STATE OF OHIO
COUNTY OF CUYAHOGA

IN THE COURT OF COMMON PLEAS

- - -

DAYSHA SHINE, et cetera, et al,

Plaintiffs,

vs. Case No. 339640

UNIVERSITY HOSPITALS OF CLEVELAND, et al,

Defendants.

DEPOSITION OF

HAROLD E. FOX, M.D.

BALTIMORE, MARYLAND

MARCH 1, 2001

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REPORTED BY: Belinda Lomax, Professional Reporter

FILE NO.: 9B010B4

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Defendants.)
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Deposition of HAROLD E. FOX, M.D. was taken on behalf of Defendants at the Johns Hopkins Hospital, 600 North Wolfe Street, Houck-Phipps Building, Room 264, Baltimore, Maryland commencing at 9:35 a.m., Thursday, March 1, 2001, before Belinda Lomax, Professional Reporter.

APPEARANCES

ON BEHALF OF THE PLAINTIFFS:
BECKER & MISHKIND, CO., L.P.A.
BY: MICHAEL F. BECKER, ESQUIRE
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ON BEHALF OF THE DEFENDANTS UNIVERSITY HOSPITALS OF CLEVELAND AND DR. SEGIL:

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The Hanna Building
1422 Euclid Avenue
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Cleveland, Ohio 44115

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WITNESS: HAROLD E. FOX, M.D.

(The exhibits were marked off the record by counsel.)

QUESTIONS WITNESS INSTRUCTED NOT TO ANSWER:
None

INFORMATION TO BE SUPPLIED:
None

CERTIFIED QUESTIONS:
NONE

PROCEEDINGS

Whereupon --

MR. MOSCARINO: The record should reflect that this is the discovery deposition of Dr. Harold Fox, who has been identified as an expert witness in the case of Daysha Shine versus University Hospitals of Cleveland.

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HAROLD E. FOX, M.D.
being first duly sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

DIRECT EXAMINATION

BY MR. MOSCARINO:

Q. Dr. Fox, we met a minute ago. My name is George Moscarino. I represent the Hospital and Dr. Segil, and I'm obviously here to ask you some questions this morning regarding your report and regarding your opinions in this case. Okay?

A. Yes, indeed. Good morning.

Q. You, I take it, have had your deposition taken before?

A. Yes.

Q. Let me tell you what I think the ground rules are and then we will be on the same

wavelength. I'm just going to ask you some questions. If you know the answer, please give it to me. If I have stumbled or mumbled or you don't understand what I'm asking or what I ask doesn't make any sense, let me know. Otherwise, respond in kind, and when we print this up we will assume that the answer that you gave me was intended for the specific question that I posed immediately before your answer. Is that fair enough?

A. Fair enough.

Q. Let's just do a couple housekeeping matters at the outset. I am showing you what I marked as Exhibit 1. This is a copy of a report given to me by Mr. Becker. That's your only report in this case?

A. Just looking at it, that looks like the report, yes.

Q. Have you issued any subsequent reports?

A. No.

Q. Are you amending or deleting any of the opinions that are contained in your letter of December 6, 2000 to Mr. Burnett?

A. No, I am not.

Q. Exhibit 2, I believe you told me,

prior to going on the record, is an updated copy of your C.V.; is that right?

A. That's correct.

Q. Is that current?

A. This is the current one.

Q. What I have marked, Dr. Fox, as Exhibit 3 is a red file which is your file in this matter; is that right?

A. That's correct.

Q. Then in addition to the things that are in the red file marked as Exhibit 3, you have read some depositions which I will just recite for the record. You reviewed the deposition of Nurse Polz, Dr. Hudock, Dr. Schwartz, Midwife Mettler, Janet Russell, Dr. De Mola, and Dr. Acheson, right?

A. That's correct.

MR. BECKER: Did you mention Dr. Segil?

THE WITNESS: I think I reviewed that as well. I don't know if it's in that pile.

Q. BY MR. BECKER: Just to make it clear, I think Dr. Segil's deposition and some of those depositions may be in this folder?

A. Right.

Q. You also read Dr. Segil's

deposition, right?

A. Correct.

Q. And Dr. Holzheimer's deposition?

A. Correct.

Q. Both of which are in this red folder?

A. Correct.

Q. Is it more appropriate that I stick them in that file?

A. No, no. I just keep them in that folder. That would be helpful.

Q. Do you know any of the caregivers in this case?

A. Not to the best of my knowledge.

Q. Do you know a Dr. Stokes from Reston, Virginia that I deposed yesterday?

A. No.

Q. Did you read his report?

A. Don't recall that I have, no.

Q. Did you read the report of Dr. Justin Lavin, from Akron, Ohio, who is identified as an expert witness for the Defendants?

A. I may have. We very recently received something. Was it a recent deposition? It's something that I might have received recently.

If it is, it's in the folder. I don't remember it per se.

Q. You don't know him?

A. No, I do not.

Q. Do you know another expert for the defense by the name of T. Murphy Goodwin at USC?

A. I know the name but I don't know him personally. I am sure we have met at meetings or at some association, but I don't have a personal relationship with him.

Q. You're not acquainted with any of the parties or any of the experts who are involved in this case?

A. Not to the best of my knowledge and recollection.

Q. Have you asked Mr. Becker for any additional information on this case?

A. Not that isn't reflected in these materials, that I recall.

Q. Are you scheduled to appear as a witness at the trial of this case, which is set to start on March 19?

A. Yes, I am.

Q. What day are you set to appear, if you know?

A. Well, I believe -- is March 19th a Tuesday?
Q. I think it's a Monday.
A. It's a Monday. Then I believe it would be Tuesday that I have arranged to be there.
Q. You have reviewed both the prenatal and the hospital records of the pregnancy which is at issue in this case; is that right?
A. Correct.
Q. I take it, from the folder of materials that I see, you have also reviewed some records from prior pregnancies?
A. That may well be.
Q. You have not reviewed any of the records of Daysha Shine's medical treatment since birth?
A. Not after the hospital stay, correct.
Q. You have not examined her?
A. No, I have not.
Q. Am I correct in concluding that you are not going to be giving any opinions on her current state of health?
A. You're absolutely correct.
Q. What were you asked to do in this

case?
A. I was asked to review the records and render an opinion regarding the care and the -- my opinion regarding the relationship of that care to the neuro sequelae.
Q. Do you work with midwives?
A. Yes, and have extensively in the past.
Q. I assume, since you're at Johns Hopkins in the position you're in, that you work with residents and fellows?
A. Yes, that's correct.
Q. How do you define the term standard of care?
A. Well, I think there isn't a standard of care. There is a range of standard of care that exists, and that is defined by the benchmarks to which one is held responsible for the care that one is delivering.
Q. Are you familiar with the standard of care for midwives?
A. I would not hold myself out as an expert because I'm not a midwife, although I have worked with midwives extensively in the past.
Q. You're familiar with the standard of

care as it pertains to a resident?
A. Yes, in terms of residency training programs, residency education, the practice of residents and their supervision. I am an expert in that area.
Q. Do you hold a resident to the same standard of care as that of an attending?
A. I really hold the resident to be responsible for using the judgment and applying the principles that are appropriate for their level of training, which is not one standard of care. There is a range, as I said before. So when you use the term "a standard of care," I don't believe there is a standard of care. It's a range of good practice.
Q. Given what you're telling me, then, would you hold a fourth year resident to a different standard of care than a first year?
A. Not in the same areas that overlap, but I would expect the fourth year resident to be able to manage and be credentialed and be responsible for providing care in areas that a junior resident would not be responsible for providing the care. But for the areas where they are providing the care, I would hold them to the same criteria.

