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.
_____/

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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.

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APPEARANCES:
MR. MICHAEL F. BECKER
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Co-counsel for Plaintiff.

MR. GEORGE E. LOUCAS
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Appearing on behalf of the Plaintiff.

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APPEARANCES: (Continued)
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Appearing on behalf of the Defendant Lucille Stine, M.D.

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Appearing on behalf of the Defendants Meridia Medical Group, Gregory Karasik, M.D., and Yelena Beregovskaya, R.N.

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Troy, Michigan
Monday, May 2, 2005
About 5:45 p.m.
(Mr. Krause not present)
DEPOSITION EXHIBITS 1 - 4
WERE MARKED BY THE REPORTER
FOR IDENTIFICATION
WILLIAM S. FLOYD, M.D.,
having first been duly sworn, was examined and testified on his oath as follows:
EXAMINATION BY MR. LOUCAS:
Q. Good evening, Doctor. My name is George Loucas. We have briefly been introduced. I will be over the telephone. I don't believe we have had the pleasure of meeting in the past.
I take it you have had your deposition taken before.
A. Yes.
Q. I am going to be asking you questions relative to your review and expert opinions in this case that you are going to be offering at trial, understood?
A. Yes.
Q. If at any point in time I put to you a question that doesn't seem to make sense, or perhaps

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you didn't hear me, please let me know. I will be happy to repeat or rephrase the question as necessary. If you answer the question, I'm going to assume you fully understood that which I asked. Is that fair enough?

A. Yes.

Q. Okay. You have had some things marked by the court reporter.

And first of all, I am going to talk about your CV, but you do not have a copy of that present.

MR. AUCIELLO: Yes, we do. He found one.

THE WITNESS: Yes, I have one, which I gave her, and it will be part, I guess, of the record.

BY MR. LOUCAS:

Q. All right. The one I have is three pages long, and ends with Professional Organizations, the last entry is Fellow, American College of Obstetrics and Gynecology, 1963. Is that what you have?

A. No, this is 16 pages. And so you have only got the first three pages, evidently, of my CV at some time.

Q. All right. So I take it, then, there's some

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-- what would the remaining 13 pages consist of?

A. Okay. Just let me summarize it as I go through, okay?

Q. Go ahead.

A. Yeah. You know, the first page really deals with my education, you know, Cass Technical High School in Detroit, MIT for biophysics, biochemistry.

Q. First three pages. If you will go to the fourth?

A. Okay. And then you have the teaching appointments and the third page are hospital appointments, professional organizations. The fourth page is professional organizations. The fifth page is honors, awards, licensure. The sixth page is honors and awards. The seventh page are national/ international boards and committees, and state boards and committees, and grants. The eighth page are grant supports, and it starts publications. There are roughly I have about 80 publications. And that really is the rest of the, you know, 16 pages.

Q. All right. And the publications, do you have a specialty interest within the field of obstetrics and gynecology?

A. It's varied. Most of the publications either deal with ovarian cancer, more lately

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reproductive endocrinology and infertility. There are essentially no articles that deal with the subject matter of either preeclampsia, HELLP syndrome, or things of that type.

Q. Or DIC I take it?

A. Or DIC.

Q. How about complications that occur during pregnancy such as, say, hypertension or chronic hypertension?

A. No, there are no articles dealing with that.

Q. Can you go ahead and tell me about your practice as it exists today, if you will give me what your typical work week is like.

A. I spend three full days in the office, Monday, Wednesday, and Thursday. I cover the hospital all day on Tuesday, do my major, you know, surgical cases. And on Friday I do my minor surgical cases. I have four Board Certified, you know, partners or associates. We each take a 24-hour segment at the hospital as far as coverage. I am the senior physician, so as of the last two years, I do not work weekends. And I am on a number of administrative committees, but those fill in usually on, you know, my surgical days, Friday or Tuesday.

Q. What type of major surgical procedures do

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you do on Tuesdays?

A. Mostly hysterectomies, bladder repairs and suspensions, and, you know, laparoscopy.

Q. What about minor surgeries on Friday?

A. Usually they're going to be D and C's, laparoscopies. That's primarily it. They're all outpatient.

Q. Do you see, then, general obstetrical patients?

A. Yes.

Q. What part of your practice is so comprised?

A. It's really hard to divide it up. You know, I see more gynecology in the office, but you end up on the rotation, obstetrics, as a group of, you know, five people, we are doing between 6 and 700 deliveries a year. I probably do at least a hundred to 125 a year.

Q. Are those your patients or are those that you see from day one of their prenatal care through delivery or otherwise?

A. No, all obstetrical patients are patients of the practice and rotate through the physicians here.

Q. Of the 100 to 125 that you deliver, how is it you come to deliver them? Are they your assigned patients that you see from beginning of patient to end or otherwise?

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

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

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

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Q. About how many?
A. I don't know.
Q. And when did you last deliver such a patient?
A. Oh, probably within the last two years. I can't really recall. You know, there's all kinds of modification of what you call HELLP syndrome. And essentially if you have an individual who has, you know, elevated enzymes and low platelets, you have defined HELLP syndrome, but not all of them have the severity that, you know, or bad outcomes.
Q. And have you ever lost a patient to preeclampsia?
A. No.
Q. Ever lost a patient to HELLP syndrome?
A. No.
Q. Have you lost a patient to DIC from HELLP syndrome?
A. No.
Q. Has your practice ever lost a patient to preeclampsia?
A. Not that I can recall.
Q. How about from HELLP syndrome?
A. Not that I recall.
Q. How about -- you know, I have seen the term

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"superimposed preeclampsia." What does that mean to you?

A. Essentially superimposed preeclampsia means that it's an individual who has chronic hypertension, meaning that they are -- have had hypertension, either prior to the pregnancy or during the pregnancy, and then develop exacerbation to define, you know, preeclampsia where they develop Albuminuria, increased hypertension, and/or edema on top of that. And it has to be, by definition, after the 26th week of pregnancy.

