the years it's just varied a lot, from**
19 **-- have I ever lectured on, you know, the**
20 **pregnancy-induced hypertensions, yes, endometriosis,**
21 **cancer, you know, the whole spectrum of gynecology and**
22 **obstetrics.**
23 Q. You don't have any of those lectures reduced
24 to writing, do you?
25 A. **Do I?**

1 Q. Yes.
2 A. **There may be at Wayne, there were some**
3 **carrels that were developed, things of this sort.**
4 Q. How difficult would it be for you to obtain
5 any of those lectures that you would have reduced to
6 writing and that exist at Wayne State dealing with
7 preeclampsia?
8 A. **Oh, first of all, I don't even know if they**
9 **continue to exist. I'm sure that they update, and the**
10 **whole spectrum of teaching has changed because our one**
11 **University Hospital closed and moved into Harper, so I**
12 **am not -- I would have to call down to the department**
13 **and find out what they have, if they are willing to do**
14 **that.**
15 Q. Doctor, with regard to your recertification
16 in 1980, what is the recommended -- how long does that
17 last?
18 A. **How long does it last?**
19 Q. Yes.
20 A. **For me, it's a lifetime.**
21 Q. Do you know if there was a recommendation
22 for a recertification at certain time intervals or not?
23 A. **Well, people who took their boards after**
24 **1980 take them every 10 years. Anybody who took their**
25 **boards prior to 1980 have lifetime certification, and**

1 **the 1980, I was not required to take the**
2 **recertification. I did it on a voluntary basis.**
3 Q. I was looking at your CV and saw that you
4 were -- if I use the correct term, whether it's present
5 or past tense -- licensed in California. Are you still
6 so licensed?
7 A. **I haven't paid my dues in about four or five**
8 **years.**
9 Q. I was just wondering why you were licensed
10 in California. I was looking through your training to
11 see if you had worked out there, and I didn't see
12 anything.
13 A. **No. In 1958, when I became licensed in the**
14 **state of Michigan, I licensed in California for 50**
15 **dollars, and I think it was 12 dollars a year, in**
16 **anticipation that some day maybe I would like to move**
17 **to California, which I never did do. So I paid my**
18 **dues, you know, for years until I think it went up to**
19 **about \$500, and decided that, well, it's time that I am**
20 **getting old enough that I am not going to move to**
21 **California.**
22 Q. Okay. I can relate to that. I was going to
23 move to Florida at some time, and the time has passed
24 me by as well.
25 All right. When were you first

1 contacted in this case?
2 A. **My first contact really was just prior to**
3 **October of 2004.**
4 Q. What were you asked to do?
5 A. **I was sent a booklet of materials, asked to**
6 **review the records, and I believe I had a copy of the**
7 **Complaint at the time relative to the actions of**
8 **Dr. Stine.**
9 Q. Now, did you ask for the Complaint or was it
10 sent along without your request?
11 A. **It was sent along without my request.**
12 Q. Did you review that Complaint?
13 A. Yes.
14 Q. Now, do you have your entire file in front
15 of you, or does any part of it exist some place other
16 than where you are?
17 A. **I have all the materials, but I don't have**
18 **all the deps with me. The only deps I have with me are**
19 **Dr. Bailin, Dr. Stine, and recently Dr. Inglis.**
20 Q. Did you write at all in those depositions or
21 mark it with Post-It Notes or, you know, or dog ear a
22 corner in any of those depositions?
23 A. No.
24 Q. How about summaries, did you provide any
25 summaries or arrive at any? Prepare any, I'm sorry.

1 **A. Only the one letter that you have marked as**
2 **Exhibit Number 2.**
3 Q. And did you bring all correspondence with
4 you on the case?
5 **A. Have I brought -- no, I mean letters that I**
6 **have received from Mr. Auciello?**
7 Q. Yes.
8 **A. No, most of those I throw out.**
9 Q. All right. What letters still exist?
10 **A. I had a letter I think dealing with -- I**
11 **don't have them with me, but a letter dealing with my**
12 **deposition being taken on this date. I don't know what**
13 **else is there. Usually every deposition or summary**
14 **came with a letter listing the materials that were**
15 **present.**
16 Q. I would ask you to please make copies of
17 those letters and make them available to me after the
18 deposition. Can you do that?
19 **A. Yes.**
20 Q. Thank you.
21 **A. They will not all be present as you know.**
22 Q. Yes. Whatever you have available, I would
23 appreciate it.
24 MR. AUCIELLO: George, the ones he
25 doesn't have I will give you.

1 MR. LOUCAS: Well, I don't know that
2 I need that.
3 BY MR. LOUCAS:
4 Q. Doctor, do you have an e-mail or a --
5 **A. Yes.**
6 Q. -- computer-based file on this case?
7 **A. No. No, I do not.**
8 Q. I see in your report, then, everything that
9 you had reviewed prior to preparing the report; is that
10 an accurate statement?
11 **A. Those are all of the original reports that I**
12 **have received. Now as I said, I received, you know,**
13 **depositions that have come in after that period of**
14 **time. One is Dr. Inglis.**
15 Q. Right. But before we get there, I just want
16 to know what it is you reviewed in preparing your
17 report, and then we will move on from there; fair
18 enough?
19 **A. Yes, I think that that document lists**
20 **everything I had at the time of that report.**
21 Q. Except for the Complaint?
22 **A. Well, I did have the Complaint, too.**
23 Q. All right. But it doesn't list the
24 Complaint, correct?
25 **A. I understand.**

1 Q. All right. Is there anything else that you
2 reviewed that's not listed here? In preparing your
3 report, I'm sorry.
4 **A. I don't know.**
5 Q. Was there anything else that you wanted
6 before preparing your report that you did not have at
7 hand?
8 **A. No.**
9 Q. Have you asked for anything in addition
10 since authoring that report?
11 **A. No.**
12 Q. When I look to the end, whose initials are
13 that after your signature?
14 **A. M and M Secretarial Services.**
15 Q. So whose initials are those after your name?
16 **A. It's M and M Secretarial.**
17 Q. No, but under sincerely yours --
18 **A. Yeah.**
19 Q. -- W.S. Floyd comma M.D. slash, that looks
20 like a P and an S.
21 **A. It doesn't show up on my letter. Is it on**
22 **yours? Oh, it's -- when I dictated this report, I**
23 **dictate it on, you know, a phone-type service to M and**
24 **M, and obviously I instructed her to mail it out with**
25 **my signature, and the slash is Peggy Sorono (phonetic)**

1 **or something like that, she is with M and M.**
2 Q. And I take it you have a copy of a letter in
3 front of you or is that an original which does not have
4 that slash with initials?
5 **A. I probably have the original.**
6 Q. All right. The original that does not have
7 this slash?
8 **A. It has no signature.**
9 Q. All right. I am confused. Are you saying
10 the original does not have your name with her initials?
11 **A. That's right.**
12 Q. And is there another report in front of you
13 that has your name but without her initials?
14 **A. The report that I have in my file, which you**
15 **will get as part of the deposition, has no signature of**
16 **mine or the slash P.S.**
17 Q. All right. Is this the only report that you
18 prepared in this case?
19 **A. Yes.**
20 Q. Did you make any changes to it before final
21 draft?
22 **A. No.**
23 MR. AUCIELLO: George, I showed him
24 my copy. My copy is the same as your copy with the
25 signature on it.

Page 26

1 BY MR. LOUCAS:
2 Q. All right. Doctor, how long have you been
3 reviewing cases?
4 A. Probably about 35 years.
5 Q. And about how many per year do you review?
6 And if it's changed at all and you know any water shed
7 time periods, please let me know.
8 A. Oh, it's hard to predict. I think probably
9 in the period of 35, even up to 40 years, I have
10 probably done about 400 cases. There are years I did
11 none, and, you know, by choice, either I was, you know,
12 doing some grant work. There were times where we
13 considered we had a malpractice crisis in Michigan that
14 I may have done as many as 12 to 18 cases a year. Now
15 I probably do off and on anywhere from six to, you
16 know, 10 cases a year at the most.
17 Q. So for the last 10 years has it been
18 steadily six to 10 or was that 12 to 18 in there as
19 well?
20 A. No, the 12 to 18 goes back quite a ways.
21 Q. What malpractice crisis was it?
22 A. Where we couldn't get insurance.
23 Q. And so why did the number of cases you
24 reviewed increase during that time period?
25 A. There were just more cases being filed in

Page 27

1 the state of Michigan. As soon as they had tort report
2 [sic] coming up they had a huge influx of cases filed
3 to beat the tort.
4 Q. So during that malpractice crisis time
5 period, did you take any cases for the patient?
6 A. Have I? Over a period of time I have taken
7 some. I would tell you that over, you know, 90 percent
8 of all of the cases I have reviewed have been on behalf
9 of a physician, a hospital.
10 Q. During the malpractice crisis when you
11 increased your reviews to 12 to 18 cases per year, did
12 you take any during that specific time period for the
13 patient?
14 A. I don't know. I can't even remember. I
15 couldn't even remember the years.
16 Q. Did you hear my question?
17 MR. AUCIELLO: We didn't hear it.
18 THE WITNESS: I thought I answered
19 the question.
20 MR. LOUCAS: Oh, I'm sorry. I
21 didn't hear you on this end.
22 BY MR. LOUCAS:
23 Q. Have you testified in federal court?
24 A. Have I?
25 Q. Yes.

Page 28

1 A. Not that I can recall in the last, you know,
2 15 years or so.
3 Q. Do you know any of the defendants in this
4 case personally or professionally?
5 A. No.
6 Q. How about any of the experts?
7 A. The only name that I recognized was
8 Dr. Rayburn.
9 Q. Do you know Dr. Rayburn personally or
10 professionally?
11 A. I have met him. He does training at the
12 University of Michigan. I have been there as a
13 lecturer. And then he went out to I believe California
14 and then to Nebraska. I know I saw he is in
15 Albuquerque now, but I haven't had any personal contact
16 with him in probably 20 years.
17 Q. So he left you behind when he went to
18 California, huh?
19 A. That's right. Well, he went out with Bob
20 Jaffee, who is also from U of M who became chair at the
21 University of San Francisco Med School.
22 Q. When is the last time that you actually
23 reviewed a case for the patient?
24 A. This year.
25 Q. What type of case was it?

Page 29

1 A. I reviewed actually two obstetrical cases
2 for a Kevin Cox. The law firm is Weiner and Cox in
3 Southfield, Michigan.
4 Q. Did the issues involve any of the issues in
5 this case?
6 A. No.
7 Q. Have you ever reviewed a case involving
8 preeclampsia, HELLP, or DIC?
9 A. I know I have, but I can't recall the case
10 or when.
11 Q. How about for the patient?
12 A. I don't recall.
13 Q. Have you ever reviewed cases other than this
14 one in Ohio?
15 A. Have I had other cases in Ohio?
16 Q. Yeah. That's a better way of asking it.
17 Thank you. Yes.
18 A. I have reviewed at least a couple cases for
19 Mr. Auciello. I have reviewed a case or case for
20 Reminger & Reminger, and that I think you were with --
21 no, at one time or twice, and I believe that there is a
22 law firm in Columbus, Ohio that I have reviewed one
23 case for.
24 Q. For the defense?
25 A. Yes.

1 Q. Any others in Cleveland?
2 A. **I -- yes.**
3 Q. What other law firms?
4 A. **I am trying to -- is there a firm Arter?**
5 Q. Yes. Arter, Haddon, formerly Arter and
6 Haddon; now Tucker and Ellis, does that sound familiar?
7 A. **Well, it was Arter and Haddon.**
8 Q. Okay.
9 A. **It's been a number of years ago, and it**
10 **dealt with, you know, product safety of intrauterine**
11 **devices. I had published a book on the, you know,**
12 **biophysical principles of IUDs.**
13 Q. Have you consulted with Reminger & Reminger
14 at any of their offices outside of Cleveland?
15 A. **I really don't know.**
16 Q. Are you consulting with any of these other
17 firms presently on other cases?
18 A. **Well, Arter, Haddon I am not, and I don't**
19 **know if I have a Reminger case or not. I don't recall.**
20 Q. And how many do you have with Mr. Auciello
21 or other members of his firm presently?
22 A. **I may have one other, but I -- and I don't**
23 **know who else is in his firm, so I don't think I have**
24 **reviewed it for anybody else in his firm.**
25 Q. When have you last testified by way of

1 deposition?
2 A. **By deposition? This year.**
3 Q. Well, this is May, so --
4 A. **Yes.**
5 Q. -- when would that have been?
6 A. **This year.**
7 Q. I understand, but can you give me anything
8 more specific? Was it last week or yesterday?
9 A. **No, it hasn't been -- you know, it may have**
10 **been February or -- and it was for Mr. Cox.**
11 Q. And when will you next be scheduled to
12 testify in deposition?
13 A. **Right now I don't know.**
14 Q. All right. How about trial, when have you
15 last testified at trial?
16 A. **Not this year. I will try to think if I did**
17 **any last year or not.**
18 Q. Well, how many times have you testified at
19 trial?
20 A. **Maybe once a year.**
21 Q. Over the course of 35 years?
22 A. **Yes.**
23 Q. Of those times have you ever testified for a
24 patient at trial?
25 A. **Yes, I have.**

1 Q. How many of those 35?
2 A. **I don't recall. I can think of two right**
3 **offhand, but that's about it. I don't know.**
4 Q. When are you next scheduled to testify at
5 trial?
6 A. **In this case, I guess.**
7 Q. And what date is that?
8 A. **I believe that he mentioned it would be**
9 **probably somewhere around the first week of June.**
10 Q. Have we agreed -- well, what have you
11 reviewed since that which has been identified in your
12 report in preparation of your opinions?
13 A. **Okay. All the material that I have reviewed**
14 **are going to be listed on your Exhibit Number 3.**
15 Q. Read through that, please.
16 A. **Pardon? Do you want me to read the whole**
17 **report to you?**
18 Q. It's a report or a listing of that which
19 you --
20 A. **Yeah, it's a listing. It's a long list.**
21 Q. Only those things that you have reviewed
22 that is not represented in the October 18 report or
23 what you have reviewed since October 18.
24 MR. AUCIELLO: It would be the
25 reports of --

1 THE WITNESS: I have a list of
2 reports of Lisa Beggio, Pasquale, Essyk, Hughes,
3 Rayburn, Saade, Sacher, Solazar.
4 BY MR. LOUCAS:
5 Q. Is that it?
6 A. **Well, I am just -- I am trying to compare**
7 **it. Yeah, I believe it is.**
8 MR. AUCIELLO: And I think he also
9 said he reviewed Dr. Inglis's deposition --
10 THE WITNESS: Right.
11 MR. AUCIELLO: -- since then.
12 BY MR. LOUCAS:
13 Q. How about Dr. Sibai's report?
14 A. **No.**
15 Q. So the depositions, you have already told me
16 what you have reviewed.
17 A. **You have them listed.**
18 Q. Drs. Bailin, Stine, and Inglis, correct?
19 A. **No, I think on the letter you have it says**
20 **Stine, Bailin --**
21 Q. Yes, I'm sorry. You are right. I am
22 reading that as you speak.
23 A. **Yeah.**
24 Q. Since that time, however, you have also
25 reviewed Dr. Inglis?

1 A. That is correct.
2 Q. You have not read Dr. Flamm's deposition,
3 then, I take it?
4 A. Dr. Who?
5 Q. Flamm.
6 A. No.
7 Q. Have you read his report?
8 A. No.
9 Q. Are you aware of who Dr. Flamm is?
10 A. I know of Dr. Flamm.
11 Q. How do you know of Dr. Flamm?
12 A. Only from either a publication or a visiting
13 speaker.
14 Q. What do you know his specialty interest to
15 be?
16 A. I really can't tell you at the present time.
17 Q. Have you been made aware of the fact that he
18 is consulting in this case?
19 A. No.
20 Q. You have no idea what his opinions are,
21 correct?
22 A. Correct.
23 Q. What's your understanding as to why a
24 C-section was performed in this case?
25 A. The cesarian section was done as, you know,

1 scheduled for a patient who came in with severe
2 pregnancy-induced hypertension, and an unfavorable
3 cervix.
4 Q. What do you mean by unscheduled?
5 A. There was discussion of Dr. Stine and
6 Dr. Bailin and, you know, it was determined to go ahead
7 and do the section.
8 Q. All right. So the section to your
9 understanding was not done because of fetal distress,
10 but to treat preeclampsia?
11 A. It was done, you know, primarily because we
12 have an individual who has, you know, severe PIH.
13 There was not evidence of fetal distress. There were a
14 couple of decels. And the cervix was felt to be
15 unfavorable to inducer. The expectancy of delivery
16 would not be, you know, soon.
17 Q. Did you review any of the fetal heart
18 monitoring strips in this case?
19 A. No.
20 Q. And what is the purpose of delivery for the
21 -- for Sherry when she presents with PIH?
22 A. One is to have the baby delivered and not
23 submit the baby to the pregnancy-induced hypertension
24 and side effects. And two, the cure of
25 pregnancy-induced hypertension is delivery.

1 Q. What are the side effects from PIH to the
2 fetus?
3 A. Well, essentially the mother is
4 hypertensive. There can be vasospasm of vessels, you
5 know, to the placenta and therefore hypoxia to the
6 baby.
7 Q. Can we agree, Doctor, that Dr. Stine should
8 bring all her knowledge and training to bear when
9 acting as a physician?
10 A. I really don't understand your question. It
11 -- Dr. Stine is, you know, a physician, you know,
12 boarded in both Maternal Fetal medicine and obstetrics,
13 but acting in this case as a house physician.
14 Q. House physician or house obstetrical
15 physician?
16 A. House obstetrical physician.
17 Q. So in that role, is it fair to assume that
18 she should bring all of her knowledge and training as a
19 house obstetrical physician to bear when acting as the
20 treating doctor for Sherry McElfish?
21 A. Well, again, your question is somewhat
22 ambiguous, because she is always using her knowledge
23 and training whenever she does anything. But she is
24 still not the physician of record. This is not her
25 patient.