Q. What is your position here at Johns Hopkins.
A. I'm the director of gynecology and obstetrics, and the obstetrician and gynecologist in chief for Johns Hopkins Medicine.
Q. How long have you held that position?
A. About four and a half years at this point.
Q. In the past, were you the medical director of the midwife program?
A. Not at Hopkins because we don't have a midwife program here, but I was medical director at Columbia Presbyterian in New York.
Q. Are you still on the standards committee of ACOG?
A. There isn't a standards committee any more. I'm on the editorial board for "Guidelines for Women's Health Care."
Q. What is the difference between those two things?
A. Well, the "Guidelines for Women's Health Care" is a publication that is undergoing review at this point in time, and I'm on that editorial board that will delineate guidelines for

women's health care, recommended guidelines for practice in certain areas, both administratively and fairly cursorily in areas of clinical care delivery.

Q. Do you have any particular writings that are on your C.V. that were germane to what you see the issues to be in this case?

A. Actually I do not. I have not published in the area of shoulder dystocia.

Q. Have you written articles on ultrasound and imaging?

A. I have several, and I have used ultrasound imaging fairly extensively in my research on fetal respiratory activity.

Q. Can you describe your practice for me, how you spend your professional time?

A. Sure. At this point in my career, I spend a good 60 percent of my time in administrative responsibilities, about 20 percent of my time in teaching responsibilities, and 15 percent in clinical, direct patient care responsibilities, and about 5 percent in research. I think that adds up to 100, off the top of my head, or close. But it's significant administration with clinical practice and

educational responsibilities.

Q. So more than 50 percent of your time is spent on administrative matters?

A. At this point in my career, it is.

Q. How long has that been the case?

A. About the last four years.

Q. And during that time period, just going through those numbers again, you said that five percent is research?

A. About five percent.

Q. Does that go for the last four years too?

A. Basically the last four, yes.

Q. Then about 15 percent, I think you told me was patient care?

A. Correct.

Q. And then 20 percent was?

A. Teaching, supervising residents. That overlaps with patient care obviously.

Q. You were not critical of the prenatal care in this case; is that right?

A. Correct. Could I have my letter to refer to? This is yours (indicating). This is highlighted. Do you want me to take my copy?

Q. You can take this one (indicating). That's in your yellow folder. That's fine. There is also one marked as Exhibit 1.

A. I focused on the areas that I felt to be most significant in this case in my letter.

Q. Your letter and the opinions that you are giving me today are confined to the point in time of delivery, correct?

A. The delivery and admission, right, from admission through the delivery, correct.

Q. How often are you involved as an expert in a medical legal matter?

A. Let me try to be as candid as I can about that. I review an average of one case a month. So that would be approximately 12 cases a year that I will accept to review.

Q. Of those cases that you review, how many, if you can tell me, over the last four or five years do you actually take on and assume the role as an expert witness?

A. I would say I become substantively involved in probably a little over half of those, maybe three-quarters of those cases.

Q. For instance, now, in March of 2001, how many active cases would you have?

A. Three, not including this one. So

there would be a total of four cases that are somewhat active. Many of those were reviewed a couple years ago initially.

Q. Have you served as an expert witness before giving opinions on the issue of shoulder dystocia standard of care and birth injuries stemming from that?

A. Giving opinions on shoulder dystocia cases, I have.

Q. Have you done that in the last four years?

A. Yes. One case, a case in Florida, that I did give a deposition in and the case then went on to settlement.

Q. Do you know what the name of that case was?

A. I do not remember the name of the case.

Q. Do you keep any type of log or roster of your expert witness activity?

A. I don't keep a log. I do have folders of cases that are like this folder that you have in front of you at home, but I don't have a list of those here.

Q. Do you simply have the folders at

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home, or do you actually have the folders and a list?
A. No, I have folders from the cases and some material. I don't keep a running list of cases.
Q. The other thing I'm going to ask you to do is just wait until I'm completely done with my question. Not because I'm not following you, but I want to make sure we're not talking at the same time.
THE WITNESS: Can we go off for a second?
(A discussion off the record took place.)
Q. BY MR. MOSCARINO: Of the three other cases that you have pending now, are those cases where you are acting as a witness for the defendant in the case or the plaintiff?
A. Actually defendant.
Q. And then over the last four years, how would you break your cases down where you have actually been engaged not just in a review but to serve as an expert?
A. Right. To serve as an expert, not just a review but actually serve?

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Q. Right.
A. I would say it's -- that's a different question than I have been asked before. About 20 percent of the cases that I review are plaintiff cases. In terms of actually serving, I would say it's probably less than that. Ten percent. That is a guess to some degree.
Q. So as far as approximation, over the last four years you have been asked to review only 20 percent of the cases for the plaintiff?
A. That's correct.
Q. And of the cases that you have actually signed on to serve as an expert, it's been less than that, in the area of ten percent?
A. That is correct.
Q. I'm sorry if I asked you this already in one form or the another. Have you ever served as an expert for a plaintiff in a case involving shoulder dystocia?
A. No, I have not.
Q. The case that you were deposed that you mentioned in Florida, that was for the defendant?
A. That is correct.
Q. Was that for a physician or

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hospital?
A. Let me see. Did I represent the hospital too? It was definitely for a physician. I don't recall whether the hospital was represented by the same firm or not, but it was certainly a physician.
Q. Would it be a time consuming process for you to look in those files for you to be able to tell us the name of that case?
A. Well, it would be virtually impossible at this moment.
Q. I mean when you went home.
A. I could attempt to locate that for you.
Q. That wouldn't be an incredibly onerous thing to do?
A. No, assuming I've got the file.
Q. At Johns Hopkins, is there an accelerated family practice residency?
A. No.
Q. At the institutions that you have worked at prior to Johns Hopkins, have you worked with accelerated family practice residents?
A. No.
Q. Are you familiar with the concept or

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the program of accelerated residency programs?
A. I have learned about it reading materials in this case.
Q. Prior to being engaged by Mr. Becker's firm, did you have a working knowledge of an accelerated residency program?
A. Not of accelerated programs, no.
Q. Do you consider yourself an expert in the construction, maintenance, protocols, and guidelines for accelerated residency programs?
A. Not for accelerated because I have no experience with it. May I qualify that? I have worked in institutions with family practice residency programs in the past, including being on the planning group or the formation group for the family practice program at Columbia Presbyterian where the chair of medicine and myself, as the interim chair of OB-GYN, and chair of pediatrics formed the administrative nidus to begin to develop that family program. But accelerated programs, no.
Q. Accelerated programs, at least from my understanding today, is that a four-year medical student spends that year rotating through specialties akin to what a first year intern does. Is that your working understanding?