Q. So was Sherry McElfish -- did she have the diagnosis of superimposed preeclampsia?

A. I don't know.

Q. And why is it you do not know that?

A. My -- all of my opinions in this case are going to be relative to her admission to the hospital, 9-16, 11:30 through to the end of delivery, and the entire period of time that Dr. Stine managed this patient.

I have not reviewed the records as to her -- as to other people's care, either prenatally, or to her postoperative, you know, care.

Q. But I take it you did review, then, the medical records from Euclid Meridia Hospital, correct?

A. Yes.

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Q. And I take it you reviewed them thoroughly in arriving at your opinions, true?

A. Yes.

Q. And you did review, then, her prenatal flow sheet that was in the Euclid Meridia Hospital chart?

A. Yes.

Q. So in reviewing those records, you were able to see exactly what had transpired with regard to her vitals and laboratory testing, etcetera, just as Dr. Stine had available to her on the evening she presented, correct?

A. Yes.

Q. And so in doing that, did you arrive at the opinion as to whether or not -- strike that.

You would agree with Dr. Bailin and others who took care of her, that she was a chronic hypertensive, true?

A. I didn't arrive at those opinions because I didn't make opinions relative to that issue.

Q. Well, what would you need to make that opinion?

A. Oh, I could look at this and see if she is hypertensive. I have got the flow sheet in front of me, and --

Q. All right. Let's do that, please.

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A. Yeah, and her blood pressures were normal, that I can see, until 8-21.

Q. Okay.

A. So -- and she was already, you know, 30 weeks pregnant or 34 weeks, you know, pregnant when she has hypertension. So I don't know that, you know, fulfills any criteria of chronic hypertension.

Q. It does not?

A. Not reviewing what I have. I have no additional history, but if her blood pressures are normal for the first, you know, 30 some weeks of pregnancy, then she is not a chronic hypertensive.

Q. Okay. And then if her hypertension does elevate as of August 21, is there a medical term for that other than chronic hypertension?

A. It would, you know, fall into the probability of, you know, pregnancy-induced hypertension.

Q. And is pregnancy-induced hypertension the same as preeclampsia?

A. Yes.

Q. As of 8-21, is it fair to say, then, she has preeclampsia?

A. I didn't review it from that point of view, but she is hypertensive at that particular time, yes.

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Q. Going back to your CV, where is it that you are -- that you have privileges? Where do you have privileges?

A. Where do I have at the present time?

Q. Yes. Thank you.

A. The only hospitals I am working out of -- only hospital I am working at the present time is William Beaumont Hospital in Royal Oak, Michigan.

Q. And when it says adjunct associate professor on your CV, is that clinical?

A. It has been -- it was actually a salaried university position.

Q. And I guess what I am getting at is was there didactic teaching involved or --

A. Yes.

Q. -- is it clinical where you would supervise residents that would come through?

A. Both.

Q. Where would you do your didactic instruction?

A. The lectures were at Wayne State University School of Medicine.

Q. And when you say "were" as in past tense, do you still presently do that or no?

A. No, I give my lectures now at William

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Beaumont Hospital and we rotate the students through the hospital both from Wayne State University and the University of Michigan.

Q. All right. Do you still, then, draw a salary --

A. No.

Q. -- at Wayne State?

A. No.

Q. When did you last do so?

A. It's probably been about four or five years.

Q. Is it fair to say that's about when you last would have done a didactic lecture?

A. No.

Q. I'm sorry. At Wayne State.

A. Yes.

Q. Okay. What would the subject matter be for your lectures?

A. Over the years it's just varied a lot, from -- have I ever lectured on, you know, the pregnancy-induced hypertensions, yes, endometriosis, cancer, you know, the whole spectrum of gynecology and obstetrics.

Q. You don't have any of those lectures reduced to writing, do you?

A. Do I?

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Q. Yes.

A. There may be at Wayne, there were some carrels that were developed, things of this sort.

Q. How difficult would it be for you to obtain any of those lectures that you would have reduced to writing and that exist at Wayne State dealing with preeclampsia?

A. Oh, first of all, I don't even know if they continue to exist. I'm sure that they update, and the whole spectrum of teaching has changed because our one University Hospital closed and moved into Harper, so I am not -- I would have to call down to the department and find out what they have, if they are willing to do that.

Q. Doctor, with regard to your recertification in 1980, what is the recommended -- how long does that last?

A. How long does it last?

Q. Yes.

A. For me, it's a lifetime.

Q. Do you know if there was a recommendation for a recertification at certain time intervals or not?

A. Well, people who took their boards after 1980 take them every 10 years. Anybody who took their boards prior to 1980 have lifetime certification, and the 1980, I was not required to take the recertification. I did it on a voluntary basis.

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Q. I was looking at your CV and saw that you were -- if I use the correct term, whether it's present or past tense -- licensed in California. Are you still so licensed?

A. I haven't paid my dues in about four or five years.

Q. I was just wondering why you were licensed in California. I was looking through your training to see if you had worked out there, and I didn't see anything.

A. No. In 1958, when I became licensed in the state of Michigan, I licensed in California for 50 dollars, and I think it was 12 dollars a year, in anticipation that some day maybe I would like to move to California, which I never did do. So I paid my dues, you know, for years until I think it went up to about $500, and decided that, well, it's time that I am getting old enough that I am not going to move to California.

Q. Okay. I can relate to that. I was going to move to Florida at some time, and the time has passed me by as well.

All right. When were you first

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contacted in this case?

A. My first contact really was just prior to October of 2004.

Q. What were you asked to do?

A. I was sent a booklet of materials, asked to review the records, and I believe I had a copy of the Complaint at the time relative to the actions of Dr. Stine.