1 Q. So she is not responsible for her --
2 A. She is responsible for the things that she
3 does, but Dr. Bailin is the physician of record and he
4 is the individual who determines who is going to be
5 called and what happens to his patient.
6 Q. Was Dr. Stine responsible for Sherry as a
7 physician and patient while -- before Dr. Bailin
8 arrived?
9 A. She had all the responsibilities that you
10 would expect of an obstetrical house physician.
11 Q. Well, was Sherry admitted under her care
12 until Dr. Bailin arrived do you know?
13 A. No, she is admitted under the care of
14 Dr. Bailin.
15 Q. Would it be fair to say that Dr. Stine
16 should be judged in her role at Euclid Meridia Hospital
17 by what a similarly situated doctor who has Maternal
18 Fetal training would do and not do?
19 A. No.
20 Q. Why not?
21 A. Basically her role is to act as a house
22 physician obstetrically, to evaluate the patient, and
23 report her findings to Dr. Bailin. The decision as to
24 what is going to be done is Dr. Bailin's. I do not
25 surrender the care of my patient that goes in to

1 **Beaumont Hospital to the resident who sees the patient,**
2 **or a house physician who may be there.**
3 Q. So am I understanding your testimony
4 correctly in that despite the fact she is trained in
5 Maternal Fetal medicine, she can leave that at the door
6 since she is working as a house obstetrical physician
7 on that evening?
8 MR. AUCIELLO: Objection, George.
9 I'm just going to object because you are making it
10 sound like she is practicing with half her brain tied
11 behind her back to make it fair. I mean I don't know
12 how she would do it.
13 MR. LOUCAS: Actually I don't know
14 who that was.
15 THE WITNESS: I'm sorry?
16 MR. LOUCAS: Who was that speaking,
17 please?
18 MR. AUCIELLO: It was me, Ernie.
19 MR. LOUCAS: Thank you, Ernie.
20 BY MR. LOUCAS:
21 Q. All right, Doctor. You may answer.
22 A. **Yes, that she is using all her knowledge.**
23 **She is reporting her knowledge to Dr. Bailin. The**
24 **decision is still his. If he chooses then to call her**
25 **as, you know, for her knowledge and use her as a**

1 **consultant, that's his choice.**
2 Q. In your practice, Doctor, do you work with
3 midwives?
4 A. **Rare.**
5 Q. On what occasions do you find yourself
6 working with midwives?
7 A. **Off and on we have had midwives working at**
8 **the hospital, and we may be called as a consultant, you**
9 **know, for them.**
10 Q. Is it then your experience at the hospital
11 that you would be called by a midwife for a patient
12 with preeclampsia?
13 MS. DiSILVIO: Objection.
14 BY MR. LOUCAS:
15 Q. You may answer, Doctor.
16 A. **Could I be called for that?**
17 Q. No, the question was: Based upon your
18 experience, in working with midwives at the hospital
19 over the years, would you be consulted by the midwives
20 for patients with preeclampsia?
21 MS. DiSILVIO: Objection.
22 BY MR. LOUCAS:
23 Q. You may answer, Doctor.
24 A. **Yeah. Not necessarily. Basically our**
25 **midwives have to identify they have a physician they**

1 **work with, and if there was an emergency that came up,**
2 **yes, I could, you know, assist her or consult with her**
3 **in the absence of her physician.**
4 Q. I see.
5 So do you recall ever having been
6 called in to assist a midwife when the attending was
7 not available to consult on a patient with
8 preeclampsia?
9 A. **No.**
10 MS. DiSILVIO: Objection.
11 BY MR. LOUCAS:
12 Q. You may answer, Doctor.
13 A. **I said no.**
14 Q. How about with hypertension?
15 MS. DiSILVIO: Objection.
16 BY MR. LOUCAS:
17 Q. You may answer.
18 A. **No.**
19 Q. For what conditions would you be called in
20 by the midwife, if ever?
21 MS. DiSILVIO: Objection.
22 THE WITNESS: If she had a surgical
23 emergency or a delivery that she could not accomplish,
24 her physician was there, and I happened to be a person
25 on the floor.

1 BY MR. LOUCAS:
2 Q. All right. And would the nurse midwife
3 deliver severely preeclamptic patients based on your
4 experience?
5 MS. DiSILVIO: Objection.
6 THE WITNESS: No.
7 BY MR. LOUCAS:
8 Q. I couldn't hear you, Doctor.
9 A. **No.**
10 Q. Is HELLP syndrome a well recognized
11 condition of preeclampsia?
12 A. **It is a recognized complication of**
13 **preeclampsia.**
14 Q. May we agree that delaying a diagnosis of
15 preeclampsia increases the risk of a patient developing
16 HELLP syndrome?
17 A. **No.**
18 Q. Why not?
19 A. **HELLP syndrome is a complication of, you**
20 **know, the pregnancy-induced hypertension. But I don't**
21 **know literature that supports that says if you don't,**
22 **you know, if you delay your diagnosis of it, that you**
23 **increase the risk. Most HELLP syndromes usually are**
24 **very acute events.**
25 Q. How about based upon your own experience,

1 have you had any experience that in delaying a
2 diagnosis of preeclampsia, it increases the risk of a
3 patient developing HELLP syndrome?
4 **A. The answer is no.**
5 Q. Are you going to be offering any opinions at
6 trial as to what caused Sherry McElfish's death?
7 **A. I don't believe I am going to be asked to.**
8 **The only opinions I am going to offer are those dealing**
9 **with the actions taken by Dr. Stine through and till,**
10 **you know, delivery.**
11 Q. What is your understanding as to whether she
12 was involved in her care at all after delivery?
13 **A. The care after delivery was under**
14 **Dr. Bailin. And that Dr. Stine did look in on**
15 **recovery, but did not do any orders or anything of that**
16 **type.**
17 Q. And until what time? Well, first of all,
18 what time did she look in on her?
19 **A. There was a period of time within the hour**
20 **after, you know, delivery.**
21 Q. And delivery was at what time?
22 **A. It was at 1:18.**
23 Q. So your understanding is she was involved in
24 her care up until 2:18?
25 **A. My understanding she only looked in;**

1 **Dr. Bailin was present; that her care ended following**
2 **the delivery of this baby.**
3 Q. What was the purpose then of looking in?
4 **A. I would assume that she is an individual who**
5 **is on the floor and that she is an interested**
6 **individual.**
7 Q. Upon what are you basing that assumption?
8 **A. Just from the questions that were asked her**
9 **in her deposition.**
10 Q. And how is it you know that she looked in on
11 her at 2:18 a.m.?
12 **A. I don't know --**
13 MR. AUCIELLO: Objection. He didn't
14 say 2:18. He said about an hour.
15 THE WITNESS: You said 2:18. I
16 didn't.
17 BY MR. LOUCAS:
18 Q. Well, I thought you testified that it was
19 one hour afterwards. I asked what you time did she
20 look in on her.
21 **A. I said about an hour. Some time after. I**
22 **do not recall the exact time.**
23 Q. When she looked in, are you aware of any
24 hands-on care at all --
25 **A. No.**

1 Q. Are you aware of any hands-on care by
2 Dr. Stine at all subsequent to the delivery?
3 **A. The answer is no.**
4 Q. Moving back to Sherry's arrival or
5 presentation, if you will, at Meridian Euclid -- first
6 of all, before I even get to that, what is your
7 understanding as to where Sherry was scheduled to
8 deliver baby Joshua?
9 **A. I don't know.**
10 Q. Do you have any idea as to whether or not
11 she was scheduled to transfer at a different facility
12 but rescheduled at Meridia Euclid?
13 **A. I don't know.**
14 Q. What's your understanding as to the time
15 that Dr. Stine made her assessment of Sherry and
16 concluded what a likely --
17 **A. I'm sorry. You didn't finish the question.**
18 Q. What's your understanding as to the time
19 that Dr. Stine completed her assessment and concluded
20 what the likely diagnosis of Sherry was?
21 **A. Approximately at around 2340.**
22 Q. What was that preliminary diagnosis?
23 **A. Severe pregnancy-induced hypertension, and,**
24 **you know, differential diagnosis of possible HELLP**
25 **syndrome, and possible abruptio.**

1 Q. Is it your understanding then that she
2 arrived at the conclusion of possible HELLP and
3 possible abruptio, abruptio, at that same time, 2340?
4 **A. Roughly, yes. But that is not a diagnosis**
5 **made. That is only part of a differential. The only**
6 **diagnosis she had at 2340 was severe pregnancy-induced**
7 **hypertension. She could not make the diagnosis of**
8 **HELLP until the enzymes came back. And there's no way**
9 **to make the diagnosis of abruptio.**
10 Q. What was her urinary output upon
11 presentation?
12 **A. Excuse me one second.**
13 MR. LOUCAS: Court reporter, could
14 you read back his last answer, please?
15 (Record repeated as requested)
16 THE WITNESS: I do not know what her
17 urinary output was. She had a Foley placed at 2352, in
18 which the urine was just described as dark.
19 BY MR. LOUCAS:
20 Q. What was the volume?
21 **A. I don't recall the volume.**
22 Q. What would you be concerned about for Sherry
23 presenting with severe preeclampsia with regard to her
24 urinary output?
25 **A. Is there something special? No, there's**

1 nothing special. I mean she is an individual who has
2 severe PIH, needs to have her severe PIH managed, and
3 eventually plan to proceed to delivery.
4 Q. And how does the severe PIH need to be
5 managed?
6 A. All the things that were done here were very
7 meritorious on the part of Dr. Stine, and that was she,
8 you know, assessed, had Respiratory come down to see
9 her for her breathing; placed her on a fetal monitor;
10 started an IV; got an EKG; got blood gasses; got her
11 labs; and initiated a mag sulphate push. She was
12 continuously monitored, both Sherry and the baby, and
13 she was then placed on a mag pump. She was given
14 oxygen, and her attending physician was notified.
15 Q. Would you be concerned at all for Sherry's
16 welfare if she presented with elevated blood pressures
17 consistent with severe PIH and little to no urinary
18 output?
19 A. No, it just supports the diagnosis of severe
20 PIH.
21 Q. What's the significance of little --
22 assuming little to no urinary output, what's the
23 significance of that?
24 A. It's only significant that we are not
25 getting renal perfusion which is part of severe PIH.

1 Q. What is the risk to Sherry as a result of
2 that?
3 A. It is no greater than the risk that is
4 defined by severe PIH and eventually HELLP.
5 Q. And what is that risk then?
6 A. It's all part of the PIH. You are not
7 getting perfusion. You are going to get, you know,
8 multi-organ, you know, failure, which is going to be
9 the liver failures and the renal failures.
10 Q. And how is -- what is the intervention
11 necessary to decrease the likelihood of that
12 multi-organ system failure of the liver and kidneys?
13 A. Once you have HELLP syndrome you stabilize
14 the patient, and you plan and do delivery, and it's not
15 an emergent, it's an urgent delivery, but not emergent.
16 Q. How do you define urgent versus emergent
17 delivery?
18 A. An emergent delivery would be if the heart
19 tones went on the baby, and the baby or the mother's
20 life were jeopardized at that moment, then you would
21 do -- you don't try and stabilize the patient, you
22 just move ahead and get the baby out. The urgent is to
23 do your full assessment, both cardiovascular on the
24 mother and the baby, and then do a section as planned.
25 Q. Is it fair to say emergent is as soon as

1 possible?
2 A. Yes.
3 Q. And emergent would be defined how?
4 MR. AUCIELLO: You mean emergent
5 again?
6 BY MR. LOUCAS:
7 Q. As soon as practicable?
8 A. Emergent? You just said it, as soon as
9 possible.
10 Q. I'm sorry. I said and urgent, probably
11 sounded like emergent. Urgent then, would it be fair
12 to say as soon as practicable?
13 A. That's right. You want to stabilize the
14 patient, know as much of the patient as you can, and
15 have all your hands on deck and proceed.
16 Q. What do you mean by all hands on deck?
17 A. Well, you want your anesthesiologist there.
18 You want your OR prepped. You would like to have the
19 attending physician so that you are -- you have an
20 extra hand or a physician assistant, you know, for the
21 section.
22 Q. Have you heard that phrase "hands on deck"
23 prior to your just having said it in the preparation
24 for this case?
25 A. Yes, I am sure I have. I know I have.

1 Q. Where did you come by that definition?
2 A. Oh, I don't know.
3 Q. In this case?
4 A. In this case, a slogan if you like, I don't
5 know.
6 Q. When did you hear that slogan, if you will?
7 A. Oh, probably about 30 years ago.
8 Q. No, I meant in the preparation for this
9 case. You said yes, you had heard that slogan.
10 A. No, I didn't.
11 Q. I thought you said yes, you had heard that
12 slogan in the preparation of this case.
13 A. No, I didn't say that.
14 MR. AUCIELLO: George, I think
15 because the nature of this phone is once he starts
16 talking, he doesn't hear you talk.
17 MR. LOUCAS: All right.
18 THE WITNESS: So we might have some
19 talk overs where you think -- you keep talking, he
20 answers, and there's some confusion.
21 MR. LOUCAS: All right.
22 BY MR. LOUCAS:
23 Q. What's your understanding as to how she
24 arrived, Dr. Stine, at the preliminary diagnosis of
25 HELLP syndrome?

1 A. She made the diagnosis of severe
2 pregnancy-induced hypertension with a differential that
3 can include, you know, HELLP syndrome. She did not
4 make the diagnosis until the enzymes came back.
5 Q. Okay. And that's my question. Is it your
6 understanding that she did eventually arrive at a
7 diagnosis of HELLP syndrome?
8 A. Yes.
9 Q. What is your understanding as to the
10 information relayed or conveyed by Dr. Stine to
11 Dr. Bailin prior to his arrival at the hospital?
12 A. She reported all her findings to him,
13 discussed the aspect that she had severe PIH, and that
14 they ought to plan, you know, for getting the baby
15 delivered.
16 Q. And what was the -- what is your
17 understanding of the urgency with which she described
18 these findings to Dr. Bailin?
19 A. Well, I only can read her deposition. I
20 can't tell you what -- how it was said on the
21 telephone, but Dr. Bailin in his dep indicated that he
22 knew that she had severe PIH. He doesn't really recall
23 much of the conversation at all. Dr. Stine said I
24 would have relayed that. She went through in the
25 deposition and the questioning what she did do. And so

1 it was clear that he was aware he had a patient in the
2 hospital with severe PIH.
3 Q. And we agree that in severely preeclamptic
4 patients like Sherry McElfish, the sooner the
5 recognized treatment of evacuation of the uterus, or
6 delivery, the greater the likelihood of no
7 complications?
8 A. Oh, I don't know if I would agree with that.
9 I think that basically the most important thing is to
10 stabilize her, give her her mag sulfate, control her
11 blood pressure, you know, stabilize it, get her some IV
12 fluids in, and to know what her cardiac status is
13 and -- you know, before you proceed with the
14 anesthetic, as long as you have fetal heart tones that
15 are not non-reassuring.
16 Q. I'm sorry, as long as you have fetal heart
17 tones?
18 A. That are not showing fetal distress.
19 Q. Why does she need IV fluids?
20 A. We always have IVs on all patients coming
21 into the hospital, and particularly those who have any
22 complication of pregnancy. It's a means in which we
23 have entry into the patient. It's our IV life line.
24 Q. And with the severely preeclamptic patient
25 who is at risk for HELLP syndrome and DIC, is there any

1 greater importance to establish IV fluids than the
2 obstetric patient presents for delivery without
3 complication?
4 A. Well, any complicated case has a more
5 important need for IVs.
6 Q. All right. What is -- if you can define for
7 me, explain to me the more -- the importance of the
8 greater need for establishing an IV with the severely
9 preeclamptic patient.
10 A. As opposed to a normal patient?
11 Q. I'm sorry, severely preeclamptic.
12 A. It is the life line that you give the mag
13 sulfate, you give all your medications to, and you
14 are -- you know, these patients are hemoconcentrated,
15 so you do want to add IV fluid to them, you know, for
16 one, dilution and profusion, and yet you don't want to
17 overload them because you want to get your EKG because
18 you don't want to push them into congestive heart
19 failure.
20 Q. And that's consistent with what you said in
21 establishing monitoring?
22 A. That is correct.
23 Q. So how do you monitor via IV fluid? How do
24 you monitor through a line established for IV fluid?
25 A. You don't monitor through a line for IV

1 fluids.
2 Q. What is the best way, then, to monitor a
3 patient with severe preeclampsia with a risk of HELLP
4 and DIC who's hemoconcentrated and that can go into
5 CHF?
6 A. You are going to clinically monitor them.
7 Are you going to say you can put central lines in?
8 Yes, but this is not mandatory in this case. Your most
9 important things are doing the things that she did.
10 Q. So how do you clinically monitor?
11 A. You clinically monitor by her pulse, her
12 blood pressure, her gasses, her EKG, and you work
13 towards getting the patient delivered.
14 Q. And what are you monitoring? What are you
15 looking for with regard to the vitals, the pulse, the
16 blood pressure?
17 A. That your blood pressure is stable, not
18 elevating, and that you are watching her pulse rate
19 relative to whether she is tachycardic or not.
20 Q. So if you have got falling blood pressure
21 and increasing tachycardia, what's the significance of
22 that, if anything?
23 A. Well, it all depends on what you're doing.
24 If you are giving her mag sulfate, you may expect her
25 blood pressure is going to drop, and you may also get a

1 dropping of your pulse rate, too.
2 Q. But what if you have falling blood pressure
3 and rising pulse rates?
4 A. Well, if the patient is bleeding out, then
5 you see visible bleeding, you may have, you know, blood
6 loss. That did not occur in this case.
7 Q. What did not occur?
8 A. The bleeding prior to her delivery.
9 Q. Did that occur after her delivery?
10 A. It occurred at some time after the delivery.
11 Q. And how did that bleeding occur?
12 A. How did it occur?
13 Q. Yes.
14 A. I don't know. I assume that she at some
15 time after the patient -- the surgery was done. There
16 certainly was no bleeding complications that I can see
17 dictated at the time of surgery. The blood loss of a
18 thousand cc's is average for a cesarean section, so any
19 bleeding that did occur occurred when she was in
20 recovery or their -- whatever they call their recovery
21 room there.
22 Q. And what's your understanding of the
23 recovery room at this facility?
24 A. I don't know.
25 Q. Are you aware of how it was staffed?