A. That is my understanding of that from the materials that I have read. It's basically taking the fourth year of medical school and doing a core content that would be included in a first year residency program -- in a thoughtfully developed way, I might add, you know, from reading the material -- beginning with family practice components, et cetera, and moving into other areas, as I recall reading the design.

Q. Is there anything that you feel that is inappropriate about moving someone from the fourth year of medical school to a supervised accelerated residency training program?

A. In my personal opinion, I will put it that way, I think there is something to be gained from the experience of fourth year medical school that adds the maturity of judgment and maturity of interaction in the health care system that is moved obviously a year ahead by taking that year out.

One must recall the person is not a doctor yet. They are in an accelerated program doing core electives that are going to count for their family practice residency, as I have interpreted the design.

So my personal opinion is that very mature medical students may, who have had a lot of experience in the health care system perhaps earlier in their careers in various ways, may do very well in that. Others may be disadvantaged a little bit by that, and be a highly selective process to move people into it. But certainly fourth year medical school in most institutions is an experience where the medical student is drilling deeper and in-depth into subspecialty areas, and then broadening their clinical experience to prepare them for their post-graduate years as a physician.

Q. Am I correct that you're not going to be giving any opinions at the trial of this case that this specific accelerated residency program, the formation of it and the way that it was written up, was somehow substandard or inappropriate in any form or fashion?

A. Don't believe I mentioned anything like that in my letter. So, no, I wouldn't be.

Q. Have you done any research or reviewed any materials other than what has been produced in the discovery of this case regarding this concept of a family practice accelerated residency program?

A. No, I haven't, sir.

Q. The 15 percent of your time that you practice patient care, can you describe that for me?

A. Well, 15 percent is our group practice. Then the 20 percent of educational time is partly divided in lectures and formal seminars, et cetera, and partly in supervising residents on the clinical service, and fellows. So the clinical responsibilities kind of encompass the 15 and 20 percent time. I see patients -- maybe this is the best way to describe it.

(Telephone interruption.)

Q. BY MR. MOSCARINO: Doctor, we got interrupted by that phone call. You were saying that the 15 percent is your group practice, and then you have the 20 percent where you supervise the residents. Am I quoting you right?

A. That's correct, working with the residents and medical students. Let me describe my week. That my help. Would that be all right?

Q. That's fine.

A. I see patients one-half day a week in our outpatient center. I mainly see obstetrical

patients, mainly high risk obstetrical patients and referral patients. I do see some gynecological patients as well in that environment. I am personally recovering from some health issues. So that used to be a full day a week. Right now it's a half day a week. It will probably increase in the near future.

I cover our obstetrical service, which means I am responsible for all the deliveries. I'm there for group patients as well as the resident patients about one full week every three months. So one full week a quarter where I spend the entire week on the labor floor plus all day Saturday and Saturday night. One is not on during the night during that week. So you're on, for continuity reasons, completely during the day.

Then I cover nights usually an average of two nights a month where I'm in the house at night with medical students, with the residents, and covering our group practice and dealing with our maternal transports and being very pragmatically involved with the operation of the service. I think that might summarize it best.

Q. So that amounts to four weeks of being on service per year?

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A. Well, it's not on service. It's not just in a supervisory role. It's actually dealing with the patients directly. So it would be four weeks plus that. It's providing direct patient care.

Q. Then for that four weeks of direct patient care plus the nights that you are on at nights, how many deliveries would that amount to per year?

A. At this point in time?

Q. Yes.

A. Well, I can give you last year's data. I had about 170, 160 deliveries, something like that last year, in that range.

Q. How does that compare to your delivery statistics prior to beginning the administrative role four years ago?

A. I have been, as you can see from my C.V., I have been director of obstetrics at Columbia. I have several thousand deliveries that I have actively been responsible for or done in my career, very active clinically.

The administrative responsibilities when I was interim chair at Columbia would have taken probably about 25 percent of my time in an

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interim role. Seventy-five percent of the time then was involved with either research or clinical practice, and about 20 to 25 was involved with research. It was about 50 percent time direct clinical responsibilities and educational responsibilities.

Q. How many times have you actually testified in court?

A. With the proviso that this is approximate and I'm not taking it from some granite record, ten times, in that range.

Q. Did you testify in court at all during the year 2000?

A. 2000, yes, once.

Q. Where was that?

A. That was in New York, and that was about mid-year.

Q. Was that, if you remember, a state court or federal court action?

A. It was a state court, and it was Manhattan.

Q. Do you happen to recall the name of the attorney that you worked with on that matter?

A. Jim Brown was the defense attorney. The plaintiff attorneys were -- I think it's

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Kramer, Kramer, Diloff & Moore.

Q. Were you retained by the plaintiff or defense in that case?

A. Defendants.

Q. What were the issues in that case?

A. That was a brain damage infant case, premature baby.

Q. Have you given a deposition in this calendar year?

A. This calendar year, no.

Q. Can you give me the definition, Dr. Fox, of the term shoulder dystocia?

A. Of the term shoulder dystocia. It's an obstetrical emergency that presents during the birth process that precludes the delivery of the baby without reduction of the impacted shoulder which is impacted upon the pelvic inlet.

Q. Can OB-GYNs like yourself actively predict a shoulder dystocia?

A. Can you accurately predict?

Q. Yes.

A. It's very difficult to accurately predict whether it will or will not occur.

Q. Are there risk factors?

A. Yes.

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Q. Could tell me what those are, please?

A. Large baby, asymmetrically grown baby, large mother, protracted labor, abnormal pelvic architecture, abnormal positioning of the baby. Actually I have seen congenital malformation of the baby, but very rare. That wouldn't be in the standard list. That can lead to shoulder girdle abnormalities that can lead to shoulder dystocia. Shoulder girdle in the baby abnormalities. So that's the majority of them.