Q. Now, did you ask for the Complaint or was it sent along without your request?

A. It was sent along without my request.

Q. Did you review that Complaint?

A. Yes.

Q. Now, do you have your entire file in front of you, or does any part of it exist some place other than where you are?

A. I have all the materials, but I don't have all the deps with me. The only deps I have with me are Dr. Bailin, Dr. Stine, and recently Dr. Inglis.

Q. Did you write at all in those depositions or mark it with Post-It Notes or, you know, or dog ear a corner in any of those depositions?

A. No.

Q. How about summaries, did you provide any summaries or arrive at any? Prepare any, I'm sorry.

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

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MR. LOUCAS: Well, I don't know that I need that.
BY MR. LOUCAS:
Q. Doctor, do you have an e-mail or a --
A. Yes.
Q. -- computer-based file on this case?
A. No. No, I do not.
Q. I see in your report, then, everything that you had reviewed prior to preparing the report; is that an accurate statement?
A. Those are all of the original reports that I have received. Now as I said, I received, you know, depositions that have come in after that period of time. One is Dr. Inglis.
Q. Right. But before we get there, I just want to know what it is you reviewed in preparing your report, and then we will move on from there; fair enough?
A. Yes, I think that that document lists everything I had at the time of that report.
Q. Except for the Complaint?
A. Well, I did have the Complaint, too.
Q. All right. But it doesn't list the Complaint, correct?
A. I understand.

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Q. All right. Is there anything else that you reviewed that's not listed here? In preparing your report, I'm sorry.
A. I don't know.
Q. Was there anything else that you wanted before preparing your report that you did not have at hand?
A. No.
Q. Have you asked for anything in addition since authoring that report?
A. No.
Q. When I look to the end, whose initials are that after your signature?
A. M and M Secretarial Services.
Q. So whose initials are those after your name?
A. It's M and M Secretarial.
Q. No, but under sincerely yours --
A. Yeah.
Q. -- W.S. Floyd comma M.D. slash, that looks like a P and an S.
A. It doesn't show up on my letter. Is it on yours? Oh, it's -- when I dictated this report, I dictate it on, you know, a phone-type service to M and M, and obviously I instructed her to mail it out with my signature, and the slash is Peggy Sorono (phonetic) or something like that, she is with M and M.

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Q. And I take it you have a copy of a letter in front of you or is that an original which does not have that slash with initials?
A. I probably have the original.
Q. All right. The original that does not have this slash?
A. It has no signature.
Q. All right. I am confused. Are you saying the original does not have your name with her initials?
A. That's right.
Q. And is there another report in front of you that has your name but without her initials?
A. The report that I have in my file, which you will get as part of the deposition, has no signature of mine or the slash P.S.
Q. All right. Is this the only report that you prepared in this case?
A. Yes.
Q. Did you make any changes to it before final draft?
A. No.
MR. AUCIELLO: George, I showed him my copy. My copy is the same as your copy with the signature on it.

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

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

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

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A. I reviewed actually two obstetrical cases for a Kevin Cox. The law firm is Weiner and Cox in Southfield, Michigan.
Q. Did the issues involve any of the issues in this case?
A. No.
Q. Have you ever reviewed a case involving preeclampsia, HELLP, or DIC?
A. I know I have, but I can't recall the case or when.
Q. How about for the patient?
A. I don't recall.
Q. Have you ever reviewed cases other than this one in Ohio?
A. Have I had other cases in Ohio?
Q. Yeah. That's a better way of asking it. Thank you. Yes.
A. I have reviewed at least a couple cases for Mr. Auciello. I have reviewed a case or case for Reminger & Reminger, and that I think you were with -- no, at one time or twice, and I believe that there is a law firm in Columbus, Ohio that I have reviewed one case for.
Q. For the defense?
A. Yes.

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

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deposition?
A. By deposition? This year.
Q. Well, this is May, so --
A. Yes.
Q. -- when would that have been?
A. This year.
Q. I understand, but can you give me anything more specific? Was it last week or yesterday?
A. No, it hasn't been -- you know, it may have been February or -- and it was for Mr. Cox.
Q. And when will you next be scheduled to testify in deposition?
A. Right now I don't know.
Q. All right. How about trial, when have you last testified at trial?
A. Not this year. I will try to think if I did any last year or not.
Q. Well, how many times have you testified at trial?
A. Maybe once a year.
Q. Over the course of 35 years?
A. Yes.
Q. Of those times have you ever testified for a patient at trial?
A. Yes, I have.

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

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THE WITNESS: I have a list of reports of Lisa Beggio, Pasquale, Essyk, Hughes, Rayburn, Saade, Sacher, Solazar.
BY MR. LOUCAS:
Q. Is that it?
A. Well, I am just -- I am trying to compare it. Yeah, I believe it is.
MR. AUCIELLO: And I think he also said he reviewed Dr. Inglis's deposition --
THE WITNESS: Right.
MR. AUCIELLO: -- since then.
BY MR. LOUCAS:
Q. How about Dr. Sibai's report?
A. No.
Q. So the depositions, you have already told me what you have reviewed.
A. You have them listed.
Q. Drs. Bailin, Stine, and Inglis, correct?
A. No, I think on the letter you have it says Stine, Bailin --
Q. Yes, I'm sorry. You are right. I am reading that as you speak.
A. Yeah.
Q. Since that time, however, you have also reviewed Dr. Inglis?