1 A. No.
2 Q. Are you aware of what equipment was
3 available?
4 A. No, it's not part of my opinions regarding
5 Dr. Stine
6 Q. Now assuming Dr. Stine was involved
7 postoperatively for one hour, would that then have any
8 relevance to your opinions?
9 A. No.
10 Q. Are you aware as to whether or not she --
11 Dr. Stine made the diagnosis of severe preeclampsia
12 without the prenatal chart in front of her?
13 A. Do I know that she did that? I don't know.
14 Q. May we agree that Dr. Stine had the
15 responsibility to communicate to Dr. Bailin that his
16 patient likely had severe preeclampsia and that she was
17 acutely ill and needed his immediate attention?
18 MR. AUCIELLO: Objection.
19 THE WITNESS: Unless you assume that
20 Dr. Bailin is a total idiot and has no obstetrical
21 experience, the fact that you would tell him what her
22 pressures were and that -- the severity and that we
23 need to plan for delivery, that is all she needs to
24 communicate.
25 BY MR. LOUCAS:

1 Q. So I take it that was a fair statement?
2 A. I don't know. I don't think that your
3 statement was a fair statement, no.
4 Q. Then what, the fair statement then is
5 that --
6 A. To communicate the findings that was had,
7 she had a diagnosis of severe preeclampsia, and they
8 need to plan for delivery.
9 Q. Now if I ask a question that doesn't make
10 sense to you, please let me know. I am very serious in
11 my questions here.
12 A. I understand.
13 Q. What was the significance of the epigastric
14 pain to you, Doctor, in your review of this case?
15 A. Epigastric pain is part of the symptoms of
16 severe preeclampsia.
17 Q. So when you said that there was no way that
18 she could diagnose abruptio, what was the basis of that
19 opinion?
20 A. There is no visible bleeding, and the heart
21 tones are fine, and the diagnosis of abruption would
22 either be made by one of those two means prior to
23 delivery.
24 Q. What was the significance of the shortness
25 of breath, if any?

1 A. Again, it's part of the severe preeclampsia.
2 They get swelling of the liver capsule. It gives you
3 your epigastric pain, and it gives you the shortness of
4 breath.
5 Q. At what time was the anesthesiologist called
6 into this case?
7 A. I can't tell you the exact time. I know
8 that at 1:00 on the anesthesia record, that she was in
9 the -- he has already recorded the first blood
10 pressure, so that she -- he was present at that time,
11 and had begun his preparations.
12 Q. So what time -- what amount of time does the
13 anesthesiologist have to review the chart
14 preoperatively?
15 A. I don't know.
16 Q. What amount of time did the anesthesiologist
17 have to consult with the patient to clear her
18 preoperatively?
19 A. I don't know.
20 Q. What amount of time would you expect for
21 either?
22 A. On an urgent basis, he would not need very
23 much time at all; that he was told that she had a
24 severe preeclamptic, and that they were doing an urgent
25 section.

1 Q. You would agree with me that the verbal
2 communication would be important in that scenario?
3 A. Yes. He could ask every question that he
4 needed and get an answer.
5 Q. And whom would you expect that he would ask?
6 The nurse?
7 A. No, I am sure he would ask Dr. Stine if she
8 was the only physician present at the time.
9 Q. And you would agree with me that obtaining
10 that information, meaning the anesthesiologist, in
11 preparing for an urgent C-section for a severely
12 preeclamptic patient, would be crucial?
13 A. Oh, I don't know if it's crucial. Basically
14 he listed her as a PS2 risk factor, which is not a high
15 anesthetic risk factor.
16 Q. Are you aware whether this anesthesiologist
17 was aware of the fact that she was severely
18 preeclamptic when he stepped in, or she?
19 A. I am sure he was because he took a blood
20 pressure.
21 Q. You are assuming by the fact that the
22 anesthesiologist took a blood pressure that he or she
23 was aware of severe preeclampsia?
24 A. You are going to have to ask him. There's a
25 note that he wrote at 5 minutes to 1:00, patient to the

1 that somebody conveyed to the anesthesiologist, other
2 than her taking a blood pressure, a preliminary
3 diagnosis of this patient going into C-section,
4 wouldn't you?
5 MR. AUCIELLO: Objection.
6 THE WITNESS: The answer is yes.
7 BY MR. LOUCAS:
8 Q. What's your understanding of type and
9 screen, the order that Dr. Stine wrote for type and
10 screen?
11 A. Any time you have anybody that has any
12 surgical procedure contemplated, you either type and
13 screen or type and cross match, depending on the
14 hospital.
15 Q. What's the difference between those two
16 orders?
17 A. One is you just do a type. The cross match
18 means that you would prepare blood, and the blood would
19 stay in the blood bank until it's called.
20 Q. So it is your understanding, then, that
21 Dr. Stine never did order blood to be brought up to the
22 floor; is that correct?
23 A. I did not see any blood brought to the floor
24 in the records that I have reviewed through the end of
25 the surgical procedure.

1 OR, and ID'd, so he was there for at least almost 20
2 minutes before the initial incision was made.
3 Q. That's at 5 until 1, correct?
4 A. Yes.
5 Q. You said at 5 until 1 in the morning?
6 A. At 0055.
7 Q. He ID'd the patient, correct?
8 A. Yes, and moving to the OR. And he listed
9 anesthesia start for his time on board at that same
10 time.
11 Q. And you are saying that based upon that
12 information, you are assuming that he was aware she was
13 severely preeclamptic, correct?
14 A. He had 20 minutes before the incision is
15 made to evaluate anything want, ask any questions he
16 would like, and I can't tell you what he knew. I
17 haven't read his deposition yet.
18 Q. But my question is for purposes of the basis
19 of your opinions in this case, you are assuming that
20 because of him or her, because I believe it is a her,
21 stepping into this case at 5 until 1 a.m., she was,
22 therefore, aware of the fact this patient was severely
23 preeclamptic, true?
24 A. Yes.
25 Q. You would expect the standard of care to be

1 Q. My question was: It is your understanding,
2 then, that Dr. Stine never ordered any blood to be
3 brought to the floor, correct?
4 A. I don't know. I did not see that order.
5 Q. But you saw an order for what, then, with
6 regard to blood?
7 A. I believe it was just type and cross.
8 Q. Type and screen?
9 A. Type and cross.
10 Q. Did you ever see an order for type and
11 screen?
12 A. I don't know. I don't recall.
13 Q. Assume that there was an order by Dr. Stine
14 for type and screen, and then subsequently after the
15 enzymes came back showing severe preeclampsia, or
16 elevated liver enzymes, type and cross, what would you
17 deduce from that information?
18 A. All I could deduce is that she was preparing
19 if there was any blood loss.
20 Q. What is it about those elevated liver
21 enzymes that would make her in this scenario with
22 Sherry McElfish be concerned about blood loss to the
23 point that she is ordering specific amounts of blood
24 and blood products to be prepared?
25 A. Only that, you know, once you have the

1 elevated enzymes, you have made the diagnosis of HELLP
2 syndrome, and part of HELLP syndrome says elevated
3 liver enzymes and eventually low platelets.
4 Q. So what's your understanding as to why she
5 ordered the type and cross blood?
6 A. To prepare, you know, for the section.
7 Q. For what, bleeding complication, or what's
8 your understanding?
9 A. Well, if you prepare blood, then you are
10 preparing for bleeding.
11 Q. And that would be because of concern of low
12 platelets with HELLP syndrome, true?
13 A. No, I think that basically it could be that,
14 but you have a patient who has severe preeclampsia, has
15 HELLP, and there's always a probability of, you know,
16 bleeding at the time of cesarean section. In this case
17 they did not get the bleeding at the time of the
18 cesarian section. That was unusual.
19 Q. How do you monitor for that bleeding?
20 A. That is something you clinically observe.
21 Q. And that goes back to the blood pressure and
22 the heart rate?
23 A. No, not at all. You look, you measure the
24 blood by your clinical estimation of how much blood
25 loss I have.

1 Q. So there's no need to look at clinical
2 parameters of vitals, then, in observing or assessing
3 for blood loss postoperatively, true?
4 A. No, I didn't say that at all.
5 Q. Sure. You just said that no, you don't do
6 that, you look for visual bleeding and output or blood
7 loss.
8 A. Let me just say this, okay. I know your
9 questions are serious, but you are so eschewing all
10 these questions and distorting my answers intentionally
11 with your questions that you are considering serious,
12 so they're not serious questions. You then take a
13 serious question and then you eschew the answer, and
14 that this patient was appropriately monitored which we
15 would do in every section, her blood pressure and pulse
16 would be maintained and watched by the
17 anesthesiologist. The clinical loss of blood is an
18 estimation made by the surgeon, by the scrub nurse, and
19 by the anesthesiologist. That is how we assess blood
20 loss.
21 Q. I asked you how to monitor for blood loss.
22 MR. AUCIELLO: And George, he told
23 you.
24 BY MR. LOUCAS:
25 Q. Excuse me. I asked you how to monitor for

1 blood loss, and I said one of the ways would be to go
2 back to the vitals and look for falling blood -- to
3 check the blood pressure and the pulse as we talked
4 about with regard to fluids, right? And you said no,
5 that would be a clinical assessment for the amount of
6 blood loss. True?
7 A. Well, I think that all your questions and
8 these answers now have gotten so garbled that you don't
9 have an understanding of what I have said. So I am not
10 trying to be offensive to you. I'm not trying to be --
11 put you down in any way, but your questions do not make
12 good medical sense. And you are trying to take medical
13 facts and convert them to lay terms, and they -- then
14 they don't make sense to me.
15 Q. Doctor, how do you monitor for hypovolemia
16 postoperatively in this type of patient?
17 A. Whoa, whoa, now this is -- okay, this is a
18 whole different question, all different facts. Let's
19 understand that, okay?
20 Q. I know exactly what I understand about my
21 question. Are you okay with the question?
22 A. I am okay if you understand that you have
23 now changed the whole question and the scenario of
24 events.
25 And postoperatively the patient is

1 monitored, you know, by blood pressure, by pulse, and
2 by visible blood loss.
3 Q. And how about respiration?
4 A. Respiration is not one of the things that we
5 use to monitor, you know, blood loss. It's one of the
6 well-beings of the patient that we are looking at.
7 Q. How do you define hypovolemia?
8 A. Hypovolemia just means low blood volume.
9 MS. DiSILVIO: Hello.
10 MR. AUSTRIA: Hello. Did we lose
11 you?
12 THE WITNESS: No, I'm still here.
13 MR. AUCIELLO: There was no
14 question.
15 THE WITNESS: Hello.
16 MR. LOUCAS: Hello.
17 THE WITNESS: Yeah, I'm still here.
18 MR. LOUCAS: Okay.
19 MR. AUCIELLO: Is George still here?
20 MR. LOUCAS: I'm still here.
21 THE WITNESS: Okay.
22 BY MR. LOUCAS:
23 Q. At what point in time, Doctor, if at all,
24 did you see evidence of hypovolemia in this chart
25 during your review?

Page 66

1 A. Well, I reviewed the chart and made opinions
2 only until, you know, Dr. Stine's participation was
3 gone. Now, the hypovolemia or blood loss were events
4 that occurred after, and if you look at her recovery
5 room record, her pressures remained normal with, you
6 know, pulse rates that were stable at least until 2:25.
7 Q. All right.
8 A. But also you have to recognize that prior to
9 that time, she received antihypertensives as
10 Apresoline, and so that Dr. Bailin was aware to a four
11 of her increased blood pressures which were always
12 elevated and ordered Apresoline IV push, and at 2:15
13 Apresoline IV push by Dr. Bailin.
14 Q. I believe my original question was what time
15 did you see evidence, if any, of hypovolemia?
16 A. I don't know. It occurred some time after
17 2:25.
18 Q. Have you ever seen a central line or a
19 Swan-Ganz line placed to help monitor the severely
20 preeclamptic patient?
21 A. Have I, yes.
22 Q. Under what circumstance is that beneficial
23 in a patient?
24 A. It helps you -- usually most of these are
25 going to be at a time, you know, following, you know,

Page 67

1 delivery, if you have a patient who becomes unstable as
2 far as bleeding, you know, present.
3 Q. And are you saying that postoperatively it
4 assists in monitoring bleeding?
5 A. It assists in replacement of blood and
6 fluid.
7 Q. How does it assist?
8 A. By measuring your pulmonary artery pressures
9 and your central venous pressures.
10 Q. And it helps to make sure that the heart
11 doesn't get overloaded with fluid, true?
12 A. That's exactly what I said.
13 Q. Do you know whether that's what happened to
14 Sherry?
15 A. I don't know, and I didn't form any opinions
16 on that.
17 Q. But when you read the record, you didn't
18 look to see if that's what happened, correct?
19 A. That's correct. I only reviewed the records
20 for the actions taken by Dr. Stine.
21 Q. Now would that have assisted the medical
22 care personnel in monitoring Sherry postoperatively?
23 MR. AUSTRIA: Objection.
24 THE WITNESS: Well, first of all,
25 what would have?

Page 68

1 MR. LOUCAS: Thank you. I was
2 trying to finish my question until that loud noise
3 deafened me.
4 MR. AUCIELLO: Your phone is better
5 than anyone else's, Bob.
6 MR. AUSTRIA: Thank you.
7 MR. LOUCAS: You woke me up, Bob.
8 Thank you.
9 MR. AUSTRIA: Okay.
10 BY MR. LOUCAS:
11 Q. A central line or Swan-Ganz.
12 A. Can it, yes.
13 Q. Now what is your understanding as to the
14 amount of intraoperative blood loss that occurred? I
15 know you said 1,000 cc's, but there were different
16 entries in the medical record, were there not?
17 A. I don't recall any.
18 Q. What is Sherry's estimated total blood
19 volume?
20 MR. AUCIELLO: You were cutting out.
21 Can you repeat that question?
22 MR. LOUCAS: Yes.
23 BY MR. LOUCAS:
24 Q. What is your estimate of Sherry's total
25 blood volume?

Page 69

1 A. Well, ordinarily in a non-pregnant
2 individual, it would be about 4,700 cc's. In a
3 pregnant individual you get about a 40 percent increase
4 in that, and so we are talking about, you know,
5 probably somewhere close to 6,000, you know, cc's. But
6 let me just say that a thousand cc's is the average
7 blood loss for a cesarean section.
8 Q. Are you aware -- strike that.
9 I want you to assume that the
10 anesthesiologist in this case has testified that she
11 would have placed an internal or a Swan-Ganz or central
12 line in Sherry had she known the patient was severely
13 preeclamptic. Do you agree or disagree?
14 A. Well, I have a hard time agreeing or
15 disagreeing with the anesthesiologist whose
16 responsibility it would have been to place that line.
17 Q. I'm sorry. Maybe I didn't make my question
18 clear. I think that's an example of an inartful
19 question. I don't think it was complete. And that is:
20 Would you agree that -- with her treatment plan, had
21 she had that information?
22 MR. AUCIELLO: Pardon?
23 THE WITNESS: Start the question
24 over.
25 BY MR. LOUCAS:

1 Q. Would you agree with the anesthesiologist's
2 treatment plan, assuming it to be true that she has
3 testified that had she been made aware that Sherry was
4 severely preeclamptic, she would have placed a central
5 line or Swan-Ganz to monitor her?

6 MR. AUCIELLO: Objection, I don't
7 understand.

8 THE WITNESS: Well, you know, one, I
9 don't understand the question really because the
10 patient was severely preeclamptic, and if the
11 anesthesiologist felt there was a need for the central
12 line or the Swan-Ganz at that time, he certainly had
13 the opportunity to place it.

14 BY MR. LOUCAS:

15 Q. I want you to assume, Doctor, that the
16 anesthesiologist was not aware that this patient was
17 severely preeclamptic, that was her testimony. I want
18 you to further assume, please, that her testimony in
19 this case has been that had she been made aware of the
20 fact this patient was severely preeclamptic, that she
21 would have placed a central line or Swan-Ganz
22 intraoperatively to monitor this patient. Assuming
23 that to be true, would you agree with that treatment
24 plan by the anesthesiologist?

25 A. My answer, if you are done with your

1 delivery of a severely preeclamptic patient?

2 A. I have had intensivists for the most part
3 who have managed the patient postoperatively.

4 Q. Why would that be?

5 A. If you have an individual who has a
6 multi-organ failure who is demonstrating the
7 possibility of congestive heart failure, or who has
8 become hypovolemic, or even a hematologist, if I am
9 getting bleeding, as to what type of blood products to
10 replace.

11 Q. And you would agree with me that would be
12 standard of care?

13 MR. AUSTRIA: Objection.

14 MR. AUCIELLO: Objection.

15 THE WITNESS: I would not say it's
16 standard of care. It depends upon the competency and
17 experience of the person who is managing it, and every
18 situation is going to be very, very different.

19 BY MR. LOUCAS:

20 Q. Did you ever consider the issue as to
21 whether or not Dr. Stine should have administered
22 antihypertensives before Dr. Bailin arrived?

23 A. Yes.

24 Q. Tell me your thinking process, please.

25 A. She gave her mag sulfate, the blood pressure

1 question, is that I would disagree with him or her, and
2 assuming that everything you say is truthful regarding
3 what is -- has been in this deposition, which I did not
4 see, I would disagree, and I don't know how the
5 anesthesiologist recording these blood pressures would
6 not know that he is dealing -- who has seen this
7 patient for 20 minutes before the incision, that this
8 is not a severe PIH.