Q. If the physician team is concerned about potential shoulder dystocia, are there certain steps ahead of time prior to the delivery that the team should take?

A. Yes.

Q. Could you tell me what those are, please?

A. You need to have the patient -- be prepared to have the patient positioned properly for the delivery, have appropriate exposure, have appropriate assistance available to manage the potential for that obstetrical emergency occurring. I think that basically covers it. Be in the right place, have the right people there, and anticipate

what your actions will be if that occurs.

Q. If it occurs, and if the OB-GYN team is faced with a dystocia, what are the steps or the methodologies that are used to relieve what you term or what you told me was an obstetrical emergency?

A. When it's recognized that shoulder dystocia exists, then the patient needs to be positioned appropriately, put in the McRobert's position, which is a hyperflexion of the hips. An episiotomy is immediately cut or extended if it's already been cut.

The position of the shoulders is established by examination of the patient. Then you move on to a number of potential algorithms for delivery of the baby. You call for help. You get other assistance there as soon as you recognize the shoulder dystocia exists. Then you move on into your own algorithm for management.

There are several different pathways: The Wood's screw maneuver; delivery of the posterior arm; even remotely a maneuver way down the line, positioning the patient depending on the environment where you're delivering. If you're not in a delivery room and you're caught in a

patient room somewhere, maybe putting the patient in the chest position to get appropriate exposure.

You have to go down an appropriate pathway for that patient in that environment. But the primary issues are to position the patient appropriately, get appropriate exposure, make as much room as you can to reduce that shoulder dystocia, and move ahead in a logical, controlled manner to expedite delivery of the baby.

Q. In your experience, what percentage of these cases were relieved by the McRobert's position?

A. In my experience, I would say in the range of -- for shoulder dystocia, 30 or 40 percent.

Q. If that is -- let me strike that. When you say McRobert's, are you referring also to applying suprapubic pressure?

A. That's the second. Usually you go to the McRobert's maneuver, and then go to direct suprapubic pressure in an attempt to take the shoulders, when they are on basically the anterior posterior plane, and rotate them to the oblique, rotate the shoulders to the oblique. That's the purpose of the suprapubic pressure. So it may or

may not be a relevant thing, but that would be the second thing that one would often do right after the McRobert's maneuver.

Q. Are a majority of these situations relieved by either McRobert's or McRobert's and suprapubic pressure combined?

A. In my experience, episiotomy because many times -- you wouldn't have seen this many years ago when episiotomies were routinely done. Today, episiotomies are not a routine obstetrical practice. So very often you will find that an episo has not been cut. So cutting an episo becomes one of the first things you do even before the McRobert's when you have the diagnosis of shoulder dystocia. I just want to put that in that algorithm.

So those combined three things, the McRobert's, episiotomy and McRobert's and suprapubic pressure will successfully deliver 30 to 40 percent, in my experience, of shoulder dystocias. You also -- I teach my residents think, plan, and then do.

Shoulder dystocias are very -- they are scary. They are scary for the staff that's in the room. They are scary for the patient, I'm

sure, and her significant other, and they are very scary for the provider because it's an obstructed delivery. You need to avoid panic. You need to avoid moving ahead too rapidly in this process. You do have some time. One of the things you need to do is think and then act; think, prepare, and act.

Q. You said that you have some time. Tell me about that. How do you gauge the time factor to attempt to relieve this obstetrical emergency?

A. When you're in the position of this process and you see a shoulder dystocia has occurred, time -- all of a sudden 15 to 20 seconds seems like about an hour. There is a time warp that seems to occur in all of our minds. So that when one realizes that you need to deliver the baby, but you need to do it in a thoughtful, controlled manner and get the appropriate personnel available, create the environment where you can safely assist in the birth of that baby.

The baby, at the time shoulder dystocia is occurring, is in a position where it's not going to be able to ventilate. It may or may not have cord occlusion at that point in time in

terms of fetal distress. Obviously the baby needs to be delivered, and going forward in a thoughtful, controlled manner is the way to approach this emergency.

Q. You told me that you would not be giving opinions as to Daysha's current state of health or the state of her injury, correct?

A. I have no data on which to base that, sir.

Q. Do you know what type of injury that she has?

A. She has a -- I believe she has a combined Klumpke's PRBS palsy.

Q. What is a Klumpke's palsy?

A. Klumpke's involves the lower cervical spine roots. The results are associated with -- well, adults can have it too. It can occur in lots of different environments, not just during the birth process. But it involves a palsy or a tearing of nerves, a stretching of nerves. Some of it recovers and some of it doesn't. Depends on the degree of injury.

Q. Can a Klumpke's or PRBS palsy injury occur even with the proper use of standard obstetric maneuvers that you just described?

A. It can.

Q. Would you agree with me that merely because a brachial plexus injury occurs does not mean that the practitioner was negligent in performing the delivery?

A. Just by the fact that it occurred?

Q. Yes.

A. No. I would agree with you.

Q. So the injury does not equal a negligent care?

A. Not in my opinion, sir.

Q. Was this a fast labor?

A. It was, yes. She progressed quite rapidly from admission. I think she was six centimeters on admission, and she went quite promptly on to deliver.

Q. Would you describe it as precipitous?

A. It would be bordering on that. If you look at the standard deviations around normal labor progress, this would be up towards the high part of that. Would I call it precipitous? I'd have to go back and look actually at the times to see if it can be scientifically defined as precipitous, but it was rapid. It was a rapid

delivery process.

Q. There was no arrested descent or prolonged second stage in that matter?

A. Not that I could see. No, sir.

Q. I think you told me earlier on that those are events that would increase suspicion for shoulder dystocia?

A. That's correct.

Q. Do you know how Mr. Becker or his associate, Mr. Burnett, engaged you? In other words, what was the connection?

A. I know I received a call. I don't know. I don't recall how they got my name. I don't remember that.

Q. I think Mr. Becker has told me you have never worked with him or his firm in the past?

A. That's correct. That's absolutely correct.

Q. Have you worked on any cases that you can recall in Cleveland, Ohio?

A. Not that I recall. No, sir.

Q. Do you always obtain the prior records of your patients' deliveries if they have had children under the care of other attending physicians?

A. If they are -- if there is an indication from the history that I get from the patient that those records may be valuable. For example, a patient with a prior cesarean section, needing to document the type of uterine incision and the closing of that uterine incision, things like that, I will, but not as a routine. I do not routinely mandate that I have to get records from prior deliveries unless from the history taking or something that would pique my need.

Q. The standard of care does not mandate that an OB-GYN or a midwife obtain the prior records of other caregivers in each and every instance, correct?