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A. That is correct.
Q. You have not read Dr. Flamm's deposition, then, I take it?
A. Dr. Who?
Q. Flamm.
A. No.
Q. Have you read his report?
A. No.
Q. Are you aware of who Dr. Flamm is?
A. I know of Dr. Flamm.
Q. How do you know of Dr. Flamm?
A. Only from either a publication or a visiting speaker.
Q. What do you know his specialty interest to be?
A. I really can't tell you at the present time.
Q. Have you been made aware of the fact that he is consulting in this case?
A. No.
Q. You have no idea what his opinions are, correct?
A. Correct.
Q. What's your understanding as to why a C-section was performed in this case?
A. The cesarian section was done as, you know, scheduled for a patient who came in with severe pregnancy-induced hypertension, and an unfavorable cervix.

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Q. What do you mean by unscheduled?
A. There was discussion of Dr. Stine and Dr. Bailin and, you know, it was determined to go ahead and do the section.
Q. All right. So the section to your understanding was not done because of fetal distress, but to treat preeclampsia?
A. It was done, you know, primarily because we have an individual who has, you know, severe PIH. There was not evidence of fetal distress. There were a couple of decels. And the cervix was felt to be unfavorable to inducer. The expectancy of delivery would not be, you know, soon.
Q. Did you review any of the fetal heart monitoring strips in this case?
A. No.
Q. And what is the purpose of delivery for the -- for Sherry when she presents with PIH?
A. One is to have the baby delivered and not submit the baby to the pregnancy-induced hypertension and side effects. And two, the cure of pregnancy-induced hypertension is delivery.

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

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Q. So she is not responsible for her --
A. She is responsible for the things that she does, but Dr. Bailin is the physician of record and he is the individual who determines who is going to be called and what happens to his patient.
Q. Was Dr. Stine responsible for Sherry as a physician and patient while -- before Dr. Bailin arrived?
A. She had all the responsibilities that you would expect of an obstetrical house physician.
Q. Well, was Sherry admitted under her care until Dr. Bailin arrived do you know?
A. No, she is admitted under the care of Dr. Bailin.
Q. Would it be fair to say that Dr. Stine should be judged in her role at Euclid Meridia Hospital by what a similarly situated doctor who has Maternal Fetal training would do and not do?
A. No.
Q. Why not?
A. Basically her role is to act as a house physician obstetrically, to evaluate the patient, and report her findings to Dr. Bailin. The decision as to what is going to be done is Dr. Bailin's. I do not surrender the care of my patient that goes in to

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Beaumont Hospital to the resident who sees the patient, or a house physician who may be there.

Q. So am I understanding your testimony correctly in that despite the fact she is trained in Maternal Fetal medicine, she can leave that at the door since she is working as a house obstetrical physician on that evening?

MR. AUCIELLO: Objection, George. I'm just going to object because you are making it sound like she is practicing with half her brain tied behind her back to make it fair. I mean I don't know how she would do it.

MR. LOUCAS: Actually I don't know who that was.

THE WITNESS: I'm sorry?

MR. LOUCAS: Who was that speaking, please?

MR. AUCIELLO: It was me, Ernie.

MR. LOUCAS: Thank you, Ernie.

BY MR. LOUCAS:

Q. All right, Doctor. You may answer.

A. Yes, that she is using all her knowledge. She is reporting her knowledge to Dr. Bailin. The decision is still his. If he chooses then to call her as, you know, for her knowledge and use her as a consultant, that's his choice.

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Q. In your practice, Doctor, do you work with midwives?

A. Rare.

Q. On what occasions do you find yourself working with midwives?

A. Off and on we have had midwives working at the hospital, and we may be called as a consultant, you know, for them.

Q. Is it then your experience at the hospital that you would be called by a midwife for a patient with preeclampsia?

MS. DiSILVIO: Objection.

BY MR. LOUCAS:

Q. You may answer, Doctor.

A. Could I be called for that?

Q. No, the question was: Based upon your experience, in working with midwives at the hospital over the years, would you be consulted by the midwives for patients with preeclampsia?

MS. DiSILVIO: Objection.

BY MR. LOUCAS:

Q. You may answer, Doctor.

A. Yeah. Not necessarily. Basically our midwives have to identify they have a physician they work with, and if there was an emergency that came up, yes, I could, you know, assist her or consult with her in the absence of her physician.

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Q. I see.

So do you recall ever having been called in to assist a midwife when the attending was not available to consult on a patient with preeclampsia?

A. No.

MS. DiSILVIO: Objection.

BY MR. LOUCAS:

Q. You may answer, Doctor.

A. I said no.

Q. How about with hypertension?

MS. DiSILVIO: Objection.

BY MR. LOUCAS:

Q. You may answer.

A. No.

Q. For what conditions would you be called in by the midwife, if ever?

MS. DiSILVIO: Objection.

THE WITNESS: If she had a surgical emergency or a delivery that she could not accomplish, her physician was there, and I happened to be a person on the floor.

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BY MR. LOUCAS:

Q. All right. And would the nurse midwife deliver severely preeclamptic patients based on your experience?

MS. DiSILVIO: Objection.

THE WITNESS: No.

BY MR. LOUCAS:

Q. I couldn't hear you, Doctor.

A. No.

Q. Is HELLP syndrome a well recognized condition of preeclampsia?

A. It is a recognized complication of preeclampsia.

Q. May we agree that delaying a diagnosis of preeclampsia increases the risk of a patient developing HELLP syndrome?

A. No.

Q. Why not?

A. HELLP syndrome is a complication of, you know, the pregnancy-induced hypertension. But I don't know literature that supports that says if you don't, you know, if you delay your diagnosis of it, that you increase the risk. Most HELLP syndromes usually are very acute events.

Q. How about based upon your own experience,

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have you had any experience that in delaying a diagnosis of preeclampsia, it increases the risk of a patient developing HELLP syndrome?

A. The answer is no.

Q. Are you going to be offering any opinions at trial as to what caused Sherry McElfish's death?

A. I don't believe I am going to be asked to. The only opinions I am going to offer are those dealing with the actions taken by Dr. Stine through and till, you know, delivery.