9 Q. Have you ever called in a specialist to
10 assist you in the delivery of a severe PIH patient or a
11 HELLP patient?

12 A. No.

13 Q. Through your experience over the years have
14 you ever seen an intensivist or a Maternal Fetal
15 specialist --

16 THE COURT REPORTER: I'm sorry. I
17 didn't hear that.

18 THE WITNESS: Start over.

19 MR. AUCIELLO: Start over.

20 MR. LOUCAS: I'm sorry. I turned
21 away from the speaker.

22 BY MR. LOUCAS:

23 Q. Through your years of experience are you
24 aware of a Maternal Fetal specialist or intensivist or
25 cardiologist ever having been called to consult in the

1 stabilized. There was not a need to give her an
2 antihypertensive at that time, but to wait until after
3 delivery.

4 Q. And what was her blood pressure pre-mag
5 sulfate versus when you say the mag sulfate brought it
6 down?

7 A. I didn't say it brought it down. I said it
8 stabilized her. The ambulance pressure was 195 over
9 105. Her first blood pressure was 179 over 93. And
10 then as you look through her other blood pressures
11 preceding up to delivery, she had 160 over 98, and so
12 there was stability.

13 Q. So if you could, demonstrate for me in the
14 chart or verbalize it to me how the mag sulfate
15 stabilized her.

16 A. Well, magnesium sulfate is the standard of
17 treatment for a severe PIH, and it does prevent
18 seizures. It does help for ways we are not sure of in
19 stabilizing blood pressure.

20 Q. Are you saying that the 160 over 98 is as a
21 result of the stabilizing effect of mag sulfate?

22 A. I don't know. All I know is this patient
23 was stable at that particular time, and things were
24 moving towards, you know, getting the patient
25 delivered.

1 Q. And so peri-operatively in delivering a
2 severely preeclamptic patient, where do you want to see
3 the blood pressures controlled?

4 A. The blood pressures he had were controlled.
5 I don't want to knock the blood pressure out and
6 compromise the baby.

7 Q. So if you could tell me, please, the
8 systolic and diastolic numbers you would like to see
9 peri-operatively.

10 A. I'm not going to give you any numbers.
11 That's going to disappoint the hell out of you, but
12 it's -- these blood pressures were stable where they
13 are. The numbers are not important.

14 Q. Are you aware of any medical literature that
15 says the systolic blood pressure should be maintained
16 under 160 --

17 A. For when? I mean you are taking things out
18 of context.

19 Q. -- in the severely --

20 THE COURT REPORTER: I'm sorry?

21 MR. AUCIELLO: You need to start
22 over. We didn't get that.

23 BY MR. LOUCAS:

24 Q. Peri-operatively, in the severely
25 preeclamptic patient like Sherry McElfish.

1 dealing with this patient anymore, and that basically,
2 you know, you have used the term Sibai before as an
3 expert, he is the expert on hypertensive work and
4 preeclampsia, nationwide. I haven't read his dep yet,
5 but he has a textbook.

6 Q. Are you aware -- same question -- but are
7 you aware of any literature indicating diastolic blood
8 pressure should be maintained under 110 upon
9 presentation of the severely preeclamptic patient?

10 A. I can't answer your question the way it's
11 posed because it takes out of context. So I do not
12 know of this circumstance that I have read about in a
13 textbook. And that's the best answer you are going to
14 get from me.

15 Q. Would you have administered antihypertensive
16 medication to Sherry preoperatively?

17 A. No.

18 Q. You would agree with me that Dr. Stine
19 appreciated how severely ill this woman was and she did
20 not believe she needed any other assistance through
21 consult?

22 MR. AUCIELLO: Objection.

23 THE WITNESS: I don't know.

24 BY MR. LOUCAS:

25 Q. Are you aware of any disagreements

1 A. What? You didn't finish your question.

2 Q. Are you aware of any medical literature that
3 says the blood systolic should be maintained at 160 or
4 below?

5 A. Under what circumstances? Are you talking
6 about a patient that we are just treating for
7 preeclampsia?

8 Q. No, I just said the severely preeclamptic
9 patient.

10 A. Preceding to delivery or what? I mean you
11 are taking a lot of things out of context, and I don't
12 think you are going to find your answer in the
13 textbook. Probably if you have got Sibai testifying,
14 that he may be able to give you that answer, because he
15 probably has the greatest experience with it.

16 Q. Doctor, I'm going to try this question
17 again. Ready?

18 A. Ready.

19 Q. Are you aware of any medical literature that
20 indicates administration of an antihypertensive
21 medication to the patient that arrives at the hospital
22 with severe preeclampsia in an effort to keep the
23 systolic blood pressure under 160?

24 A. Not in this circumstance. I think you have
25 taken everything so out of context that you are not

1 whatsoever between Drs. Stine and Bailin during the
2 management of this patient?

3 A. No.

4 MR. AUSTRIA: Objection.

5 MR. AUCIELLO: He answered no, if
6 you didn't get that.

7 THE WITNESS: Yeah, no.

8 BY MR. LOUCAS:

9 Q. Would it have been beneficial to Sherry
10 McElfish in any way to have afforded the
11 anesthesiologist more time than the 20 minutes you
12 indicated to prepare for her case?

13 A. I don't know why, but I don't -- I can't
14 answer the question. You have to ask the
15 anesthesiologist that.

16 Q. You would agree with me that it would have
17 been prudent medical practice to contact the
18 anesthesiologist in anticipation of the C-section in an
19 effort to afford that anesthesiologist enough time to
20 get all the facts on the case?

21 A. Your question is ambiguous again. I feel
22 that there was 20 minutes. That was adequate, unless
23 the anesthesiologist says it was not adequate.

24 Q. All right. And my question is: Would it
25 have been prudent medical practice to have given that

1 anesthesiologist more than 20 minutes?
2 **A. The same answer I just gave you.**
3 Q. Go ahead. You can answer.
4 **A. I just said, if the anesthesiologist felt**
5 **that he needed more time, he can answer the question**
6 **better than I can, but certainly he had adequate time**
7 **in 20 minutes to assess what's happening in the short**
8 **time that she is in the hospital.**
9 Q. But I want to know based on your experience,
10 your education and training through the years, would it
11 have been prudent medical practice to afford this
12 anesthesiologist more than 20 minutes to help prepare
13 for this case?
14 **A. The answer is no.**
15 Q. I take it you do not believe it was
16 necessary for Sherry to be in an intensive care setting
17 postoperatively?
18 **A. Well, recovery room is an intensive care**
19 **area.**
20 Q. And would you please define for me recovery
21 room.
22 **A. Recovery room is a patient -- is where the**
23 **patient after surgery is monitored.**
24 Q. You mean like a med/surg post-anesthesia
25 care unit?

1 **A. I don't know what you're referring to.**
2 Q. Well, tell me what you believe that type of
3 recovery room -- what type of equipment that recovery
4 room should have to monitor the severely preeclamptic
5 patient who has just been diagnosed with elevated liver
6 enzymes and low platelets.
7 **A. From all the appearance that I saw when this**
8 **patient finished the surgery, there was nothing severe**
9 **happening, and that a recovery room where there is a**
10 **nurse, you know, patient one-on-one ratio with the**
11 **ability to take blood pressure, pulse, was adequate.**
12 **But again, that goes to the issue of not where I am**
13 **testifying, because I am only testifying on the actions**
14 **of Dr. Stine.**
15 Q. Doctor, is it true you do not do 24-hour
16 urines on your patients in whom you expect
17 preeclampsia?
18 **A. Who said that?**
19 Q. I am asking you a question. Is it true or
20 not true?
21 **A. Well, no, you did not ask me a question.**
22 **You assumed something that I did not do. That is not a**
23 **question. Do you want to ask it different?**
24 Q. Sir, is it true or not true --
25 **A. Ask me the question, do I do 24-hour urines**

1 **on patients who are preeclamptic, the answer is yes.**
2 Q. And that's standard of care, true?
3 MR. AUSTRIA: Objection.
4 THE WITNESS: It can be depending
5 upon the circumstances that you are dealing with and
6 what you are, you know, the patient's clinical
7 circumstance at that time, but it's also beyond the
8 scope of where I am testifying in this case.
9 BY MR. LOUCAS:
10 Q. Well, under what circumstances would you go
11 ahead and order the 24-hour urine for the preeclamptic
12 patient?
13 MR. AUCIELLO: I'm going to object
14 because Dr. Stine -- there is no theory involving
15 Dr. Stine doing a 24-hour urine. This is just
16 completely extraneous to any issue relating to my
17 client or any of my experts, but go ahead.
18 MR. AUSTRIA: Objection.
19 BY MR. LOUCAS:
20 Q. Go ahead, Doctor. You may answer.
21 **A. I will do it on patients that I have**
22 **hospitalized, you know, for pregnancy-induced**
23 **hypertension.**
24 Q. And have you ordered 24-hour urines on those
25 patients on an outpatient basis in an effort to

1 diagnose whether they were preeclamptic?
2 MR. AUCIELLO: Objection.
3 THE WITNESS: No.
4 MS. DiSILVIO: Objection.
5 MR. AUCIELLO: He said no if you
6 didn't hear it over the objection.
7 MS. DiSILVIO: Withdrawn.
8 BY MR. LOUCAS:
9 Q. What is your definition of severe
10 preeclampsia, Doctor?
11 **A. Blood pressures exceed 160, diastolics over**
12 **110 with Albuminuria and/or edema.**
13 Q. To what extent of Albuminuria?
14 **A. Two plus or greater.**
15 Q. And when you say two plus, is that on a dip
16 stick?
17 **A. Yes.**
18 Q. And what would that translate in to by way
19 of a 24-hour urine, a two plus dip stick?
20 **A. Oh, probably about 300 milligrams.**
21 Q. Almost done, Doctor. Bear with me a moment.
22 Did you perceive any need in this
23 case to know exactly when the obstetrician was going to
24 arrive for delivery?
25 **A. No.**

1 Q. Would you agree that a 130 over 80 blood
2 pressure for a 27-year-old woman prenatally like Sherry
3 McElfish would be considered elevated?
4 A. No.
5 Q. Would you agree with me that it is higher
6 than what you would normally see for a 27-year-old
7 primigravida?
8 A. No.
9 Q. On average?
10 A. No. You are not talking about, you know --
11 how much does she weigh? Two hundred some pounds?
12 That doesn't make her average.
13 Q. What was her weight prenatally? Let me ask
14 it a different way. Does it make any difference if she
15 was less than 200 pounds prenatally?
16 A. Well, you know, I can't tell you what her
17 prenatal weight was, but I can tell you at nine weeks
18 of pregnancy, which is very early, she weighed 221
19 pounds. Now she didn't get 100 pounds in the first,
20 you know, six weeks of pregnancy.
21 Q. Doctor, may we agree that the only treatment
22 for HELLP syndrome is rapid delivery of the child?
23 A. We can agree that the treatment of severe
24 preeclampsia or HELLP is delivery, and removing your
25 adjective.

1 (On the record at about 6:48 p.m.)
2 (Mr. Krause present via telephone)
3 BY MR. LOUCAS:
4 Q. Doctor, do you have an opinion as to when
5 Sherry developed DIC?
6 MR. AUSTRIA: Objection.
7 THE WITNESS: It had to be some time
8 after delivery because there wasn't evidence of it at
9 the time of delivery through closure.
10 BY MR. LOUCAS:
11 Q. Would you expect the nurse at Euclid Meridia
12 to be aware of this patient's admitting diagnosis?
13 MS. DiSILVIO: Objection.
14 MR. AUCIELLO: Objection. It is way
15 beyond the scope of what this witness has been asked to
16 do, but go ahead.
17 THE WITNESS: What nurse?
18 BY MR. LOUCAS:
19 Q. The nurse -- the labor and delivery nurse.
20 MS. DiSILVIO: Objection.
21 THE COURT REPORTER: Who is that
22 objecting?
23 MS. DiSILVIO: DiSilvio.
24 MR. AUCIELLO: We thought you were
25 gone.

1 Q. Would you give me your opinion, please, on
2 Sherry's condition when she presented on September 16
3 to Euclid Meridia. Was she in fair, stable, or
4 critical condition?
5 MR. AUCIELLO: Objection. Go ahead.
6 THE WITNESS: She was a severe
7 preeclamptic, and with some respiratory distress, and
8 so that -- I have never designated patients critical or
9 in the terms that you have used. So you are adding
10 medical terms that I have never used.
11 BY MR. LOUCAS:
12 Q. What other terms would you use? I think we
13 talked about urgent or emergent. After her liver
14 enzymes came back, I take it your opinion, then, is
15 that she was -- needed to be urgently delivered?
16 A. Yes, they need to, you know, again
17 stabilize, plan her delivery, and get her delivered.
18 MR. LOUCAS: Anybody else have any
19 questions?
20 MS. DiSILVIO: No.
21 MR. LOUCAS: I will take a few
22 minutes to review my notes while you guys are asking
23 questions. If you don't, I just need a few minutes to
24 go over.
25 (Off the record at about 6:45 p.m.)

1 MS. DiSILVIO: Yeah, I faked you all
2 out. And now that I see George's questions, I can tell
3 he thought I was gone, too.
4 THE WITNESS: Yeah, I really don't
5 know because see, when, how, you know, you mean prior
6 to her coming in there, when she is there? The
7 question is too ambiguous.
8 BY MR. LOUCAS:
9 Q. Well, how about up until -- how about up
10 through the surgery, let's -- I want you to assume that
11 the labor and delivery nurse was actually the surgical
12 nurse as well involved in the surgery. Would you
13 expect her to be aware of the admitting diagnosis of
14 that patient?
15 A. The surgical nurse, maybe not.
16 MS. DiSILVIO: Objection to any
17 questions relative to the nurses, and the nurses'
18 standard of care is beyond this witness's expertise and
19 outside the four corners of his report.
20 MR. LOUCAS: And you are objecting
21 for whom, please, Marilena?
22 MS. DiSILVIO: I'm objecting for me
23 and for all the good defendants who believe in this.
24 BY MR. LOUCAS:
25 Q. Doctor, go ahead. You may answer.

1 MR. AUCIELLO: I'm also objecting in
2 the interest of truth and justice, but he can still
3 answer.
4 BY MR. LOUCAS:
5 Q. Go ahead, Doctor.
6 A. I would expect the labor and delivery nurse
7 to know that she had a patient with pregnancy-induced
8 hypertension.
9 Q. Doctor, do you believe that Dr. Bailin
10 delayed getting to the hospital?
11 MR. AUSTRIA: Objection.
12 THE WITNESS: Do I believe he
13 delayed?
14 BY MR. LOUCAS:
15 Q. Yes. That he was delayed in getting to the
16 hospital.
17 A. I don't know.
18 Q. In other words, do you believe that he
19 should have been there sooner?
20 A. Again, I don't know.
21 Q. What information would you need to be able
22 to arrive at an opinion?
23 A. Oh, I would -- number one, I didn't find any
24 breach of the standard of practice, and I thought that
25 everything that was done for this lady right up through

1 promptly.
2 Q. Did Sherry have a complicated pregnancy?
3 MS. DiSILVIO: Objection.
4 MR. AUCIELLO: Objection.
5 MR. AUSTRIA: Objection.
6 THE WITNESS: Yes.
7 BY MR. LOUCAS:
8 Q. Did she have any complications pre-delivery?
9 MS. DiSILVIO: Objection.
10 THE WITNESS: Again, I did not
11 review those records, you know, for the purpose of this
12 dep, but as I understand it, she had issues dealing
13 with, you know, blood pressure prior to admission to
14 the hospital. But I don't know the details of it.
15 BY MR. LOUCAS:
16 Q. Well, was her pregnancy complicated by
17 preeclampsia?
18 MS. DiSILVIO: Objection.
19 MR. AUSTRIA: Objection.
20 THE WITNESS: Again, I didn't review
21 it for that purpose, so I can't tell you.
22 BY MR. LOUCAS:
23 Q. Do you think this patient -- the staffing
24 and equipment at the Cleveland Clinic was superior to
25 the staffing and equipment offered at Euclid Meridia?

1 delivery, you know, met the standard of practice.
2 Q. What's your understanding as to when he was
3 first contacted?
4 MR. AUSTRIA: Objection.
5 THE WITNESS: As to what?
6 BY MR. LOUCAS:
7 Q. By the hospital or by anybody at the
8 hospital about Sherry presenting.
9 A. Yeah, what is your question?
10 Q. What's your understanding as to when he was
11 first contacted?
12 A. At 2355.
13 Q. What's your understanding as to when he
14 arrived?
15 A. Somewhere prior to 1:00.
16 Q. And within what time would you expect him to
17 be there, within what time with a severely preeclamptic
18 patient who needs to be delivered?
19 MR. AUSTRIA: Objection.
20 BY MR. LOUCAS:
21 Q. You may answer.
22 A. Again, depending upon where he was, what --
23 you know, at that time he might have been totally
24 undressed, I don't know. But I would expect that he
25 would make plans and proceed to the hospital, you know,

1 MS. DiSILVIO: Objection.
2 MR. AUCIELLO: Objection. George, I
3 have not provided him with any information comparing
4 the staffing and equipment between the two hospitals,
5 but you can answer if you can.
6 THE WITNESS: Well, I really can't.
7 I was offered the chair of reproductive endocrine there
8 in 1972 or '73, but I have been through the hospital,
9 and obviously the Cleveland Clinic is a well-known
10 national institute that is capable of doing many things
11 better than other hospitals throughout the world.
12 BY MR. LOUCAS:
13 Q. Do you still maintain any ties with the
14 Cleveland Clinic? Do you know anybody over there?
15 A. Oh, I did, you know, for a while. And I
16 still have occasional ties there.
17 Q. Who is it you know over there?
18 A. Oh, I can't recall at the present time.
19 Q. Have you ever testified as an expert on
20 behalf of the Cleveland Clinic?
21 A. Have I ever testified on behalf? I have one
22 case that I have, yeah, reviewed. I can't remember
23 whether I testified or not.
24 Q. Have you ever attended a lecture, seminar or
25 conference presented by the Cleveland Clinic?