A. I focused my review on the hospital part of this interaction, but that is correct.

Q. Did you receive an initial letter from Mr. Becker that focused your area of inquiry?

A. It's possible if it's in the folder. I mean I don't recall right at this minute. I didn't go through that.

(A discussion off the record took place.)

Q. BY MR. MOSCARINO: Is it true that ACOG practice standards have concluded that no

combination of risk factors can accurately predict the risk of shoulder dystocia?

A. I believe that is the statement, yes.

Q. Do you agree with this statement from ACOG conclusions that, "Most cases of shoulder dystocia cannot be predicted or prevented because accurate methods for identifying which fetuses will experience this complication do not exist, and performing cesarean deliveries for all women suspected of carrying a macrosomic fetus is not appropriate."

A. Yes, I do agree that you cannot predict with any accuracy, any real precision, the risk for shoulder dystocia. You can, however, raise your level of concern that it may occur.

Shoulder dystocia occurs very frequently with babies that are normal birth weight. They are not even 4,000 grams. You see it in babies that are less than 4,000 grams. As I tried to describe before, there are a lot of different things that can interplay to lead to a shoulder dystocia. You just can't predict those. But there are characteristics of patients that are more likely to experience, during a birth process,

shoulder dystocia. I just wanted to clarify that terminology.

Q. But you would agree that performing cesarean deliveries for all women who are suspected of carrying a macrosomic fetus is not appropriate?

A. I agree, depending on your definition of macrosomia. I suspect you're aware there is a wide range of definitions.

Q. What do you go by?

A. I would recommend a cesarean section for a patient if we have data to indicate a baby is over 5,500 to 5,500 grams. That's outside. Beyond that, the definitions, some people use 4500 grams. Others will use 4,000 grams as defining macrosomia. We know those are bigger babies.

When you think you have a bigger baby, one realizes there is an increased probability that there could be an obstetrical emergency such as shoulder dystocia occurring during the labor process. But it's not saying it would happen, therefore, we will do a cesarean section. I hope that answers your question.

Q. How about you in your practice? Where have you drawn the line as far as what the definition of a macrosomic fetus is?

A. In my own practice, if I have data that indicates a baby is significantly asymmetric in its growth; i.e., an infant of a diabetic mother that is pushing the 4500 gram mark and asymmetry, I will recommend a cesarean section to that patient.

Will I tell the patient they would have a shoulder dystocia if they delivered vaginally? No, but I would say in my opinion and in my experience, they would have a higher likelihood of having an obstetrical emergency that could relate to birth trauma occurring during that labor process. That's the way I would approach it.

Q. How does an OB-GYN like yourself have this data that would suggest a baby at this 4500 level?

A. Well, you would do clinical estimates of fetal weight, which are plus or minus about 200 grams per kilogram. So that gets to be a pretty wide range. You can think the baby is 48, 4900 grams and it could be 4,000. You are perfectly aware of that.

Also, using ultrasound and biometry to measure ponderal indices of the baby in order to calculate and estimate fetal weight, with still variability but a little higher precision, and

looking at the symmetry of the growth of the baby. A baby with an extremely large abdominal circumference compared to head, for example, showing large truncal dimensions, that can be truncal obesity related to diabetic, glucose values during a pregnancy. That would lead to a higher risk of obstetrical emergency during delivery.

Q. During your practice and in your experience, in nongestational diabetic, you would not recommend as a general rule a cesarean section for a fetus with an estimated weight of 4,000?

A. No, that's right. As I said, my letter is focused on the delivery process, et cetera. I think that this patient coming in to deliver was appropriate.

Q. So you do not believe that it was a breach of the standard of care for Ms. Johnson to come to University Hospitals of Cleveland on the day of delivery as opposed to having been scheduled for a cesarean section?

A. Well, I may be wrong on this, but I thought she was scheduled to come in that day for an induction, to be delivered. But she came in in labor on the day she was scheduled for an induction, which was pretty good planning in terms

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of maturity. The baby obviously was ready to be born. I think it was appropriate for her to have a trial of labor.

Q. You would then disagree with another expert who opines that a cesarean section should have been done in this specific case?

MR. BECKER: Objection. You can answer.

THE WITNESS: I would say that other physicians will have their opinions based on often their mode of practice, you know, their personal practice experience. My opinion would be different from another individual's.

Q. BY MR. MOSCARINO: I want to go to the findings in your report, if I may.

A. Certainly.

Q. It's your opinion, in the middle or towards the latter middle of Page 2, you state, "It is my opinion that had a senior, experienced obstetrician been present earlier for the delivery, it is more likely than not that the brachial plexus injury would not have occurred."

A. That's correct, sir.

Q. You stand by that statement today?

A. Yes, I do.

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Q. Your reason for that is what?

A. When a senior physician arrived, I believe that was Dr. Holzheimer, the delivery was executed in a -- as I have almost described before, in a methodical way. Episiotomy was cut. The patient was positioned and the episiotomy was cut, and the delivery was executed, I believe, in about -- I think the time period I recollect is less than a minute, 30 seconds, something like that, for resolution of the shoulder dystocia. That's the basis for my opinion.

Q. And you state later on in your report that Dr. Segil failed to control the delivery as evidenced by the patient pushing up on the birthing bed.

A. I believe I said the delivery situation. So it's the environment of the delivery. The patient -- the picture I have, in reading the composite of the record, is that the patient was very uncomfortable. The delivery was happening very quickly. The patient was pushing up on the bed, and Caregiver Segil was attempting to deliver the baby with the patient pushing up on the bed and moving in lots of different orientations, is what I take from the records.

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Q. Based on your review of the records and your experience, and the fact that this patient did not have an anesthetic and it was moving quite quickly, at least, by your testimony, borderlined precipitously, this woman was in a high degree of discomfort, pain, correct?

A. Precipitously to the point of the shoulder dystocia. So high degree of pain. I would suspect she was very uncomfortable, yes, absolutely.

Q. Am I correct in concluding that she was withdrawing from the caregiver towards the wall, do you know?

A. I don't know the orientation of the bed. I wasn't there. But I -- in my mind's eye, I can picture a patient who was pulling up on the bed trying to get away from the pain that she was experiencing.

When Dr. Holzheimer became involved and I perceive took control of the situation, and you can do this even with patients in severe pain, moving the patient down, not moving ahead immediately to deliver the baby to get the baby out, but to get her positioned so you can safely get the baby out was the event that then took

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place. That's the picture I have in my mind.

Q. Do experienced caregivers have situations where they have difficulty getting control of a patient when they are under discomfort as in this case?

A. They certainly can, absolutely.

Q. Is the fact that the patient is in discomfort and somewhat out of control, is that in and of itself a breach of the standard of care by the caregiver or the obstetrician?