Q. What is your understanding as to whether she was involved in her care at all after delivery?

A. The care after delivery was under Dr. Bailin. And that Dr. Stine did look in on recovery, but did not do any orders or anything of that type.

Q. And until what time? Well, first of all, what time did she look in on her?

A. There was a period of time within the hour after, you know, delivery.

Q. And delivery was at what time?

A. It was at 1:18.

Q. So your understanding is she was involved in her care up until 2:18?

A. My understanding she only looked in;

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Dr. Bailin was present; that her care ended following the delivery of this baby.

Q. What was the purpose then of looking in?

A. I would assume that she is an individual who is on the floor and that she is an interested individual.

Q. Upon what are you basing that assumption?

A. Just from the questions that were asked her in her deposition.

Q. And how is it you know that she looked in on her at 2:18 a.m.?

A. I don't know --

MR. AUCIELLO: Objection. He didn't say 2:18. He said about an hour.

THE WITNESS: You said 2:18. I didn't.

BY MR. LOUCAS:

Q. Well, I thought you testified that it was one hour afterwards. I asked what you time did she look in on her.

A. I said about an hour. Some time after. I do not recall the exact time.

Q. When she looked in, are you aware of any hands-on care at all --

A. No.

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Q. Are you aware of any hands-on care by Dr. Stine at all subsequent to the delivery?

A. The answer is no.

Q. Moving back to Sherry's arrival or presentation, if you will, at Meridian Euclid -- first of all, before I even get to that, what is your understanding as to where Sherry was scheduled to deliver baby Joshua?

A. I don't know.

Q. Do you have any idea as to whether or not she was scheduled to transfer at a different facility but rescheduled at Meridia Euclid?

A. I don't know.

Q. What's your understanding as to the time that Dr. Stine made her assessment of Sherry and concluded what a likely --

A. I'm sorry. You didn't finish the question.

Q. What's your understanding as to the time that Dr. Stine completed her assessment and concluded what the likely diagnosis of Sherry was?

A. Approximately at around 2340.

Q. What was that preliminary diagnosis?

A. Severe pregnancy-induced hypertension, and, you know, differential diagnosis of possible HELLP syndrome, and possible abruptio.

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Q. Is it your understanding then that she arrived at the conclusion of possible HELLP and possible abruption, abruptio, at that same time, 2340?

A. Roughly, yes. But that is not a diagnosis made. That is only part of a differential. The only diagnosis she had at 2340 was severe pregnancy-induced hypertension. She could not make the diagnosis of HELLP until the enzymes came back. And there's no way to make the diagnosis of abruption.

Q. What was her urinary output upon presentation?

A. Excuse me one second.

MR. LOUCAS: Court reporter, could you read back his last answer, please?

(Record repeated as requested)

THE WITNESS: I do not know what her urinary output was. She had a Foley placed at 2352, in which the urine was just described as dark.

BY MR. LOUCAS:

Q. What was the volume?

A. I don't recall the volume.

Q. What would you be concerned about for Sherry presenting with severe preeclampsia with regard to her urinary output?

A. Is there something special? No, there's

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nothing special. I mean she is an individual who has severe PIH, needs to have her severe PIH managed, and eventually plan to proceed to delivery.

Q. And how does the severe PIH need to be managed?

A. All the things that were done here were very meritorious on the part of Dr. Stine, and that was she, you know, assessed, had Respiratory come down to see her for her breathing; placed her on a fetal monitor; started an IV; got an EKG; got blood gasses; got her labs; and initiated a mag sulphate push. She was continuously monitored, both Sherry and the baby, and she was then placed on a mag pump. She was given oxygen, and her attending physician was notified.

Q. Would you be concerned at all for Sherry's welfare if she presented with elevated blood pressures consistent with severe PIH and little to no urinary output?

A. No, it just supports the diagnosis of severe PIH.

Q. What's the significance of little -- assuming little to no urinary output, what's the significance of that?

A. It's only significant that we are not getting renal profusion which is part of severe PIH.

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Q. What is the risk to Sherry as a result of that?

A. It is no greater than the risk that is defined by severe PIH and eventually HELLP.

Q. And what is that risk then?

A. It's all part of the PIH. You are not getting profusion. You are going to get, you know, multi-organ, you know, failure, which is going to be the liver failures and the renal failures.

Q. And how is -- what is the intervention necessary to decrease the likelihood of that multi-organ system failure of the liver and kidneys?

A. Once you have HELLP syndrome you stabilize the patient, and you plan and do delivery, and it's not an emergent, it's an urgent delivery, but not emergent.

Q. How do you define urgent versus emergent delivery?

A. An emergent delivery would be if the heart tones went on the baby, and the baby or the mother's life were jeopardized at that moment, then you would do -- you don't try and stabilize the patient, you just move ahead and get the baby out. The urgent is to do your full assessment, both cardiovascular on the mother and the baby, and then do a section as planned.

Q. Is it fair to say emergent is as soon as possible?

A. Yes.

Q. And emergent would be defined how?

MR. AUCIELLO: You mean emergent again?

BY MR. LOUCAS:

Q. As soon as practicable?

A. Emergent? You just said it, as soon as possible.

Q. I'm sorry. I said and urgent, probably sounded like emergent. Urgent then, would it be fair to say as soon as practicable?

A. That's right. You want to stabilize the patient, know as much of the patient as you can, and have all your hands on deck and proceed.

Q. What do you mean by all hands on deck?

A. Well, you want your anesthesiologist there. You want your OR prepped. You would like to have the attending physician so that you are -- you have an extra hand or a physician assistant, you know, for the section.

Q. Have you heard that phrase "hands on deck" prior to your just having said it in the preparation for this case?

A. Yes, I am sure I have. I know I have.

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Q. Where did you come by that definition?