Page 90

1 A. Have I, yes.
2 Q. When was the last time?
3 A. Oh, it's probably about eight, ten years
4 ago.
5 Q. And has anybody over at the Cleveland Clinic
6 ever presented testimony at your facility?
7 A. Testimony?
8 Q. I'm sorry, not testimony, forgive me, the
9 hour is late. A conference or a speaking.
10 A. Not in obstetrics or gynecology because they
11 are not known for obstetrics, but I am sure they have
12 done a great deal on, you know, renal diseases and
13 heart surgery.
14 Q. Would you agree with me it would be prudent
15 medical process to have offered Sherry every service
16 available at Euclid Meridia to increase the likelihood
17 of her surviving a complication of her pregnancy?
18 MR. AUCIELLO: Objection.
19 THE WITNESS: Again, it's an
20 ambiguous question, but the answer is yes.
21 MR. LOUCAS: I don't have any more
22 questions.
23 THE WITNESS: Thank you.
24 MR. AUCIELLO: Nobody else have
25 questions?

Page 91

1 All right. We will read it.
2 (The deposition was concluded at
3 6:51 p.m.)
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Page 92

1 I have reviewed the above transcript
2 and have listed corrections, if any, on the attached
3 errata sheet,
4
5 this ____ day of _____, 20 ____.
6
7
8
9
10 SIGNATURE OF THE WITNESS
11
12 SUBSCRIBED AND SWORN to before me this ____ day of
13 _____, 20 ____.
14
15
16
17 NOTARY PUBLIC
18 My Commission expires: _____.
19
20
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Page 93

1 CERTIFICATE OF NOTARY
2
3 STATE OF MICHIGAN)
4) SS
5 COUNTY OF ST. CLAIR)
6 I, Rhonda M. Foster, Certified Shorthand Reporter,
7 a Notary Public in and for the above county and state,
8 do hereby certify that the above deposition was taken
9 before me at the time and place hereinbefore set forth;
10 that the witness was by me first duly sworn to testify
11 to the truth, and nothing but the truth, that the
12 foregoing questions asked and answers made by the
13 witness were duly recorded by me stenographically and
14 reduced to computer transcription; that this is a true,
15 full and correct transcript of my stenographic notes so
16 taken; and that I am not related to, nor of counsel to
17 either party nor interested in the event of this cause.
18
19
20
21 Rhonda M. Foster, CSR
22 Notary Public,
23 St. Clair County, Michigan
24
25 My Commission expires: March 11, 2008

1 INDEX TO EXAMINATIONS

2 Witness Page

3 WILLIAM S. FLOYD, M.D.

4

5 EXAMINATION BY MR. LOUCAS: 5

6

7

8

9 INDEX TO EXHIBITS

10

11 Exhibit Page

12 (Exhibits attached to transcript)

13

14

15 DEPOSITION EXHIBITS 1 - 4 5

16

17

18

19

20

21

22

23

24

25

May 2, 2005

A	61:14 66:4	57:13,16	7:11,12	54:14 55:19
ability 79:11	66:16 73:2	58:10,16,22	appreciate	61:13 69:9
able 15:7	78:23 83:13	60:1 63:17	22:23	70:15,18
75:14 86:21	84:8	63:19 69:10	appreciated	85:10
above 92:1	afterwards	69:15 70:11	76:19	assumed 79:22
93:7,8	43:19	70:16,24	appropriately	assuming 46:22
abruptio 44:25	again 36:21	71:5 77:11	63:14	55:6 58:21
45:3 56:18	48:5 57:1	77:15,18,19	Approximately	59:12,19
abruption 45:3	75:17 77:21	77:23 78:1,4	44:21	70:2,22 71:2
45:9 56:21	79:12 83:16	78:12	Apresoline	assumption
absence 40:3	86:20 87:22	anesthesiol...	66:10,12,13	43:7
accomplish	88:10,20	70:1	area 78:19	attached 92:2
40:23	90:19	anesthetic	around 32:9	94:12
accurate 23:10	ago 12:20 30:9	51:14 58:15	44:21	attended 89:24
act 37:21	49:7 90:4	another 25:12	arrival 44:4	attending 40:6
acting 36:9,13	agree 15:15	answer 6:3	50:11	46:14 48:19
36:19	36:7 41:14	38:21 39:15	arrive 15:13	attention
actions 21:7	51:3,8 55:14	39:23 40:12	15:18 21:25	55:17
42:9 67:20	58:1,9 69:13	40:17 42:4	50:6 81:24	Auciello 3:2
79:13	69:20 70:1	44:3 45:14	86:22	6:12 10:10
actually 17:11	70:23 72:11	58:4 60:6	arrived 37:8	22:6,24
28:22 29:1	76:18 77:16	63:13 70:25	37:12 45:2	25:23 27:17
38:13 85:11	82:1,5,21,23	75:12,14	49:24 72:22	29:19 30:20
acute 41:24	90:14	76:10,13	87:14	32:24 33:8
acutely 55:17	agreed 32:10	77:14 78:2,3	arrives 75:21	33:11 38:8
add 52:15	agreeing 69:14	78:5,14 80:1	arriving 15:2	38:18 43:13
adding 83:9	ahead 7:4 8:11	80:20 85:25	Arter 30:4,5,5	48:4 49:14
addition 24:9	11:4 35:6	86:3 87:21	30:7,18	55:18 60:5
additional	47:22 78:3	89:5 90:20	artery 67:8	63:22 65:13
16:10	80:11,17,20	answered 27:18	articles 8:2	65:19 68:4
adequate 77:22	83:5 84:16	77:5	8:10	68:20 69:22
77:23 78:6	85:25 86:5	answers 49:20	asked 6:4 21:4	70:6 71:19
79:11	al 1:12	63:10 64:8	21:5 24:9	72:14 74:21
adjective	Albuminuria	93:12	42:7 43:8,19	76:22 77:5
82:25	14:8 81:12	anticipation	63:21,25	80:13 81:2,5
adjunct 17:9	81:13	20:16 77:18	84:15 93:12	83:5 84:14
administered	Albuquerque	antihyperte...	asking 5:19	84:24 86:1
72:21 76:15	28:15	73:2 75:20	29:16 79:19	88:4 89:2
administration	almost 59:1	76:15	83:22	90:18,24
75:20	81:21	antihyperte...	aspect 50:13	August 16:14
administrative	along 21:10,11	66:9 72:22	assess 63:19	AUSTRIA 4:12
8:22	already 16:4	anybody 19:24	78:7	65:10 67:23
Administrator	33:15 57:9	30:24 60:11	assessed 46:8	68:6,9 72:13
1:6	always 11:17	83:18 87:7	assessing 63:2	77:4 80:3,18
admission	36:22 51:20	89:14 90:5	assessment	84:6 86:11
14:16 88:13	62:15 66:11	anymore 76:1	44:15,19	87:4,19 88:5
admitted 37:11	ambiguous	anyone 68:5	47:23 64:5	88:19
37:13	36:22 77:21	anything 12:8	assigned 9:23	authoring
admitting	85:7 90:20	20:12 24:1,5	assist 40:2,6	24:10
84:12 85:13	ambulance 73:8	24:9 31:7	67:7 71:10	available
afford 77:19	American 6:20	36:23 42:15	assistance	11:17 15:10
78:11	amount 57:12	53:22 59:15	76:20	22:17,22
afforded 77:10	57:16,20	anywhere 26:15	assistant	40:7 55:3
after 10:15	64:5 68:14	appearance	48:20	90:16
12:2 14:10	amounts 61:23	79:7	assisted 67:21	Avenue 3:5,16
19:23 22:17	and/or 14:9	APPEARANCES	assists 67:4,5	4:6,16
23:13 24:13	81:12	2:1 3:1 4:1	associate 17:9	average 54:18
24:15 42:12	anesthesia	Appearing 2:18	associates	69:6 82:9,12
42:13,20	57:8 59:9	3:8,19 4:9	8:19	awards 7:14,15
43:21 54:9	anesthesiol...	4:19	assume 6:3	aware 34:9,17
54:10,15	48:17 57:5	appointments	36:17 43:4	43:23 44:1

William S. Floyd, M.D.
May 2, 2005

51:1 54:25	Becker 2:2,4	59:9	43:1,24 44:1	changed 19:10
55:2,10	become 72:8	boarded 36:12	59:25 67:22	26:6 64:23
58:16,17,23	becomes 67:1	boards 7:16,16	72:12,16	changes 25:20
59:12,22	before 1:25	19:23,25	78:16,18,25	Charles 4:19
66:10 69:8	5:17 23:15	Bob 28:19 68:5	80:2 85:18	chart 11:22
70:3,16,19	24:6 25:20	68:7	career 12:17	12:3 15:5
71:24 74:14	37:7 44:6	book 30:11	carrels 19:3	55:12 57:13
75:2,19 76:6	51:13 59:2	booklet 21:5	case 5:21	65:24 66:1
76:7,25	59:14 71:7	both 10:10	14:15 21:1	73:14
84:12 85:13	72:22 76:2	17:18 18:2	22:4 23:6	check 64:3
away 71:21	92:12 93:9	36:12 46:12	25:18 28:4	CHF 53:5
a.m 43:11	Beggio 33:2	47:23	28:23,25	child 82:22
59:21	beginning 9:24	brain 38:10	29:5,7,9,19	choice 26:11
	begun 57:11	breach 86:24	29:19,23	39:1
B	behalf 2:18	breath 56:25	30:19 32:6	chooses 38:24
baby 35:22,23	3:8,19 4:9	57:4	34:18,24	CHRISTINE 4:2
36:6 43:2	4:19 27:8	breathing 46:9	35:18 36:13	chronic 8:8
44:8 46:12	89:20,21	briefly 5:13	48:24 49:3,4	14:4 15:16
47:19,19,22	behind 28:17	bring 22:3	49:9,12 52:4	16:7,12,15
47:24 50:14	38:11	36:8,18	53:8 54:6	circumstance
74:6	being 22:12	brought 22:5	56:14 57:6	66:22 75:24
back 17:1	26:25	60:21,23	59:19,21	76:12 80:7
26:20 38:11	believe 5:14	61:3 73:5,7	62:16 69:10	circumstances
44:4 45:8,14	21:6 28:13	Building 2:15	70:19 77:12	75:5 80:5,10
50:4 61:15	29:21 32:8	3:4,15 4:5	77:20 78:13	Clair 93:5,23
62:21 64:2	33:7 42:7	4:15	80:8 81:23	clear 51:1
83:14	59:20 61:7	Bulkley 3:4	89:22	57:17 69:18
bad 13:11	66:14 76:20		cases 8:17,17	Cleveland 2:8
Bailin 4:20	78:15 79:2	C	26:3,10,14	2:16 3:6,17
15:15 21:19	85:23 86:9	calculated	26:16,23,25	4:7,17 30:1
33:18,20	86:12,18	12:20	27:2,5,8,11	30:14 88:24
35:6 37:3,7	below 75:4	California	29:1,13,15	89:9,14,20
37:12,14,23	beneficial	20:5,10,14	29:18 30:17	89:25 90:5
38:23 42:14	66:22 77:9	20:17,21	Cass 7:6	client 80:17
43:1 50:11	Beregovskaya	28:13,18	cause 93:17	Clinic 88:24
50:18,21	3:21	call 10:15,21	caused 42:6	89:9,14,20
55:15,20	best 53:2	13:7 19:12	cc's 54:18	89:25 90:5
66:10,13	76:13	38:24 54:20	68:15 69:2,5	clinical 17:10
72:22 77:1	better 29:16	called 37:5	69:6	17:16 62:24
86:9	68:4 78:6	39:8,11,16	central 53:7	63:1,17 64:5
Bailin's 37:24	89:11	40:6,19 57:5	66:18 67:9	80:6
bank 60:19	between 9:15	60:19 71:9	68:11 69:11	clinically
based 39:17	60:15 77:1	71:25	70:4,11,21	53:6,10,11
41:3,25	89:4	came 22:14	certain 19:22	62:20
59:11 78:9	beyond 80:7	35:1 40:1	certainly	close 69:5
basically	84:15 85:18	45:8 50:4	54:16 70:12	closed 19:11
37:21 39:24	Big 1:20	61:15 83:14	78:6	closure 84:9
51:9 58:13	biochemistry	cancer 7:25	CERTIFICATE	Co 2:4
62:13 76:1	7:7	18:21	93:1	College 6:20
basing 43:7	biophysical	capable 89:10	certification	Columbus 29:22
basis 20:2	30:12	capsule 57:2	19:25	come 9:23
56:18 57:22	biophysics 7:7	cardiac 51:12	Certified 8:18	17:17 23:13
59:18 80:25	bladder 9:2	cardiologist	93:6	46:8 49:1
bear 36:8,19	bleeding 54:4	71:25	certify 93:8	coming 27:2
81:21	54:5,8,11,16	cardiovascular	cervix 35:3,14	51:20 85:6
beat 27:3	54:19 56:20	47:23	cesarean 54:18	comma 24:19
Beaumont 17:8	62:7,10,16	care 9:18	62:16 69:7	Commencing
18:1 38:1	62:17,19	14:21,22	cesarian 34:25	1:23
Beaver 1:20	63:6 67:2,4	15:16 37:11	62:18	Commission
became 20:13	72:9	37:13,25	chair 28:20	92:18 93:25
28:20	board 8:18	42:12,13,24	89:7	committees

William S. Floyd, M.D.

May 2, 2005

7:16,17 8:23	consist 7:1	31:21	deck 48:15,16	72:6
COMMON 1:1	consistent	court 1:1 6:8	48:22	dep 50:21 76:4
communicate	46:17 52:20	27:23 45:13	deduce 47:11	88:12
55:15,24	consult 40:2,7	71:16 74:20	deduce 61:17	department
56:6	57:17 71:25	84:21	61:18	19:12
communication	76:21	cover 8:15	Defendant 3:8	depending
11:21 12:9	consultant	coverage 8:20	4:9,19	60:13 80:4
58:2	39:1,8	10:3,19	defendants	87:22
compare 33:6	consulted	Cox 29:2,2	1:13 3:19	depends 53:23
comparing 89:3	30:13 39:19	31:10	28:3 85:23	72:16
competency	consulting	Coyne 1:10	defense 29:24	deposition
72:16	30:16 34:18	Co-counsel	define 14:7	1:18 5:5,17
Complaint 21:7	contact 21:2	2:10	47:16 52:6	22:12,13,18
21:9,12	28:15 77:17	crisis 26:13	65:7 78:20	25:15 31:1,2
23:21,22,24	contacted 21:1	26:21 27:4	defined 13:10	31:12 33:9
complete 69:19	87:3,11	27:10	47:4 48:3	34:2 43:9
completed	contemplated	criteria 16:7	definition	50:19,25
44:19	60:12	critical 83:4	14:10 49:1	59:17 71:3
completely	context 74:18	83:8	81:9	91:2 93:8
80:16	75:11,25	cross 60:13,17	delay 41:22	94:15
complicated	76:11	61:7,9,16	delayed 86:10	depositions
52:4 88:2,16	continue 11:11	62:5	86:13,15	21:20,22
complication	11:12 19:9	crucial 58:12	delaying 41:14	23:13 33:15
11:2,14	Continued 3:1	58:13	42:1	deps 21:18,18
41:12,19	4:1	CSR 93:21	deliver 9:22	described
51:22 52:3	continuously	CSR-3612 1:25	9:23 13:3	45:18 50:17
62:7 90:17	46:12	cure 35:24	41:3 44:8	designated
complications	control 51:10	cutting 68:20	delivered	83:8
8:7 51:7	controlled	CUYAHOGA 1:2	12:12,23	despite 38:4
54:16 88:8	74:3,4	CV1:9 6:10,23	35:22 50:15	details 88:14
comprised 9:11	conversation	17:1,10 20:3	53:13 73:25	determined
compromise	50:23	C's 9:5	83:15,17	35:6
74:6	convert 64:13	C-section	87:18	determines
computer 93:14	conveyed 50:10	34:24 58:11	deliveries	37:4
computer-based	60:1	60:3 77:18	9:15 10:14	Detroit 7:7
23:6	copies 22:16		12:21	develop 14:7,8
concern 62:11	copy 6:10	D	delivering	developed 19:3
concerned	11:22 21:6	D 9:5	74:1	84:5
45:22 46:15	25:2,24,24	dark 45:18	delivery 9:19	developing
61:22	25:24	date 22:12	10:18,22	41:15 42:3
concluded	corner 21:22	32:7	14:17 35:15	develops 11:3
44:16,19	corners 85:19	DAVID 3:12	35:20,25	devices 30:11
91:2	correct 14:24	day 8:16 9:18	40:23 42:10	diabetes 11:3
conclusion	15:11 20:4	10:1,2 20:16	42:12,13,20	11:3
45:2	23:24 33:18	92:5,12	42:21 43:2	diabetics
condition	34:1,21,22	days 8:14,24	44:2 46:3	10:25
41:11 83:2,4	52:22 59:3,7	deafened 68:3	47:14,15,17	diagnose 56:18
conditions	59:13 60:22	deal 7:25 8:2	47:18 51:6	81:1
40:19	61:3 67:18	90:12	52:2 54:8,9	diagnosed 79:5
conference	67:19 93:15	dealing 8:10	54:10 55:23	diagnosis
89:25 90:9	corrections	19:6 22:10	56:8,23 67:1	14:12 41:14
confused 25:9	92:2	22:11 42:8	71:10 72:1	41:22 42:2
confusion	correctly 38:4	71:6 76:1	73:3,11	44:20,22,24
49:20	correspondence	80:5 88:12	75:10 81:24	45:4,6,7,9
congestive	22:3	deals 7:5	82:22,24	46:19 49:24
52:18 72:7	counsel 93:16	dealt 30:10	83:17 84:8,9	50:1,4,7
consider 72:20	county 1:2	death 42:6	84:19 85:11	55:11 56:7
considered	93:5,7,23	decels 35:14	86:6 87:1	56:21 60:3
26:13 82:3	couple 29:18	decided 20:19	demonstrate	62:1 84:12
considering	35:14	decision 37:23	73:13	85:13
63:11	course 12:17	38:24	demonstrating	diastolic 74:8