A. No, I would not say that's a breach of the standard of care. That it's going very rapidly, you can't predict that.

Q. In your experience, have you seen where there is one obstetrician or resident taking care of the patient, and then a second person comes in and sometimes the patient will act differently towards that second caregiver?

A. That can happen.

Q. Because that patient acts different for that second caregiver, that doesn't mean in and of itself that that first caregiver or obstetrician was acting beneath the standard of care; is that right?

A. It becomes a very difficult task to

determine what level of experience and what level of control is brought to bear on working with the patient and what the immediate goals are. If the immediate goal is to attempt to, as best you can, reassure the patient, get the patient to understand that her participation and control is extremely important in this process for herself and the baby, and to move along the lines that I have already described a couple of times in terms of managing the birth process, I think that that type of approach is the standard of care, is within the standard of care in this situation.

Q. Just on a yes or no basis, because the patient acts differently or is more responsive to the second caregiver does not mean in and of itself that the first caregiver was acting beneath the standard of care?

A. No, not on its face value.

Q. With respect to Number 1 on Page 2, what, in your opinion, specifically did Dr. Segil fail to do to prepare for possible shoulder dystocia?

A. When you're concerned that a patient may -- is at in increased risk for an obstetrical emergency such as shoulder dystocia, then you would

be assuring that you will have help available to deal with that crisis. In the situation with Mr. Segil, he's an inexperienced post-graduate, an inexperienced pre-post-graduate individual providing the obstetrical care. The responsibility of having senior individuals available to participate in the management of that case should that obstetrical emergency occur is partly what I'm referring to there.

Q. And you have already given me your reasons for Number 2?

A. I believe so. Yes, sir.

Q. Are you critical of Dr. Segil or any of the other caregivers for being unable to administer anesthesia during this quick labor?

A. Well, Dr. Segil, by the time -- when Caregiver Segil came back to the room, the patient was in the process of delivering the head. It would be too late to administer a peripheral regional block like the pudendal block at that point in time to give her some pain relief.

Local anesthesia with a distended perineum would be essentially irrelevant at that point in time. With the picture that we have of this birth process, not being able to get regional

anesthetic to the patient would not be, I think, Dr. Segil's responsibility at that point.

Q. With respect to the time period from when Ms. Johnson came to University Hospitals to the point in time when Dr. Segil is called in the room, which I believe is around 8:12 a.m., are you critical --

A. I'm trying to remember. She came in around 7. I don't remember exactly when she arrived, but 8:12 is when she felt something was coming out.

Q. I think, not having the records, I think your memory is correct, that she came in at 7 a.m.

A. That was my recollection. Thank you.

Q. I'm drawing your attention, Dr. Fox, to the time period of 7 a.m. to 8:12. Are you critical of Dr. Segil or any member of the team for not having this patient undergo an epidural?

A. No, I'm not.

Q. Moving to Number 3, you state that Caregiver Segil failed to position the patient appropriately. Can you tell me what you mean by that?

A. The description is the patient was pushing up on the bed as Mr. Segil was attempting to execute the delivery. So the patient was not positioned appropriately to give a posterior space that would allow for delivery of the shoulders.

Q. Are you aware of the fact that I believe in his deposition Dr. Holzheimer said that when he came in the room, the patient was in McRobert's position and suprapubic pressure was being applied?

A. I'm aware that there is a description of that. At that point in time, Dr. Holzheimer went on to move the patient down the bed, which gives the posterior space. One of the issues when a patient pushes up on the bed is that the bed is flat and there is no posterior space.

So the McRobert's maneuver can certainly assist in helping to execute delivery of the shoulder dystocia, but with no episiotomy and without a posterior space, without something under the patient's hips -- which is not optimal, the patient's hips being at the bottom of the bed -- so that there is a posterior open space to be able to move the head straight down and help disimpact the anterior shoulder, that's what I mean by the

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position. That wasn't done.
So I envision the patient up on the bed as you describe, McRobert's position, suprapubic pressure being applied, and no posterior space being available. One of the things Dr. Holzheimer describes is going through the process of moving the patient down on the bed, cutting the episiotomy, and executing the delivery.
Q. So you're telling me that she was in a McRobert's position with suprapubic pressure being applied, but it's not effective because of lack of posterior space?
A. Correct, it's not going to be as effective because of lack of posterior space.
Q. Are you telling me that it's useless?
A. No, I would not go so far as to say it's useless. One of the, as I mentioned a couple of times before, the important factors are to move through methodically in a logical manner, to position the patient appropriately, get the posterior space, cut an episiotomy in order to allow for the posterior shoulder to descend.
You can have the patient in McRobert's maneuver, putting suprapubic pressure on

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and attempting to rotate the shoulder off of the anterior/posterior to an oblique, and no space for it to rotate if the patient is not positioned properly. You never say never it wouldn't work, but it certainly is not optimal by any means.
Q. I forgot to ask you one thing, by the way. Have you been furnished with the deposition of Rosalie Johnson, the mother? I did not see it in your materials.
A. Let me see if I listed it here.
Q. I know you would not have listed it, Doctor, because it was taken after your report.
A. Then I don't believe so.
Q. Okay. The effort by Dr. Segil to have this patient in the McRobert's position and to have Dr. Schwartz assist with suprapubic pressure, in and of themselves, those are standard of care maneuvers or methodologies when faced with a shoulder dystocia presentation, correct?
A. Those are appropriate maneuvers to pursue.
Q. I think what you told me before, those would be the first two in conjunction with the episiotomy?
A. Correct. Position the patient is

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not a McRobert's maneuver. I have to be clear about this. The McRobert's maneuver is flexing the thighs up onto the abdomen. It changes pelvic tilt and architecture. That helps to reduce the shoulder dystocia. It does not provide posterior space. Moving the patient down on the table, getting the patient positioned appropriately combined with the McRobert's maneuver, et cetera.
In a situation where you have a shoulder dystocia and you have no way of turning the patient sideways on the bed, bringing her perineum to the edge of the bed, and getting a posterior space, as I mentioned before. Moving her into even a knee/chest position can be a very useful maneuver in that circumstance. It becomes anterior space at that point, but you get the room to deliver the baby. With the patient in a knee/chest position, she is in McRobert's position by virtue of the fact that she's crouching.
Q. Was the bed broken down?
A. At some point it became broken down, and I believe the bed was broken but she pushed up on the bed. The mattresses in fact -- and I don't know what bed was being used here. The mattresses are pretty firm on these birthing beds and they