A. Oh, I don't know.

Q. In this case?

A. In this case, a slogan if you like, I don't know.

Q. When did you hear that slogan, if you will?

A. Oh, probably about 30 years ago.

Q. No, I meant in the preparation for this case. You said yes, you had heard that slogan.

A. No, I didn't.

Q. I thought you said yes, you had heard that slogan in the preparation of this case.

A. No, I didn't say that.

MR. AUCIELLO: George, I think because the nature of this phone is once he starts talking, he doesn't hear you talk.

MR. LOUCAS: All right.

THE WITNESS: So we might have some talk overs where you think -- you keep talking, he answers, and there's some confusion.

MR. LOUCAS: All right.

BY MR. LOUCAS:

Q. What's your understanding as to how she arrived, Dr. Stine, at the preliminary diagnosis of HELLP syndrome?

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A. She made the diagnosis of severe pregnancy-induced hypertension with a differential that can include, you know, HELLP syndrome. She did not make the diagnosis until the enzymes came back.

Q. Okay. And that's my question. Is it your understanding that she did eventually arrive at a diagnosis of HELLP syndrome?

A. Yes.

Q. What is your understanding as to the information relayed or conveyed by Dr. Stine to Dr. Bailin prior to his arrival at the hospital?

A. She reported all her findings to him, discussed the aspect that she had severe PIH, and that they ought to plan, you know, for getting the baby delivered.

Q. And what was the -- what is your understanding of the urgency with which she described these findings to Dr. Bailin?

A. Well, I only can read her deposition. I can't tell you what -- how it was said on the telephone, but Dr. Bailin in his dep indicated that he knew that she had severe PIH. He doesn't really recall much of the conversation at all. Dr. Stine said I would have relayed that. She went through in the deposition and the questioning what she did do. And so

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it was clear that he was aware he had a patient in the hospital with severe PIH.

Q. And we agree that in severely preeclamptic patients like Sherry McElfish, the sooner the recognized treatment of evacuation of the uterus, or delivery, the greater the likelihood of no complications?

A. Oh, I don't know if I would agree with that. I think that basically the most important thing is to stabilize her, give her her mag sulfate, control her blood pressure, you know, stabilize it, get her some IV fluids in, and to know what her cardiac status is and -- you know, before you proceed with the anesthetic, as long as you have fetal heart tones that are not non-reassuring.

Q. I'm sorry, as long as you have fetal heart tones?

A. That are not showing fetal distress.

Q. Why does she need IV fluids?

A. We always have IVs on all patients coming into the hospital, and particularly those who have any complication of pregnancy. It's a means in which we have entry into the patient. It's our IV life line.

Q. And with the severely preeclamptic patient who is at risk for HELLP syndrome and DIC, is there any

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greater importance to establish IV fluids than the obstetric patient presents for delivery without complication?

A. Well, any complicated case has a more important need for IVs.

Q. All right. What is -- if you can define for me, explain to me the more -- the importance of the greater need for establishing an IV with the severely preeclamptic patient.

A. As opposed to a normal patient?

Q. I'm sorry, severely preeclamptic.

A. It is the life line that you give the mag sulfate, you give all your medications to, and you are -- you know, these patients are hemoconcentrated, so you do want to add IV fluid to them, you know, for one, dilution and profusion, and yet you don't want to overload them because you want to get your EKG because you don't want to push them into congestive heart failure.

Q. And that's consistent with what you said in establishing monitoring?

A. That is correct.

Q. So how do you monitor via IV fluid? How do you monitor through a line established for IV fluid?

A. You don't monitor through a line for IV

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fluids.

Q. What is the best way, then, to monitor a patient with severe preeclampsia with a risk of HELLP and DIC who's hemoconcentrated and that can go into CHF?

A. You are going to clinically monitor them. Are you going to say you can put central lines in? Yes, but this is not mandatory in this case. Your most important things are doing the things that she did.

Q. So how do you clinically monitor?

A. You clinically monitor by her pulse, her blood pressure, her gasses, her EKG, and you work towards getting the patient delivered.

Q. And what are you monitoring? What are you looking for with regard to the vitals, the pulse, the blood pressure?

A. That your blood pressure is stable, not elevating, and that you are watching her pulse rate relative to whether she is tachycardic or not.

Q. So if you have got falling blood pressure and increasing tachycardia, what's the significance of that, if anything?

A. Well, it all depends on what you're doing. If you are giving her mag sulfate, you may expect her blood pressure is going to drop, and you may also get a

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

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

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

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

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

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

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

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

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elevated enzymes, you have made the diagnosis of HELLP syndrome, and part of HELLP syndrome says elevated liver enzymes and eventually low platelets.

Q. So what's your understanding as to why she ordered the type and cross blood?

A. To prepare, you know, for the section.

Q. For what, bleeding complication, or what's your understanding?

A. Well, if you prepare blood, then you are preparing for bleeding.

Q. And that would be because of concern of low platelets with HELLP syndrome, true?

A. No, I think that basically it could be that, but you have a patient who has severe preeclampsia, has HELLP, and there's always a probability of, you know, bleeding at the time of cesarean section. In this case they did not get the bleeding at the time of the cesarian section. That was unusual.

Q. How do you monitor for that bleeding?

A. That is something you clinically observe.

Q. And that goes back to the blood pressure and the heart rate?

A. No, not at all. You look, you measure the blood by your clinical estimation of how much blood loss I have.

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Q. So there's no need to look at clinical parameters of vitals, then, in observing or assessing for blood loss postoperatively, true?

A. No, I didn't say that at all.

Q. Sure. You just said that no, you don't do that, you look for visual bleeding and output or blood loss.

A. Let me just say this, okay. I know your questions are serious, but you are so eschewing all these questions and distorting my answers intentionally with your questions that you are considering serious, so they're not serious questions. You then take a serious question and then you eschew the answer, and that this patient was appropriately monitored which we would do in every section, her blood pressure and pulse would be maintained and watched by the anesthesiologist. The clinical loss of blood is an estimation made by the surgeon, by the scrub nurse, and by the anesthesiologist. That is how we assess blood loss.