William S. Floyd, M.D.
May 2, 2005

76:7	65:23 70:15	60:12 93:17	established	64:20 67:12
diastolics	75:16 79:15	EKG 46:10	52:24	81:23
81:11	80:20 81:10	52:17 53:12	establishing	EXAMINATION
DIC 8:5, 6	81:21 82:21	elevate 16:14	52:8, 21	5:11 94:5
13:17 29:8	84:4 85:25	elevated 13:9	Estate 1:7	EXAMINATIONS
51:25 53:4	86:5, 9	46:16 61:16	estimate 68:24	94:1
84:5	document 12:9	61:20 62:1, 2	estimated	examined 5:9
dictate 24:23	23:19	66:12 79:5	68:18	example 69:18
dictated 24:22	dog 21:21	82:3	estimation	exceed 81:11
54:17	doing 9:15	elevating	62:24 63:18	Except 23:21
didactic 17:14	15:13 26:12	53:18	et 1:12	Excuse 45:12
17:19 18:12	53:9, 23	Ellis 30:6	etcetera 15:9	63:25
difference	57:24 80:15	else's 68:5	Euclid 3:5	Exhibit 22:2
60:15 82:14	89:10	emergency 40:1	4:10, 16	32:14 94:11
different	dollars 20:15	40:23	14:24 15:5	Exhibits 5:5
44:11 64:18	20:15	emergent 47:15	37:16 44:5	94:9, 12, 15
64:18 68:15	done 12:21	47:15, 16, 18	44:12 83:3	exist 19:6, 9
72:18 79:23	18:12 26:10	47:25 48:3, 4	84:11 88:25	21:15 22:9
82:14	26:14 34:25	48:8, 11	90:16	exists 8:12
differential	35:9, 11	83:13	evacuation	expect 37:10
44:24 45:5	37:24 46:6	Emma 2:14	51:5	53:24 57:20
50:2	54:15 70:25	end 9:13, 24	evaluate 37:22	58:5 59:25
difficult 19:4	81:21 86:25	12:8 14:17	59:15	79:16 84:11
dilution 52:16	90:12	24:12 27:21	even 19:8 26:9	85:13 86:6
dip 81:15, 19	door 38:5	60:24	27:14, 15	87:16, 24
disagree 69:13	down 19:12	ended 43:1	44:6 72:8	expectancy
71:1, 4	46:8 64:11	endocrine 89:7	evening 5:12	35:15
disagreeing	73:6, 7	endocrinology	15:10 38:7	experience
69:15	draft 25:21	8:1	event 93:17	39:10, 18
disagreements	draw 18:4	endometriosis	events 41:24	41:4, 25 42:1
76:25	drop 53:25	18:20	64:24 66:3	55:21 71:13
disappoint	dropping 54:1	ends 6:19	eventually	71:23 72:17
74:11	Drs 33:18 77:1	enough 6:5	46:3 47:4	75:15 78:9
discussed	dues 20:7, 18	20:20 23:18	50:6 62:3	expert 5:20
50:13	duly 5:9 93:10	77:19	ever 10:21	76:3, 3 89:19
discussion	93:13	entire 14:18	12:12 13:12	expertise
35:5	during 8:7	21:14	13:15, 20	85:18
diseases 90:12	14:6 26:24	entries 68:16	18:19 29:7	experts 28:6
DiSILVIO 3:11	27:4, 10, 12	entry 6:20	29:13 31:23	80:17
39:13, 21	65:25 77:1	51:23	40:5, 20	expires 92:18
40:10, 15, 21		enzymes 13:9	61:10 66:18	93:25
41:5 65:9	<hr/>	45:8 50:4	71:9, 14, 25	explain 52:7
81:4, 7 83:20	E 2:12	61:15, 16, 21	72:20 89:19	extent 81:13
84:13, 20, 23	each 8:19	62:1, 3 79:6	89:21, 24	extra 48:20
84:23 85:1	ear 21:21	83:14	90:6	extraneous
85:16, 22	early 82:18	epigastric	every 10:6	80:16
88:3, 9, 18	edema 14:9	56:13, 15	19:24 22:13	e-mail 23:4
89:1	81:12	57:3	58:3 63:15	
distorting	education 7:6	equipment 55:2	72:17 90:15	<hr/>
63:10	78:10	79:3 88:24	everything	F 2:2
distress 35:9	effect 73:21	88:25 89:4	23:8, 20 71:2	facility 44:11
35:13 51:18	effects 35:24	ERNEST 3:2	75:25 86:25	54:23 90:6
83:7	36:1	Ernie 38:18, 19	evidence 35:13	fact 34:17
divide 9:12	effort 75:22	errata 92:3	65:24 66:15	38:4 55:21
doctor 5:12	77:19 80:25	eschew 63:13	84:8	58:17, 21
19:15 23:4	eight 90:3	eschewing 63:9	evidently 6:23	59:22 70:20
26:2 36:7, 20	eighth 7:17	essentially	exacerbation	factor 58:14
37:17 38:21	either 7:25	8:2 13:8	14:7	58:15
39:2, 15, 23	8:3 14:5, 21	14:3 36:3	exact 43:22	facts 64:13, 18
40:12 41:8	26:11 34:12	Essyk 33:2	57:7	77:20
56:14 64:15	56:22 57:21	establish 52:1	exactly 15:8	failure 47:8

William S. Floyd, M.D.
May 2, 2005

47:12 52:19	82:19 87:3	further 70:18	gone 66:3	90:13
72:6,7	87:11 93:10		84:25 85:3	hell 74:11
failures 47:9	five 9:14	<hr/> G <hr/>	good 5:12	Hello 65:9,10
47:9	18:10 20:7	Gallagher 3:3	64:12 85:23	65:15,16
fair 6:4 16:22	Flamm 34:5,9	garbled 64:8	gotten 64:8	HELLP 8:3
18:11 23:17	34:10,11	gasses 46:10	grant 7:17	12:24 13:7
36:17 37:15	Flamm's 34:2	53:12	26:12	13:10,15,17
38:11 47:25	floor 3:4	gave 6:15	grants 7:17	13:23 29:8
48:11 56:1,3	40:25 43:5	72:25 78:2	great 90:12	41:10,16,19
56:4 83:3	60:22,23	general 9:8	greater 47:3	41:23 42:3
faked 85:1	61:3	George 2:12	51:6 52:1,8	44:24 45:2,8
fall 16:16	Florida 20:23	5:12 22:24	81:14	47:4,13
falling 53:20	flow 15:4,23	25:23 38:8	greatest 75:15	49:25 50:3,7
54:2 64:2	Floyd 1:19 5:8	49:14 63:22	Gregory 3:20	51:25 53:3
familiar 30:6	24:19 94:3	65:19 89:2	Groethe 2:14	62:1,2,12,15
far 8:20 67:2	fluid 52:15,23	George's 85:2	group 1:11	71:11 82:22
February 31:10	52:24 67:6	gestational	3:20 9:14	82:24
federal 27:23	67:11	11:3	11:25	help 66:19
feel 77:21	fluids 51:12	getting 17:13	guess 6:15	73:18 78:12
Fellow 6:20	51:19 52:1	20:20 46:25	17:13 32:6	helps 66:24
felt 35:14	53:1 64:4	47:7 50:14	guys 83:22	67:10
70:11 78:4	Foley 45:17	53:13 72:9	gynecology	hematologist
fetal 10:22,23	following 43:1	73:24 86:10	6:21 7:23	72:8
11:4,15,25	66:25	86:15	9:13 18:21	hemoconcent...
35:9,13,17	follows 5:10	give 8:12	90:10	52:14 53:4
36:12 37:18	foregoing	17:25 22:25		hereinbefore
38:5 46:9	93:12	31:7 51:10	<hr/> H <hr/>	93:9
51:14,16,18	forgive 90:8	52:12,13	Haddon 30:5,6	high 7:6 10:17
71:14,24	form 12:6	73:1 74:10	30:7,18	10:22 12:9
fetus 36:2	67:15	75:14 83:1	half 38:10	58:14
few 83:21,23	formerly 30:5	given 46:13	hand 24:7	higher 82:5
field 7:22	forth 93:9	77:25	48:20	him 25:23
fifth 7:13	Foster 1:25	gives 57:2,3	hands 48:15,16	28:11,16
file 21:14	93:6,21	giving 53:24	48:22	50:12 55:21
23:6 25:14	found 6:12	go 7:2,4,8	hands-on 43:24	58:24 59:20
filed 26:25	four 8:18	8:11 10:12	44:1	71:1 87:16
27:2	12:19 18:10	11:3 35:6	Hanna 4:15	89:3
fill 8:23	20:7 66:10	53:4 64:1	happened 40:24	history 16:10
final 25:20	85:19	78:3 80:10	67:13,18	Hon 1:10
find 19:13	fourth 7:9,12	80:17,20	happening 78:7	honors 7:14,14
39:5 75:12	Francisco	83:5,24	79:9	hospital 4:10
86:23	28:21	84:16 85:25	happens 10:17	7:11 8:15,20
findings 37:23	Friday 8:17,24	86:5	37:5	10:3,8,12,18
50:12,18	9:4	goes 26:20	happy 6:2	11:12 14:16
56:6	from 9:18,24	37:25 62:21	hard 9:12 26:8	14:24 15:5
fine 56:21	13:17,23	79:12	69:14	17:7,8 18:1
finish 10:14	14:24 16:24	going 5:19,21	Harper 19:11	18:2 19:11
44:17 68:2	18:2,18 22:6	6:3,9 9:5	having 5:9	27:9 37:16
75:1	23:17 26:15	14:16 17:1	40:5 48:23	38:1 39:8,10
finished 79:8	28:20 34:12	20:20,22	71:25	39:18 50:11
firm 29:2,22	36:1 43:8	32:14 37:4	hear 6:1 27:16	51:2,21
30:4,21,23	61:17 71:21	37:24 38:9	27:17,21	60:14 75:21
30:24	76:14 79:7	42:5,7,8	41:8 49:6,16	78:8 86:10
firms 30:3,17	front 15:23	47:7,8 53:6	71:17 81:6	86:16 87:7,8
first 5:9 6:9	21:14 25:3	53:7,25	heard 48:22	87:25 88:14
6:23 7:5,8	25:12 55:12	58:24 60:3	49:9,11	89:8
16:11 19:8	fulfills 16:7	66:25 72:18	heart 35:17	hospitalized
20:25 21:2	full 8:14	74:10,11	47:18 51:14	80:22
32:9 42:17	47:23 93:15	75:12,16	51:16 52:18	hospitals 17:6
44:5 57:9	fully 6:4	76:13 80:13	56:20 62:22	89:4,11
67:24 73:9	Fulton 3:3	81:23	67:10 72:7	hour 42:19

William S. Floyd, M.D.
May 2, 2005

43:14,19,21	include 50:3	interested	KARL 1:4	22:11,14
55:7 90:9	increase 26:24	43:5 93:17	keep 49:19	24:21 25:2
house 12:1	41:23 69:3	internal 69:11	75:22	33:19
36:13,14,14	90:16	international	Kevin 29:2	letters 22:5,9
36:16,19	increased 14:8	7:16	kidneys 47:12	22:17
37:10,21	27:11 66:11	intervals	kinds 13:6	let's 15:25
38:2,6	increases	19:22	knew 50:22	64:18 85:10
huge 27:2	41:15 42:2	intervention	59:16	licensed 20:5
Hughes 33:2	increasing	47:10	knock 74:5	20:6,9,13,14
huh 28:18	53:21	intraoperative	knowledge 36:8	licensure 7:14
hundred 9:16	INDEX 94:1,9	68:14	36:18,22	life 47:20
82:11	indicated	intraoperat...	38:22,23,25	51:23 52:12
hypertension	50:21 77:12	70:22	known 69:12	lifetime 19:20
8:8,9 14:4,5	indicates	intrauterine	90:11	19:25
14:9 16:6,7	75:20	30:10	Krause 3:12	like 8:13
16:13,15,18	indicating	introduced	5:4 84:2	20:16 24:20
16:19 35:2	76:7	5:13		25:1 38:10
35:23,25	individual	involve 29:4	L	48:11,18
40:14 41:20	13:8 14:4	involved 17:14	L 4:12	49:4 51:4
44:23 45:7	35:12 37:4	42:12,23	labor 84:19	59:16 74:8
50:2 80:23	43:4,6 46:1	55:6 85:12	85:11 86:6	74:25 78:24
86:8	69:2,3 72:5	involving 29:7	laboratory	82:2
hypertensions	Individually	80:14	15:9	likelihood
18:20	1:5	issue 15:19	labs 46:11	47:11 51:6
hypertensive	inducer 35:15	72:20 79:12	lady 86:25	90:16
15:17,23	infertility	80:16	laparoscopies	likely 44:16
16:12,25	8:1	issues 29:4,4	9:6	44:20 55:16
36:4 76:3	influx 27:2	88:12	laparoscopy	line 51:23
hypovolemia	information	IUDs 30:12	9:3	52:12,24,25
64:15 65:7,8	50:10 58:10	IV 46:10 51:11	large 11:25	66:18,19
65:24 66:3	59:12 61:17	51:19,23	last 6:20 8:21	68:11 69:12
66:15	69:21 86:21	52:1,8,15,23	12:15 13:3,5	69:16 70:5
hypovolemic	89:3	52:24,25	18:9,11	70:12,21
72:8	Inglis 21:19	66:12,13	19:17,18	lines 53:7
hypoxia 36:5	23:14 33:18	IVs 51:20 52:5	26:17 28:1	Lisa 33:2
hysterectomies	33:25		28:22 30:25	list 23:23
9:2	Inglis's 33:9	J	31:8,15,17	32:20 33:1
	initial 59:2	J 1:10	45:14 90:2	listed 24:2
I	initials 24:12	Jaffee 28:20	late 90:9	32:14 33:17
idea 34:20	24:15 25:4	jeopardized	late 7:25	58:14 59:8
44:10	25:10,13	47:20	law 29:2,22	92:2
IDENTIFICATION	initiated	Joshua 44:8	30:3	listing 22:14
5:7	46:11	judged 37:16	lay 64:13	32:18,20
identified	institute	June 32:9	least 9:16	lists 23:19
32:11	89:10	just 7:2 15:9	29:18 59:1	literature
identify 39:25	instructed	18:18 20:9	66:6	41:21 74:14
idiot 55:20	24:24	21:2 23:15	leave 38:5	75:2,19 76:7
ID'd 59:1,7	instruction	26:25 33:6	lecture 18:12	little 46:17
II 1:4	17:20	38:9 43:8	89:24	46:21,22
ill 55:17	insurance	45:18 46:19	lectured 18:19	live 10:8
76:19	26:22	47:22 48:8	lecturer 28:13	liver 47:9,12
immediate	intensive	48:23 60:17	lectures 17:21	57:2 61:16
55:17	78:16,18	61:7 63:5,8	17:25 18:17	61:20 62:3
importance	intensivist	65:8 69:6	18:23 19:5	79:5 83:13
52:1,7	71:14,24	75:6,8 78:2	left 28:17	long 6:19
important 51:9	intensivists	78:4 79:5	less 82:15	19:16,18
52:5 53:9	72:2	80:15 83:23	let 6:1 7:2	26:2 32:20
58:2 74:13	intentionally	justice 86:2	26:7 56:10	51:14,16
inartful 69:18	63:10	K	63:8 69:6	look 15:22
incision 59:2	interest 7:22	Karasik 3:20	82:13	24:12 42:14
59:14 71:7	34:14 86:2		letter 22:1,10	42:18 43:20

William S. Floyd, M.D.