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have a cutout into the lower component of the mattress actually to facilitate that posterior space development when you are bringing the patient down and still support the posterior thigh.
Q. The breaking down of the bed, is that an appropriate decision?
A. It's an appropriate decision to make, yes.
Q. Did Dr. Segil attempt to do an episiotomy?
A. I would have to go back and look. I don't recall that being written in the records, but I would have to go back and look at that specifically.
Q. If he planned to do an episiotomy or he was doing that or that was his next step, that would be an appropriate step in this presentation?
A. An episiotomy would be one of the first things that one would do in this circumstance. She didn't have an episiotomy and they weren't going to be enlarging it. I believe he said -- I mean one of the early things he did was bring the patient down and cut an episiotomy. Those are the appropriate things to do.
Q. Have you given me your reasons for

your Conclusion Number 3 on Page 2?
A. Let me just read it once more, sir. Yes.
Q. Turning to the next page, you conclude that, "Caregiver Segil deviated from within the standard of care by failing to safely and adequately perform maneuvers to execute delivery of a shoulder dystocia." You stand by that statement today, correct?
A. Yes, that's correct, sir.
Q. What did Dr. Segil do?
A. What did Dr. Segil do?
Q. Yes.
A. Dr. Segil, I believe was attempting to deliver the shoulders by getting Dr. Schwartz to administer suprapubic pressure by doing a McRobert's maneuver. This is not successful. So these were the maneuvers he was doing.
I believe there is testimony or data to show that he had tried to rotate shoulders at some point in time. But at no time do I see that the patient was positioned appropriately and an episiotomy being done to expedite the delivery of the shoulder dystocia.
Q. All I want to do is find out exactly

what your opinions are here so that when we meet again in Cleveland, if we do, I understand what you're saying.
A. No problem. If I didn't answer it, ask again.
Q. If I wrap up and I have asked you the same question before, just bear with me. I'm not here to take up more time than I have to.
A. No problem.
Q. You told me, and I think you made it clear that he didn't have her, in your opinion, in the right position?
A. Correct.
Q. You have also made it clear to me that it's your opinion that he should have been able to cut an episiotomy, and that is one of the first things you would have done, correct?
A. Correct.
Q. Those are two things that you're saying he did not do, correct?
A. Correct, absolutely.
Q. Did he do things, in your opinion, that were inappropriate? Did he take affirmative action in any form or fashion that you find to be negligent?

A. He was attempting to deliver the shoulders without taking those actions, which, in this case, we had a large baby. But even in a normal size baby, by not having the appropriate space to deliver the baby, you can end up with complications associated with shoulder dystocia such as neuro trauma. So I think moving ahead to attempt to execute the delivery of the shoulders without taking appropriate actions was outside of the standard of care.
Q. What did he do to attempt to deliver or attempt to remove the impacted shoulder or shoulders?
A. He was attempting for a period of time. I think when we go through the record it says 2 minutes or 4 minutes, and then 30 seconds of that would have been Dr. Holzheimer trying to get the time line together here. But for at least a couple of minutes, perhaps up to three and a half minutes, he was attempting to deliver the shoulders without the patient being appropriately managed.
So I don't know. I was not there. I can't say what type of maneuver was being done at that time to do -- to accomplish that delivery. But it can be virtually impossible to do that

safely without the patient being positioned appropriately.
Q. You are not of the opinion that he was applying excessive or improper traction for three and a half minutes, are you?
A. I'm not saying three and a half minutes. I think that it's my opinion, to a reasonable degree of the medical certainty, that the injury that this baby has evidence of, the neuro deficits, is related to the timing, the process during that period of time attempting to deliver the shoulders without the patient being appropriately prepared for that maneuver. That's my opinion.
Q. I'm sorry if I asked you this before and I didn't understand your answer. What exactly did he do, if you know, to attempt to deliver the baby?
A. Well, recalling the depositions, which I have not immediately reviewed prior to this deposition, et cetera --
MR. BECKER: Doctor, if you want to look at the depos, you're free to do that.
THE WITNESS: I understand that. There were maneuvers applied and attempts to

deliver the shoulders with the patient not appropriately positioned and prepared to do that. That can lead to excessive traction, excessive maneuvers that can lead to the neuro deficits that have been evidenced here.

Q. BY MR. MOSCARINO: So we can leave this without me belaboring the point, is it your opinion, Dr. Fox, that without this patient having the episiotomy and being in what you term to be the correct position, that any attempt to deliver the baby would be substandard?

A. No. A gentle attempt to see if the baby -- if there was enough room to deliver this baby would be perfectly appropriate. When you determine it's a shoulder dystocia, that this is an obstructed delivery, that this is an obstetrical emergency, it is my opinion that that's when you stop and do the right thing to accomplish the delivery as safely as possible for the baby.

That includes the things that we have been over; the positioning of the patient, and certainly the cutting of the episiotomy, and certainly applying the logical maneuvers, including the suprapubic pressure and the McRobert's maneuver and, of course, getting help.

Q. Is it unheard of or uncommon that a patient like this without anesthesia, in this type of quick labor, would not listen to even the experienced caregiver regarding positioning and would continue to withdraw from a doctor with your experience?

A. That's where you stop and you work with the patient to make this a safer environment to deliver. It can certainly happen, but look at what happened when the experienced attending walked in the room.

He took control of the situation, moved the patient down, got the position, cut the episiotomy. Relatively rapidly, the baby delivered. It is that scenario of events that leads me to opine in this situation that the maneuvers prior to that were done inappropriately without the positioning and the episiotomy.

Q. Am I correct, then, that you are using Dr. Holzheimer's result and Dr. Holzheimer's methods as evidence in your own mind to conclude that Dr. Segil did not comply with the standard of care?

A. As evidenced to -- well, no. He did not comply. He was not practicing within the

standard of care based on the fact that he should have appropriately positioned the patient regardless of what went on. Had this gone on and been another 10 or 15 minute process, God forbid, to the baby, in the best of hands, I could not fault the situation if the positioning had been done, if all the maneuvers had been done. These are very basic maneuvers to deal with a shoulder dystocia.

Q. If Dr. Holzheimer had come in, instead of taking 20 to 30 seconds, it would have taken him five minutes or so to deliver the baby, would you still be critical of Dr. Segil?

A. Yes, because we would still have the two or three and a half minutes, whatever it was, of time prior to Dr. Holzheimer becoming involved.

Q. Are you of the opinion that the time period, if indeed it was three and a half minutes, is too long for the attempt to deliver, in and of itself, a shoulder dystocia presentation?

A. No, sir.

Q. If the patient was in the appropriate position, gentle traction is appropriate?

A. Yes.

MR. BECKER: This is before or after shoulder dystocia is diagnosed?