Q. I asked you how to monitor for blood loss.

MR. AUCIELLO: And George, he told you.

BY MR. LOUCAS:

Q. Excuse me. I asked you how to monitor for blood loss, and I said one of the ways would be to go back to the vitals and look for falling blood -- to check the blood pressure and the pulse as we talked about with regard to fluids, right? And you said no, that would be a clinical assessment for the amount of blood loss. True?

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A. Well, I think that all your questions and these answers now have gotten so garbled that you don't have an understanding of what I have said. So I am not trying to be offensive to you. I'm not trying to be -- put you down in any way, but your questions do not make good medical sense. And you are trying to take medical facts and convert them to lay terms, and they -- then they don't make sense to me.

Q. Doctor, how do you monitor for hypovolemia postoperatively in this type of patient?

A. Whoa, whoa, now this is -- okay, this is a whole different question, all different facts. Let's understand that, okay?

Q. I know exactly what I understand about my question. Are you okay with the question?

A. I am okay if you understand that you have now changed the whole question and the scenario of events.

And postoperatively the patient is

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monitored, you know, by blood pressure, by pulse, and by visible blood loss.

Q. And how about respiration?

A. Respiration is not one of the things that we use to monitor, you know, blood loss. It's one of the well-beings of the patient that we are looking at.

Q. How do you define hypovolemia?

A. Hypovolemia just means low blood volume.

MS. DiSILVIO: Hello.

MR. AUSTRIA: Hello. Did we lose you?

THE WITNESS: No, I'm still here.

MR. AUCIELLO: There was no question.

THE WITNESS: Hello.

MR. LOUCAS: Hello.

THE WITNESS: Yeah, I'm still here.

MR. LOUCAS: Okay.

MR. AUCIELLO: Is George still here?

MR. LOUCAS: I'm still here.

THE WITNESS: Okay.

BY MR. LOUCAS:

Q. At what point in time, Doctor, if at all, did you see evidence of hypovolemia in this chart during your review?

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A. Well, I reviewed the chart and made opinions only until, you know, Dr. Stine's participation was gone. Now, the hypovolemia or blood loss were events that occurred after, and if you look at her recovery room record, her pressures remained normal with, you know, pulse rates that were stable at least until 2:25.

Q. All right.

A. But also you have to recognize that prior to that time, she received antihypertensives as Apresoline, and so that Dr. Bailin was aware to a four of her increased blood pressures which were always elevated and ordered Apresoline IV push, and at 2:15 Apresoline IV push by Dr. Bailin.

Q. I believe my original question was what time did you see evidence, if any, of hypovolemia?

A. I don't know. It occurred some time after 2:25.

Q. Have you ever seen a central line or a Swan-Ganz line placed to help monitor the severely preeclamptic patient?

A. Have I, yes.

Q. Under what circumstance is that beneficial in a patient?

A. It helps you -- usually most of these are going to be at a time, you know, following, you know,

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delivery, if you have a patient who becomes unstable as far as bleeding, you know, present.

Q. And are you saying that postoperatively it assists in monitoring bleeding?

A. It assists in replacement of blood and fluid.

Q. How does it assist?

A. By measuring your pulmonary artery pressures and your central venous pressures.

Q. And it helps to make sure that the heart doesn't get overloaded with fluid, true?

A. That's exactly what I said.

Q. Do you know whether that's what happened to Sherry?

A. I don't know, and I didn't form any opinions on that.

Q. But when you read the record, you didn't look to see if that's what happened, correct?

A. That's correct. I only reviewed the records for the actions taken by Dr. Stine.

Q. Now would that have assisted the medical care personnel in monitoring Sherry postoperatively?

MR. AUSTRIA: Objection.

THE WITNESS: Well, first of all, what would have?

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MR. LOUCAS: Thank you. I was trying to finish my question until that loud noise deafened me.

MR. AUCIELLO: Your phone is better than anyone else's, Bob.

MR. AUSTRIA: Thank you.

MR. LOUCAS: You woke me up, Bob. Thank you.

MR. AUSTRIA: Okay.

BY MR. LOUCAS:

Q. A central line or Swan-Ganz.

A. Can it, yes.

Q. Now what is your understanding as to the amount of intraoperative blood loss that occurred? I know you said 1,000 cc's, but there were different entries in the medical record, were there not?

A. I don't recall any.

Q. What is Sherry's estimated total blood volume?

MR. AUCIELLO: You were cutting out. Can you repeat that question?

MR. LOUCAS: Yes.

BY MR. LOUCAS:

Q. What is your estimate of Sherry's total blood volume?

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A. Well, ordinarily in a non-pregnant individual, it would be about 4,700 cc's. In a pregnant individual you get about a 40 percent increase in that, and so we are talking about, you know, probably somewhere close to 6,000, you know, cc's. But let me just say that a thousand cc's is the average blood loss for a cesarean section.

Q. Are you aware -- strike that.

I want you to assume that the anesthesiologist in this case has testified that she would have placed an internal or a Swan-Ganz or central line in Sherry had she known the patient was severely preeclamptic. Do you agree or disagree?

A. Well, I have a hard time agreeing or disagreeing with the anesthesiologist whose responsibility it would have been to place that line.

Q. I'm sorry. Maybe I didn't make my question clear. I think that's an example of an inartful question. I don't think it was complete. And that is: Would you agree that -- with her treatment plan, had she had that information?

MR. AUCIELLO: Pardon?

THE WITNESS: Start the question over.