May 2, 2005

62:23 63:1,6	64:11,14	14:1 22:5	milligrams	M.D1:19 3:9
64:2 66:4	67:10 69:17	35:4 38:11	81:20	3:20 4:20
67:18 73:10	82:12,14	46:1 48:4,16	mine 25:16	5:8 24:19
looked 42:25	87:25	74:17 75:10	minor 8:17 9:4	94:3
43:10,23	making 38:9	78:24 85:5	minutes 58:25	
looking 20:3	malpractice	meaning 14:5	59:2,14 71:7	N
20:10 43:3	26:13,21	58:10	77:11,22	name 5:12
53:15 65:6	27:4,10	means 14:3	78:1,7,12	24:15 25:10
looks 24:19	manage 11:1,8	51:22 56:22	83:22,23	25:13 28:7
lose 65:10	11:12	60:18 65:8	Mishkind 2:4	national 7:15
loss 54:6,17	managed 14:18	meant 49:8	MIT 7:7	89:10
61:19,22	46:2,5 72:3	measure 62:23	modification	nationwide
62:25 63:3,7	management	measuring 67:8	13:7	76:4
63:17,20,21	77:2	Med 28:21	moment 47:20	nature 49:15
64:1,6 65:2	manages 10:20	medical 1:11	81:21	Nebraska 28:14
65:5 66:3	managing 72:17	3:20 14:24	Monday 1:24	necessarily
68:14 69:7	mandatory 53:8	16:14 64:12	5:2 8:15	39:24
lost 13:12,15	many 12:17	64:12 67:21	monitor 46:9	necessary 6:2
13:17,20	13:1 26:5,14	68:16 74:14	52:23,24,25	47:11 78:16
lot 12:18	30:20 31:18	75:2,19	53:2,6,10,11	need 15:20
18:18 75:11	32:1 89:10	77:17,25	62:19 63:21	23:2 46:4
loud 68:2	March 93:25	78:11 83:10	63:25 64:15	51:19 52:5,8
low 13:9 62:3	Marilena 3:11	90:15	65:5 66:19	55:23 56:8
62:11 65:8	85:21	medication	70:5,22 79:4	57:22 63:1
79:6	mark 21:21	75:21 76:16	monitored	70:11 73:1
Lucille 3:8	marked 5:6 6:7	medications	46:12 63:14	74:21 81:22
L.L.C1:12	22:1	52:13	65:1 78:23	83:16,23
L.P.A2:4	match 60:13,17	medicine 10:23	monitoring	86:21
M	material 32:13	11:15,25	35:18 52:21	needed 55:17
M1:25 4:20	materials 21:5	17:22 36:12	53:14 67:4	58:4 76:20
24:14,14,16	21:17 22:14	38:5	67:22	78:5 83:15
24:16,23,24	Maternal 10:21	med/surg 78:24	more 7:25 9:13	needs 46:2
25:1,1 28:20	10:23 11:4	meeting 5:15	11:25 26:25	55:23 87:18
93:6,21	11:14,24	members 30:21	31:8 52:4,7	never 20:17
made 34:17	36:12 37:17	mentioned 32:8	77:11 78:1,5	60:21 61:2
44:15 45:5	38:5 71:14	Meridia 1:11	78:12 90:21	83:8,10
50:1 55:11	71:24	3:19 4:9	morning 10:13	next 31:11
56:22 59:2	matter 8:3	14:24 15:5	10:15 59:5	32:4
59:15 62:1	18:16	37:16 44:12	Moscarino 4:14	night 10:1
63:18 66:1	may 1:24 5:2	83:3 84:11	most 7:24	nine 82:17
70:3,19	19:2 26:14	88:25 90:16	10:23 12:1	Nobody 90:24
93:12	30:22 31:3,9	Meridian 44:5	22:8 26:16	noise 68:2
mag 46:11,13	38:2,21 39:8	meritorious	41:23 51:9	none 26:11
51:10 52:12	39:15,23	46:7	53:8 66:24	non-pregnant
53:24 72:25	40:12,17	met 28:11 87:1	72:2	69:1
73:5,14,21	41:14 53:24	MICHAEL 2:2	Mostly 9:2	non-reassuring
magnesium	53:25 54:5	Michigan 1:22	mother 36:3	51:15
73:16	55:14 75:14	5:1 17:8	47:24	normal 16:1,11
mail 24:24	80:20 82:21	18:3 20:14	mother's 47:19	52:10 66:5
maintain 89:13	85:25 87:21	26:13 27:1	move 20:16,20	normally 82:6
maintained	maybe 20:16	28:12 29:3	20:23 23:17	Norman 3:3
63:16 74:15	31:20 69:17	93:3,23	47:22	Notary 92:17
75:3 76:8	85:15	Midland 3:15	moved 19:11	93:1,7,22
major 8:16,25	McELFISH 1:4,7	4:5	moving 44:4	note 58:25
make 5:25	14:11 36:20	midwife 39:11	59:8 73:24	notes 21:21
15:19,20	51:4 61:22	40:6,20 41:2	much 11:1	83:22 93:15
22:16,17	74:25 77:10	midwives 39:3	48:14 50:23	nothing 46:1
25:20 38:11	82:3	39:6,7,18,19	57:23 62:24	79:8 93:11
45:7,9 50:4	McElfish's	39:25	82:11	notification
56:9 61:21	42:6	might 49:18	multi-organ	11:24 12:5
	mean 11:21	87:23	47:8,12 72:6	notified 11:15

William S. Floyd, M.D.

May 2, 2005

11:18,19	24:24 89:9	89:21	19:13 20:11	particular
46:14	occasional	ones 22:24	22:8 24:24	16:25 73:23
number 8:22	89:16	one-on-one	28:13,19	particularly
22:2 26:23	occasions 39:5	79:10	47:22 54:4	51:21
30:9 32:14	occur 8:7 10:5	only 6:22 12:4	68:20 74:5	partner 12:19
86:23	54:6,7,9,11	17:6,7 21:18	74:11,17	partners 8:18
numbers 74:8	54:12,19	22:1 25:17	75:11,25	party 93:17
74:10,13	occurred 54:10	28:7 32:21	76:11 85:2	Pasquale 33:2
nurse 41:2	54:19 66:4	34:12 42:8	outcomes 13:11	passed 20:23
58:6 63:18	66:16 68:14	42:25 45:5,5	outpatient 9:7	past 5:15
79:10 84:11	October 21:3	46:24 50:19	80:25	17:23 20:5
84:17,19,19	32:22,23	58:8 61:25	output 45:10	patients 9:9
85:11,12,15	off 26:15 39:7	66:2 67:19	45:17,24	9:17,20,20
86:6	83:25	79:13 82:21	46:18,22	9:24 12:23
nurses 85:17	offensive	open 12:3	63:6	39:20 41:3
85:17	64:10	opinion 15:14	outside 30:14	51:4,20
	offer 42:8	15:21 56:19	85:19	52:14 79:16
<hr/> O <hr/>	offered 88:25	83:1,14 84:4	ovarian 7:25	80:1,21,25
Oak 17:8	89:7 90:15	86:22	over 5:14 11:4	83:8
oath 5:10	offering 5:21	opinions 5:20	11:22 12:17	patient's 80:6
object 38:9	42:5	14:15 15:2	18:18 27:6,7	84:12
80:13	offhand 32:3	15:18,19	31:21 39:19	Peggy 24:25
objecting	office 2:5	32:12 34:20	69:24 71:13	people 9:15
84:22 85:20	8:14 9:13	42:5,8 55:4	71:18,19	19:23
85:22 86:1	offices 30:14	55:8 59:19	73:8,9,11,20	people's 14:21
objection 38:8	often 10:5	66:1 67:15	74:22 81:6	per 26:5 27:11
39:13,21	11:25	opportunity	81:11 82:1	perceive 81:22
40:10,15,21	Oh 13:5 15:22	70:13	83:24 89:14	percent 27:7
41:5 43:13	19:8 24:22	opposed 52:10	89:17 90:5	69:3
55:18 60:5	26:8 27:20	order 60:9,21	overload 52:17	performed
67:23 70:6	49:2,7 51:8	61:4,5,10,13	overloaded	34:24
72:13,14	58:13 81:20	80:11	67:11	perhaps 5:25
76:22 77:4	86:23 89:15	ordered 61:2	overs 49:19	period 10:24
80:3,18 81:2	89:18 90:3	62:5 66:12	own 41:25	14:18 23:13
81:4,6 83:5	Ohio 1:2 2:8	80:24	oxygen 46:14	26:9,24 27:5
84:6,13,14	2:16 3:6,17	ordering 61:23		27:6,12
84:20 85:16	4:7,17 29:14	orders 42:15	<hr/> P <hr/>	42:19
86:11 87:4	29:15,22	60:16	P 24:20	periods 26:7
87:19 88:3,4	okay 6:7 7:2,3	ordinarily	page 1:16 7:5	peri-operat...
88:5,9,18,19	7:10 16:3,13	69:1	7:11,13,13	74:1,9,24
89:1,2 90:18	18:16 20:22	organizations	7:14,15,17	person 10:20
observe 62:20	30:8 32:13	6:19 7:12,13	94:2,11	40:24 72:17
observing 63:2	50:5 63:8	original 23:11	pages 6:18,22	personal 28:15
obstetric 52:2	64:17,19,21	25:3,5,6,10	6:23 7:1,8	personally
obstetrical	64:22 65:18	66:14	7:20	28:4,9
9:8,20 29:1	65:21 68:9	other 10:25	paid 20:7,17	personnel
36:14,16,19	old 20:20	14:21 16:15	pain 56:14,15	67:22
37:10 38:6	once 10:25	21:15 29:13	57:3	phone 49:15
55:20	31:20 47:13	29:15 30:3	parameters	68:4
obstetrically	49:15 61:25	30:16,17,21	63:2	phonetic 24:25
37:22	one 6:13,14,18	30:22 60:1	Pardon 32:16	phone-type
obstetrician	9:18 12:19	73:10 76:20	69:22	24:23
81:23	19:10 22:1	83:12 86:18	part 6:15 9:11	phrase 48:22
obstetrics	23:14 29:14	89:11	10:23 21:15	physician 8:21
6:20 7:23	29:21,22	others 15:16	25:15 45:5	27:9 36:9,11
9:14 18:22	30:22 35:22	30:1	46:7,25 47:6	36:13,14,15
36:12 90:10	43:19 45:12	otherwise 9:19	55:4 56:15	36:16,19,24
90:11	52:16 55:7	9:25	57:1 62:2	37:3,7,10,22
obtain 19:4	56:22 60:17	ought 50:14	72:2	38:2,6 39:25
obtaining 58:9	64:1 65:4,5	ourselves 11:1	participation	40:3,24
obviously	70:8 86:23	out 11:10 17:6	66:2	46:14 48:19

William S. Floyd, M.D.

May 2, 2005

48:20 58:8	pounds 82:11	80:22 86:7	74:5,15	profusion
physicians	82:15,19,19	pregnant 16:5	75:23 76:8	46:25 47:7
9:21	practicable	16:5 69:3	79:11 82:2	52:16
PIH 35:12,21	48:7,12	preliminary	88:13	progresses
36:1 46:2,2	practice 8:12	44:22 49:24	pressures 16:1	11:9
46:4,17,20	9:11,21 11:5	60:2	16:10 46:16	promptly 88:1
46:25 47:4,6	12:22 13:20	prenatal 9:18	55:22 66:5	Prospect 3:16
50:13,22	39:2 77:17	10:24 15:4	66:11 67:8,9	4:6
51:2 71:8,10	77:25 78:11	55:12 82:17	71:5 73:10	provide 21:24
73:17	86:24 87:1	prenatally	74:3,4,12	provided 89:3
place 21:15	practicing	14:21 82:2	81:11	prudent 77:17
69:16 70:13	38:10	82:13,15	pretty 11:1	77:25 78:11
93:9	preceding	preoperatively	prevent 73:17	90:14
placed 45:17	73:11 75:10	57:14,18	pre-delivery	PS2 58:14
46:9,13	predict 26:8	76:16	88:8	Public 92:17
66:19 69:11	preeclampsia	preparation	pre-mag 73:4	93:7,22
70:4,21	8:3 11:7,10	32:12 48:23	primarily 9:6	publication
placenta 36:5	13:13,21	49:8,12	11:24 35:11	34:12
Plaintiff 1:8	14:1,3,8,12	preparations	primigravida	publications
2:10,18	16:20,23	57:11	82:7	7:18,19,21
plan 46:3	19:7 29:8	prepare 21:25	principles	7:24
47:14 50:14	35:10 39:12	60:18 62:6,9	30:12	published
55:23 56:8	39:20 40:8	77:12 78:12	prior 14:6	30:11
69:20 70:2	41:11,13,15	prepared 25:18	19:25 21:2	pulmonary 67:8
70:24 83:17	42:2 45:23	61:24	23:9 48:23	pulse 53:11,15
planned 47:24	53:3 55:11	preparing 23:9	50:11 54:8	53:18 54:1,3
plans 87:25	55:16 56:7	23:16 24:2,6	56:22 66:8	63:15 64:3
platelets 13:9	56:16 57:1	58:11 61:18	85:5 87:15	65:1 66:6
62:3,12 79:6	58:23 61:15	62:10	88:13	79:11
PLEAS 1:1	62:14 75:7	prepped 48:18	privileges	pump 46:13
please 6:1	75:22 76:4	present 2:3	17:2,3	purpose 11:16
15:25 22:16	79:17 81:10	5:4 6:11	probability	35:20 43:3
26:7 32:15	82:24 88:17	17:4,7 20:4	16:17 62:15	88:11,21
38:17 45:14	preeclamptic	22:15,21	probably 9:16	purposes 59:18
56:10 70:18	11:9 12:13	34:16 43:1	13:5 18:10	push 46:11
72:24 74:7	41:3 51:3,24	57:10 58:8	25:5 26:4,8	52:18 66:12
78:20 83:1	52:9,11	67:2 84:2	26:10,15	66:13
85:21	57:24 58:12	89:18	28:16 32:9	put 5:24 53:7
pleasure 5:15	58:18 59:13	presentation	48:10 49:7	64:11
plus 81:14,15	59:23 66:20	44:5 45:11	69:5 75:13	p.m 1:23 5:3
81:19	69:13 70:4	76:9	75:15 81:20	83:25 84:1
point 5:24	70:10,17,20	presented	90:3	91:3
16:24 61:23	72:1 74:2,25	15:11 46:16	problem 11:1	P.S 25:16
65:23	75:8 76:9	83:2 89:25	problems 10:25	
posed 76:11	79:4 80:1,11	90:6	procedure	
position 17:12	81:1 83:7	presenting	60:12,25	Q
possibility	87:17	45:23 87:8	procedures	question 5:25
72:7	preeclamptics	presently	8:25	6:2,3 27:16
possible 44:24	11:8	17:24 30:17	proceed 46:3	27:19 36:10
44:25 45:2,3	pregnancy 8:8	30:21	48:15 51:13	36:21 39:17
48:1,9	11:14 14:6,6	presents 35:21	87:25	44:17 50:5
postoperative	14:10 16:12	52:2	process 72:24	56:9 58:3
14:22	51:22 82:18	pressure 51:11	90:15	59:18 61:1
postoperati...	82:20 88:2	53:12,16,17	product 30:10	63:13 64:18
55:7 63:3	88:16 90:17	53:20,25	products 61:24	64:21,21,23
64:16,25	pregnancy-i...	54:2 57:10	72:9	65:14 66:14
67:3,22 72:3	16:17,19	58:20,22	professional	68:2,21
78:17	18:20 35:2	60:2 62:21	6:19 7:12,13	69:17,19,23
post-anesth...	35:23,25	63:15 64:3	professionally	70:9 71:1
78:24	41:20 44:23	65:1 72:25	28:4,10	75:1,16 76:6
Post-It 21:21	45:6 50:2	73:4,8,9,19	professor 17:9	76:10 77:14
				77:21,24

William S. Floyd, M.D.
May 2, 2005

78:5 79:19	recommended	23:17,20	30:24 32:11	salaried 17:11
79:21,23,25	19:16	24:3,6,10,22	32:13,21,23	salary 18:5
85:7 87:9	record 6:16	25:12,14,17	33:9,16,25	same 10:11
90:20	36:24 37:3	27:1 32:12	60:24 66:1	16:20 25:24
questioning	45:15 57:8	32:17,18,22	67:19 89:22	45:3 59:9
50:25	66:5 67:17	33:13 34:7	92:1	76:6 78:2
questions 5:19	68:16 83:25	37:23 85:19	reviewing 15:7	San 28:21
43:8 56:11	84:1	reported 50:12	16:9 26:3	saw 20:3 28:14
59:15 63:9	recorded 57:9	reporter 5:6	reviews 27:11	61:5 79:7
63:10,11,12	93:13	6:8 45:13	Rhonda 1:25	saying 25:9
64:7,11	recording 71:5	71:16 74:20	93:6,21	59:11 67:3
83:19,23	records 14:20	84:21 93:6	right 6:18,25	73:20
85:2,17	14:24 15:7	reporting	7:21 10:4	says 17:9
90:22,25	21:6 60:24	38:23	11:2 15:25	33:19 41:21
93:12	67:19 88:11	reports 23:11	18:4 20:25	62:2 74:15
quite 26:20	recovery 42:15	32:25 33:2	22:9 23:15	75:3 77:23
	54:20,20,23	represented	23:23 24:1	scenario 58:2
R	66:4 78:18	32:22	25:6,9,11,17	61:21 64:23
rapid 82:22	78:20,22	reproductive	26:2 28:19	scheduled
Rare 39:4	79:3,3,9	8:1 89:7	31:13,14	31:11 32:4
rate 53:18	reduced 18:23	request 12:4	32:2 33:10	35:1 44:7,11
54:1 62:22	19:5 93:14	21:10,11	33:21 35:8	School 7:6
rates 54:3	refer 11:4,10	requested	38:21 41:2	17:22 28:21
66:6	referring 79:1	45:15	48:13 49:17	scope 80:8
ratio 79:10	regard 15:8	required 20:1	49:21 52:6	84:15
Rayburn 28:8,9	19:15 45:23	rescheduled	64:4 66:7	screen 60:9,10
33:3	53:15 61:6	44:12	77:24 86:25	60:13 61:8
read 32:15,16	64:4	resident 11:20	91:1	61:11,14
34:2,7 45:14	regarding 55:4	11:24 12:5	rising 54:3	scrub 63:18
50:19 59:17	71:2	38:1	risk 10:17,22	second 2:6
67:17 76:4	REID 4:2	residents	12:9 41:15	45:12
76:12 91:1	relate 20:22	17:17	41:23 42:2	Secretarial
reading 33:22	related 93:16	respiration	47:1,3,5	24:14,16
Ready 75:17,18	relating 80:16	65:3,4	51:25 53:3	section 34:25
really 7:5,19	relative 5:20	respiratory	58:14,15	35:7,8 47:24
9:12 13:6	14:16 15:19	46:8 83:7	RMR 1:25	48:21 54:18
21:2 30:15	21:7 53:19	responsibil...	Road 1:20	57:25 62:6
34:16 36:10	85:17	37:9	ROBERT 4:12	62:16,18
50:22 70:9	relayed 50:10	responsibility	role 36:17	63:15 69:7
85:4 89:6	50:24	55:15 69:16	37:16,21	see 9:8,13,18
recall 13:6,22	relevance 55:8	responsible	room 54:21,23	9:24 11:11
13:24 28:1	remained 66:5	37:1,2,6	66:5 78:18	12:2 15:8,22
29:9,12	remaining 7:1	rest 7:20	78:21,22	16:2 20:11
30:19 32:2	remember 27:14	result 47:1	79:3,4,9	20:11 23:8
40:5 43:22	27:15 89:22	73:21	rotate 9:21	40:4 46:8
45:21 50:22	Reminger 3:14	retired 12:19	18:1	54:5,16
61:12 68:17	3:14 4:4,4	12:20	rotation 9:14	60:23 61:4
89:18	29:20,20	review 5:20	10:1,2	61:10 65:24
received 22:6	30:13,13,19	14:23 15:4	roughly 7:19	66:15 67:18
23:12,12	removing 82:24	16:24 21:6	45:4	71:4 74:2,8
66:9	renal 46:25	21:12 26:5	Royal 17:8	82:6 85:2,5
recently 21:19	47:9 90:12	35:17 56:14	RPR 1:25	seem 5:25
recertifica...	repairs 9:2	57:13 65:25	rule 11:13	seen 13:25
19:15,22	repeat 6:2	83:22 88:11	R.N 3:21	66:18 71:6
20:2	10:11 68:21	88:20		71:14
recognize 66:8	repeated 45:15	reviewed 14:20	S	sees 38:1
recognized	rephrase 6:2	15:1 23:9,16	S 1:19 4:2 5:8	segment 8:19
28:7 41:10	replace 72:10	24:2 26:24	24:20 94:3	seizures 73:18
41:12 51:5	replacement	27:8 28:23	Saade 33:3	seminar 89:24
recommendation	67:5	29:1,7,13,18	Sacher 33:3	senior 8:20
19:21	report 23:8,9	29:19,22	safety 30:10	sense 5:25