BY MR. LOUCAS:

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

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

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

BY MR. LOUCAS:

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

A. My answer, if you are done with your

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

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

A. No.

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

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

THE WITNESS: Start over.

MR. AUCIELLO: Start over.

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

BY MR. LOUCAS:

Q. Through your years of experience are you aware of a Maternal Fetal specialist or intensivist or cardiologist ever having been called to consult in the delivery of a severely preeclamptic patient?

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

Q. Why would that be?

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

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

MR. AUSTRIA: Objection.

MR. AUCIELLO: Objection.

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

BY MR. LOUCAS:

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

A. Yes.

Q. Tell me your thinking process, please.

A. She gave her mag sulfate, the blood pressure

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. -- in the severely --

THE COURT REPORTER: I'm sorry?

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

BY MR. LOUCAS:

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

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

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

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

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

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

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

A. Ready.

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

A. Not in this circumstance. I think you have taken everything so out of context that you are not dealing with this patient anymore, and that basically, you know, you have used the term Sibai before as an expert, he is the expert on hypertensive work and preeclampsia, nationwide. I haven't read his dep yet, but he has a textbook.

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

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

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

A. No.

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

MR. AUCIELLO: Objection.

THE WITNESS: I don't know.

BY MR. LOUCAS:

Q. Are you aware of any disagreements whatsoever between Drs. Stine and Bailin during the management of this patient?

A. No.

MR. AUSTRIA: Objection.

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

THE WITNESS: Yeah, no.

BY MR. LOUCAS:

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

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

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

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

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

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

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

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Q. And that's standard of care, true?
MR. AUSTRIA: Objection.
THE WITNESS: It can be depending upon the circumstances that you are dealing with and what you are, you know, the patient's clinical circumstance at that time, but it's also beyond the scope of where I am testifying in this case.
BY MR. LOUCAS:
Q. Well, under what circumstances would you go ahead and order the 24-hour urine for the preeclamptic patient?
MR. AUCIELLO: I'm going to object because Dr. Stine -- there is no theory involving Dr. Stine doing a 24-hour urine. This is just completely extraneous to any issue relating to my client or any of my experts, but go ahead.
MR. AUSTRIA: Objection.
BY MR. LOUCAS:
Q. Go ahead, Doctor. You may answer.
A. I will do it on patients that I have hospitalized, you know, for pregnancy-induced hypertension.
Q. And have you ordered 24-hour urines on those patients on an outpatient basis in an effort to diagnose whether they were preeclamptic?
MR. AUCIELLO: Objection.
THE WITNESS: No.
MS. DiSILVIO: Objection.
MR. AUCIELLO: He said no if you didn't hear it over the objection.
MS. DiSILVIO: Withdrawn.
BY MR. LOUCAS:
Q. What is your definition of severe preeclampsia, Doctor?
A. Blood pressures exceed 160, diastolics over 110 with Albuminuria and/or edema.
Q. To what extent of Albuminuria?
A. Two plus or greater.
Q. And when you say two plus, is that on a dip stick?
A. Yes.
Q. And what would that translate in to by way of a 24-hour urine, a two plus dip stick?
A. Oh, probably about 300 milligrams.
Q. Almost done, Doctor. Bear with me a moment. Did you perceive any need in this case to know exactly when the obstetrician was going to arrive for delivery?
A. No.

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

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

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

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

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

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delivery, you know, met the standard of practice.
Q. What's your understanding as to when he was first contacted?
MR. AUSTRIA: Objection.
THE WITNESS: As to what?
BY MR. LOUCAS:
Q. By the hospital or by anybody at the hospital about Sherry presenting.
A. Yeah, what is your question?
Q. What's your understanding as to when he was first contacted?
A. At 2355.
Q. What's your understanding as to when he arrived?
A. Somewhere prior to 1:00.
Q. And within what time would you expect him to be there, within what time with a severely preeclamptic patient who needs to be delivered?
MR. AUSTRIA: Objection.
BY MR. LOUCAS:
Q. You may answer.
A. Again, depending upon where he was, what -- you know, at that time he might have been totally undressed, I don't know. But I would expect that he would make plans and proceed to the hospital, you know,

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promptly.
Q. Did Sherry have a complicated pregnancy?
MS. DiSILVIO: Objection.
MR. AUCIELLO: Objection.
MR. AUSTRIA: Objection.
THE WITNESS: Yes.
BY MR. LOUCAS:
Q. Did she have any complications pre-delivery?
MS. DiSILVIO: Objection.
THE WITNESS: Again, I did not review those records, you know, for the purpose of this dep, but as I understand it, she had issues dealing with, you know, blood pressure prior to admission to the hospital. But I don't know the details of it.
BY MR. LOUCAS:
Q. Well, was her pregnancy complicated by preeclampsia?
MS. DiSILVIO: Objection.
MR. AUSTRIA: Objection.
THE WITNESS: Again, I didn't review it for that purpose, so I can't tell you.
BY MR. LOUCAS:
Q. Do you think this patient -- the staffing and equipment at the Cleveland Clinic was superior to the staffing and equipment offered at Euclid Meridia?

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

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

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All right. We will read it.
(The deposition was concluded at 6:51 p.m.)

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I have reviewed the above transcript and have listed corrections, if any, on the attached errata sheet,

this_____day of_____, 20____.

_____
SIGNATURE OF THE WITNESS

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20_____.

_____
NOTARY PUBLIC
My Commission expires: _____.

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CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF ST. CLAIR)

I, Rhonda M. Foster, Certified Shorthand Reporter, a Notary Public in and for the above county and state, do hereby certify that the above deposition was taken before me at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth, and nothing but the truth, that the foregoing questions asked and answers made by the witness were duly recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to either party nor interested in the event of this cause.

_____

Rhonda M. Foster, CSR
Notary Public,
St. Clair County, Michigan

My Commission expires: March 11, 2008

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