May 2, 2005

56:10 64:12	Sherry's 44:4	79:22	59:25 72:12	submit 35:23
64:14	46:15 68:18	somewhat 36:21	72:16 73:16	SUBSCRIBED
sent 11:22	68:24 83:2	somewhere 32:9	80:2 85:18	92:12
21:5,10,11	short 78:7	69:5 87:15	86:24 87:1	subsequent
September 83:2	Shorthand 93:6	soon 27:1	start 59:9	44:2
serious 56:10	shortness	35:16 47:25	69:23 71:18	subsequently
63:9,11,12	56:24 57:3	48:7,8,12	71:19 74:21	61:14
63:13	show 24:21	sooner 51:4	started 46:10	Suite 1:21 2:7
service 24:23	showed 25:23	86:19	starts 7:18	sulfate 51:10
90:15	showing 51:18	Sorono 24:25	49:15	52:13 53:24
Services 24:14	61:15	sorry 18:14	state 7:16	72:25 73:5,5
set 93:9	Sibai 75:13	21:25 24:3	17:21 18:2,7	73:14,16,21
setting 78:16	76:2	27:20 33:21	18:14 19:6	sulphate 46:11
seventh 7:15	Sibai's 33:13	38:15 44:17	20:14 27:1	summaries
severe 11:10	sic 27:2	48:10 51:16	93:3,7	21:24,25
35:1,12	side 35:24	52:11 69:17	statement	summarize 7:2
44:23 45:6	36:1	71:16,20	23:10 56:1,3	summary 22:13
45:23 46:2,2	signature	74:20 90:8	56:3,4	superimposed
46:4,17,19	24:13,25	sort 19:3	status 51:12	14:1,3,12
46:25 47:4	25:8,15,25	sound 30:6	stay 10:13	superior 88:24
50:1,13,22	92:10	38:10	60:19	supervise
51:2 53:3	significance	sounded 48:11	steadily 26:18	17:16
55:11,16	46:21,23	Southfield	stenographic	supports 7:18
56:7,16 57:1	53:21 56:13	29:3	93:15	41:21 46:19
57:24 58:23	56:24	speak 33:22	stenographi...	sure 19:9
61:15 62:14	significant	speaker 34:13	93:13	48:25 58:7
71:8,10	46:24	71:21	stepped 58:18	58:19 63:5
73:17 75:22	similarly	speaking 38:16	stepping 59:21	67:10 73:18
79:8 81:9	37:17	90:9	stick 81:16,19	90:11
82:23 83:6	since 24:10	special 45:25	still 17:24	surgeon 63:18
severely 12:12	32:11,23	46:1	18:4 20:5	surgeries 9:4
41:3 51:3,24	33:11,24	specialist	22:9 36:24	surgery 10:14
52:8,11	38:6	10:22 71:9	38:24 65:12	54:15,17
58:11,17	sincerely	71:15,24	65:17,19,20	78:23 79:8
59:13,22	24:17	specialty 7:22	86:2 89:13	85:10,12
66:19 69:12	Sir 79:24	34:14	89:16	90:13
70:4,10,17	situated 37:17	specific 27:12	Stine 3:9	surgical 8:16
70:20 72:1	situation	31:8 61:23	14:18 15:10	8:17,24,25
74:2,19,24	72:18	spectrum 18:21	21:8,19	11:1 40:22
75:8 76:9,19	six 26:15,18	19:10	33:18,20	60:12,25
79:4 87:17	82:20	spend 8:14	35:5 36:7,11	85:11,15
severity 13:11	sixth 3:4 7:14	10:7	37:6,15 42:9	surrender
55:22	Skylight 2:5	SS 93:4	42:14 44:2	37:25
Sharp 3:3	slash 24:19,25	St 93:5,23	44:15,19	surviving
shed 26:6	25:4,7,16	stability	46:7 49:24	90:17
sheet 15:5,23	slogan 49:4,6	73:12	50:10,23	suspensions
92:3	49:9,12	stabilize	55:5,6,11,14	9:3
Sherry 1:7	Solazar 33:3	47:13,21	58:7 60:9,21	Swan-Ganz
14:11 35:21	some 6:7,23,25	48:13 51:10	61:2,13	66:19 68:11
36:20 37:6	16:11 19:2	51:11 83:17	67:20 72:21	69:11 70:5
37:11 42:6	20:16,23	stabilized	76:18 77:1	70:12,21
44:7,15,20	21:15 26:12	73:1,8,15	79:14 80:14	swelling 57:2
45:22 46:12	27:7 43:21	stabilizing	80:15	sworn 5:9
47:1 51:4	49:18,20	73:19,21	Stine's 66:2	92:12 93:10
61:22 67:14	51:11 54:10	stable 53:17	Street 2:6	symptoms 56:15
67:22 69:12	54:14 66:16	66:6 73:23	strike 15:14	syndrome 8:3
70:3 74:25	82:11 83:7	74:12 83:3	69:8	12:24 13:7
76:16 77:9	84:7	staffed 54:25	strips 35:18	13:10,15,18
78:16 82:2	somebody 60:1	staffing 88:23	students 18:1	13:23 41:10
84:5 87:8	something 25:1	88:25 89:4	subject 8:2	41:16,19
88:2 90:15	45:25 62:20	standard 2:15	18:16	42:3 44:25

William S. Floyd, M.D.
May 2, 2005

47:13 49:25	term 13:25	three 6:18,23	31:14,15,19	44:7,14,18
50:3,7 51:25	16:14 20:4	7:8 8:14	31:24 32:5	45:1 49:23
62:2,2,12	76:2	through 7:3	42:6	50:6,9,17
82:22	terms 64:13	9:18,21 12:6	Troy 1:22 5:1	54:22 60:8
syndromes	83:9,10,12	14:17 17:17	true 15:2,17	60:20 61:1
41:23	testified 5:10	18:1 20:10	59:23 62:12	62:4,8 64:9
system 47:12	27:23 30:25	32:15 42:9	63:3 64:6	68:13 87:2
systolic 74:8	31:15,18,23	50:24 52:24	67:11 70:2	87:10,13
74:15 75:3	43:18 69:10	52:25 60:24	70:23 79:15	understood
75:23	70:3 89:19	71:13,23	79:19,20,24	5:22 6:4
	89:21,23	73:10 76:20	79:24 80:2	undressed
<hr/> T <hr/>	testify 31:12	78:10 84:9	93:14	87:24
tachycardia	32:4 93:10	85:10 86:25	truth 86:2	unfavorable
53:21	testifying	89:8	93:11,11	35:2,15
tachycardic	75:13 79:13	throughout	truthful 71:2	unit 78:25
53:19	79:13 80:8	89:11	try 31:16	university
take 5:16 6:25	testimony 38:3	throw 22:8	47:21 75:16	17:12,21
8:5,19 14:23	70:17,18	Thursday 8:15	trying 30:4	18:2,3 19:11
15:1 19:24	90:6,7,8	tied 38:10	33:6 64:10	28:12,21
20:1 25:2	testing 15:9	ties 89:13,16	64:10,12	unless 55:19
27:5,12 34:3	textbook 75:13	till 42:9	68:2	77:22
56:1 63:12	76:5,13	times 26:12	Tucker 30:6	unscheduled
64:12 78:15	Thank 17:5	31:18,23	Tuesday 8:16	35:4
79:11 83:14	22:20 29:17	today 8:12	8:24 10:6,8	unstable 67:1
83:21	38:19 68:1,6	told 33:15	10:13	until 10:15
taken 1:20	68:8 90:23	57:23 63:22	Tuesdays 9:1	16:2 20:18
5:17 22:12	their 9:18	tones 47:19	turned 71:20	37:12 42:17
27:6 42:9	12:8 19:23	51:14,17	twice 29:21	42:24 45:8
67:20 75:25	19:24 30:14	56:21	two 8:21 12:20	50:4 59:3,5
93:8,16	54:20,20	top 14:9	13:5 29:1	59:21 60:19
takes 76:11	theory 80:14	tort 27:1,3	32:2 35:24	66:2,6 68:2
taking 60:2	thing 51:9	total 55:20	56:22 60:15	73:2 85:9
74:17 75:11	things 6:7 8:4	68:18,24	81:14,15,19	unusual 62:18
talk 6:9 49:16	19:3 32:21	totally 87:23	82:11 89:4	update 19:9
49:19	37:2 46:6	towards 53:13	type 8:4,25	urgency 50:17
talked 64:3	53:9,9 65:4	73:24	11:14 28:25	urgent 47:15
83:13	73:23 74:17	Tower 2:5	42:16 60:8,9	47:16,22
talking 10:11	75:11 89:10	trained 38:4	60:12,13,17	48:10,11
49:16,19	think 10:10	training 20:10	61:7,8,9,10	57:22,24
69:4 75:5	20:15,18	28:11 36:8	61:14,16	58:11 83:13
82:10	22:10 23:19	36:18,23	62:5 64:16	urgently 83:15
teaching 7:10	26:8 29:20	37:18 78:10	72:9 79:2,3	urinary 45:10
17:14 19:10	30:23 31:16	transcript	typical 8:13	45:17,24
Technical 7:6	32:2 33:8,19	92:1 93:15		46:17,22
telephone 2:13	49:14,19	94:12	<hr/> U <hr/>	urine 45:18
3:13 4:3,13	51:9 56:2	transcription	U 28:20	80:11,15
5:14 50:21	62:13 64:7	93:14	under 24:17	81:19
84:2	69:18,19	transfer 44:11	37:11,13	urines 79:16
Telephonic	75:12,24	translate	42:13 66:22	79:25 80:24
1:18	83:12 88:23	81:18	74:16 75:5	use 10:24 20:4
tell 8:11	thinking 72:24	transpired	75:23 76:8	38:25 65:5
12:18 27:7	third 7:11	15:8	80:10	83:12
34:16 50:20	thoroughly	treat 35:10	understand	used 76:2 83:9
55:21 57:7	15:1	treating 36:20	23:25 31:7	83:10
59:16 72:24	though 11:13	75:6	36:10 56:12	using 36:22
74:7 79:2	thought 27:18	treatment 51:5	64:19,20,22	38:22
82:16,17	43:18 49:11	69:20 70:2	70:7,9 88:12	usually 8:23
85:2 88:21	84:24 85:3	70:23 73:17	understanding	9:5 22:13
ten 90:3	86:24	82:21,23	34:23 35:9	41:23 66:24
tense 17:23	thousand 54:18	Treu 4:14	38:3 42:11	uterus 51:5
20:5	69:6	trial 5:21	42:23,25	

William S. Floyd, M.D.

May 2, 2005

V			Y	
varied 7:24	ways 26:20	3:16 4:6	yeah 7:5 16:1	15 28:2
18:18	64:1 73:18	whatsoever	24:18 29:16	15,000 12:21
vasospasm 36:4	Wednesday 8:15	77:1	32:20 33:7	1501 3:5
venous 67:9	10:15	while 10:18	33:23 39:24	16 6:22 7:20
verbal 12:9	week 8:13	37:7 83:22	65:17 77:7	83:2
58:1	14:10 31:8	89:15	85:1,4 87:9	160 73:11,20
verbalize	32:9	whoa 64:17,17	89:22	74:16 75:3
73:14	weekends 8:22	whole 18:21	year 9:16,16	75:23 81:11
verbally 12:6	weeks 16:5,5	19:10 32:16	12:16 20:15	1660 2:6
12:7	16:11 82:17	64:18,23	26:5,14,16	1700 2:15
versus 47:16	82:20	William 1:10	27:11 28:24	179 73:9
73:5	weigh 82:11	1:19 5:8	31:2,6,16,17	18 26:14,18,20
very 41:24	weighed 82:18	17:8,25 94:3	31:20	27:11 32:22
46:6 56:10	weight 82:13	willing 19:13	years 8:21	32:23
57:22 72:18	82:17	Withdrawn 81:7	12:20,22	195 73:8
72:18 82:18	Weiner 29:2	witness 6:14	13:5 18:10	1958 20:13
vessels 36:4	welfare 46:16	10:12 27:18	18:18 19:24	1963 6:21
via 2:13 3:13	well 12:18	33:1,10	20:8,18 26:4	1972 89:8
4:3,13 52:23	15:20 19:23	38:15 40:22	26:9,10,17	1980 19:16,24
84:2	20:19,24	41:6 43:15	27:15 28:2	19:25 20:1
view 16:24	23:1,22	45:16 49:18	28:16 30:9	2
visible 54:5	26:19 28:19	55:19 60:6	31:21 39:19	2 1:24 5:2
56:20 65:2	30:7,18 31:3	65:12,15,17	49:7 71:13	22:2
visiting 34:12	31:18 32:10	65:21 67:24	71:23 78:10	2:15 66:12
visual 63:6	33:6 36:3,21	69:23 70:8	90:3	2:18 42:24
vitals 15:9	37:11 41:10	76:23 77:7	Yelena 3:21	43:11,14,15
53:15 63:2	42:17 43:18	80:4 81:3	yesterday 31:8	2:25 66:6,17
64:2	48:17 50:19	83:6 84:7,15		20 28:16 59:1
volume 45:20	52:4 53:23	84:17 85:4	\$	59:14 71:7
45:21 65:8	54:4 62:9	86:12 87:5	\$500 20:19	77:11,22
68:19,25	64:7 66:1	88:6,10,20	0	78:1,7,12
voluntary 20:2	67:24 69:1	89:6 90:19	0055 59:6	92:5,13
vs 1:9	69:14 70:8	90:23 92:10	04 1:9	200 82:15
	73:16 78:18	93:10,13		2004 21:3
	79:2,21	94:2		2005 1:24 5:2
	80:10 82:16			2008 93:25
	85:9,12	witness's		21 16:14
	88:16 89:6	85:18		216 2:9,17 3:7
W 3:2		woke 68:7		3:18 4:8,18
wait 73:2	well-beings	woman 76:19		221 82:18
want 23:15	65:6	82:2		2340 44:21
32:16 48:13	well-known	wondering 20:9		45:3,6
48:17,18	89:9	words 86:18		2352 45:17
52:15,16,17	went 20:18	work 8:13,21		2355 87:12
52:18 59:15	28:13,17,19	10:9 11:23		24-hour 8:19
69:9 70:15	47:19 50:24	26:12 39:2		10:3,18
70:17 74:2,5	were 5:6 10:10	40:1 53:12		79:15,25
78:9 79:23	15:7 16:1	76:3		80:11,15,24
85:10	17:21,23	worked 20:11		81:19
wanted 24:5	19:2,3 20:4	working 17:6,7		241-2600 2:9
wasn't 84:8	20:9,25 21:4	38:6 39:6,7		241-5310 2:17
watched 63:16	22:14 26:12	39:18		3:7
watching 53:18	26:25 29:20	world 89:11		26th 14:10
water 26:6	35:13 43:8	wouldn't 60:4		27-year-old
way 29:16	46:6,6 47:20	write 21:20		82:2,6
30:25 45:8	55:22 57:24	writing 18:24		
53:2 56:17	66:3,6,11	19:6		
64:11 76:10	68:15,16,20	written 12:6		
77:10 81:18	73:23 74:4	wrote 58:25		
82:14 84:14	74:12 81:1	60:9		
Wayne 17:21	84:24 93:13	W.S 24:19		
18:2,7,14	West 1:20 2:6			
19:2,6				

William S. Floyd, M.D.
May 2, 2005

300 81:20
3290 1:20
34 16:5
35 26:4,9
31:21 32:1

4

4 5:5 94:15
4,700 69:2
40 26:9 69:3
400 26:10
44 12:22
44113 2:8,16
44115 3:6 4:17
44115-1093
3:17 4:7
444 1:21

5

5 58:25 59:3,5
59:21 94:5
94:15
5:45 1:23 5:3
50 20:14
525188 1:9

6

6 9:15
6,000 69:5
6:45 83:25
6:48 84:1
6:51 91:3
621-1000 4:18
630 4:15
660 2:7
687-1311 3:18
4:8

7

7:00 10:13
700 9:15
73 89:8

8

8-21 16:2,22
80 7:19 82:1

9

9-16 14:17
90 27:7
93 73:9
94 1:16
98 73:11,20