THE WITNESS: In the appropriate position, with an episiotomy, with posterior space, with McRobert's maneuver at the same time as suprapubic pressure is placed and -- define the word gentle, but moving the head directly parallel to the axis of the pelvis to the floor, which does not put a downward traction on the plexus that we're talking about here, is an appropriate maneuver. A down and out maneuver is absolutely inappropriate because that's exactly how a palsy or a physical transection can occur.

Q. BY MR. MOSCARINO: Are you saying that Dr. Segil did a down and out maneuver?

A. I wasn't there. I can't say. I can just see the picture that has been painted from looking at the composite of the records.

Q. With respect to his actual placement of his hands on this baby's head, you're not critical of anything that he did with respect to that?

A. I was not there. I don't know what pressures he put on.

Q. Have we discussed your opinions and

your basis for your opinions for Number 4?
A. Yes.
Q. Moving on to Number 5, the focus here is Dr. Schwartz?
A. Yes.
Q. Dr. Schwartz, in your opinion, deviated from the standard of care?
A. Yes, from within the standard of care.
Q. What was her role here?
A. Caregiver Segil was the person that was hands-on with this delivery. She had come as the resident physician to be with him in this process, and had, I think, six months more experience. She was a PGY-1 in OB.
She, as Mr. Segil's supervisor, should have held off on any maneuvers or encouraged him to hold off on these maneuvers, if she had the wisdom to do that at her young state in maturing in obstetrical experience, until the patient was positioned appropriately, episiotomy was cut, et cetera. I think that was a failure on her part to supervise Dr. Segil adequately in performing this delivery. That's the basis for that.
(Pause in proceedings.)

Q. BY MR. MOSCARINO: Dr. Fox, then your opinions regarding Dr. Schwartz are confined to supervision. You're not saying that she did anything affirmatively that was incorrect or below the standard of care?
A. That is correct, sir.
Q. Do you know any of the OB-GYN physicians, the attending physicians at University Hospitals of Cleveland?
A. I'm sure I know some, sure.
Q. Have you ever been to the University Hospitals of Cleveland to lecture?
A. I have been to Cleveland but not University Hospitals. I have been to -- gosh. What's it called -- Metro years ago. I'm talking many, many years ago. I was there once. Then I did a perinatal education program at one of the large community hospitals in the area. For the life of me, I can't remember what it was. That was a long time ago. It was probably 15 years ago.
Q. Number 6 is directed at the institution. Your opinion here is that the hospital failed to assure the adequate supervision of Dr. Schwartz and Dr. Segil in the performance of their task in supervising the birth of Daysha Shine

as required by the special requirements for residency training?
A. Correct.
Q. What is the phrase "by the special requirements for residency training" mean?
A. We are all -- our residency programs are all governed by the specific residency review criteria put forth by the ACGME, the certifying group for residency education programs. I believe the family practice program is also an ACGME. There is also the ABMS, which is another certification program. These are all ACGME.
As educators, we are required to assure the adequate supervision of residents for their level of training. Both of these documents have wording to this effect. The specific wording, I'm not exactly sure of at that time, but it is to assure adequate education and to assure patient safety.
A first year -- six-month, first year residents in OB supervising a fourth year medical student, a first year residency participant in family medicine, you know, the accelerated program position doesn't provide adequate supervision for a patient who is at risk for an

obstetrical emergency.
A fourth year resident, a third year or fourth year resident may be delegated that responsibility, primary responsibility, by the attending that is in charge of the obstetrical service depending on their experience and what experience they have had in dealing with obstetrical emergencies. By the third or fourth year of a residency, most everyone had has considerable experience and they can supervise the junior residents.
The attending who is responsible for the patients in a resident practice, which is what this seemed to be, is ultimately responsible for that. That, I see as the responsibility of the educational institution, to ensure that appropriate supervision is available. That's my basis.
Q. So the answer that you gave to me just now is based on your understanding as to the standard of care at teaching hospitals for the supervision of residents?
A. As indicated by the standards for having approved residency programs, correct.
Q. You're not specifically saying that this hospital failed to comply with the accelerated

residency program guidelines?

A. No, I am not. I have no idea exactly what the accelerated residency program guidelines are. I know what the guidelines are for supervision of a resident in family practice or a resident in obstetrics and gynecology, and that supervisory responsibility would be present for an entity that is participating in this accelerated program.

Q. Would this criticism be the same if Dr. Segil was a first year resident and Dr. Schwartz was in the room with him and she was a second year resident?

A. I think the second year resident, depending on the amount of obstetrical experience. That varies with residency programs. At the end of their second year residency, they may be qualified to supervise a first year resident for an obstetrical emergency.

By the time they have had substantive obstetrical experience, they will develop the skill of recognition of this emergency, and then the need to coordinate care and to intervene in a reasonable manner. So I would say an ending second year resident could subsupervise a

PGY-1.

Q. In your comments, Dr. Fox, under Number 6, which we are discussing right now, did they begin at the time that the shoulder dystocia or obstetrical emergency presents?

A. Did they begin. They called for help, I believe when they defined the shoulder dystocia. The patient was defined as being at increased risk for this obstetrical emergency upon admission. I think Mr. Segil indicated that he thought the baby was large but she had had larger babies before.

There was a question there and it was, I think, clarified in the depositions about the term dystocia was there, risk for dystocia. In the depositions it became pretty clear to me. At first I was a little surprised seeing at risk for dystocia. Do they mean a protracted labor, you know.

She's already six centimeters dilated with essentially an engaged vertex. Anyway, what they were talking about, it became clear it was risk for the shoulder dystocia. So there had been the recognition around the time of admission that there was this increased risk for an

obstetrical emergency.

It is with that recognition that the steps should be put in place to get appropriate supervision available for that delivery, someone who has considerable experience in dealing with that emergency. I think for a patient presenting with this constellation of risk, it was probably in the range of a 10 to 15 percent chance, 20 percent maybe, that it's going to happen. But you better be prepared for it because it can be a very -- it is a very severe process.

So the senior person may have needed to have been there just at the time the delivery was going to occur, gone at the time they were called to the room. There should have been an anticipation of that, and there was in the record. Mr. Segil recognized that this was a potential risk.

Q. When you say available, does that necessarily mean that from 7 a.m. on, that the senior person has to be in the delivery room?

A. No, but available on the delivery unit so that as soon as the shoulder dystocia is evident, they can be in the room I would say within less than 60 seconds, be immediately available to

participate, standing outside the door if you're going to give the resident the autonomy to go ahead with that birth.

That's the judgment of the supervising senior physician who is there, ready to go, allowing the more junior physician some autonomy in terms of the learning process of how to deal with this, but be there immediately available to participate when it becomes evident that there is an obstetrical emergency. That's practicing within the standard of care, and that is the responsibility of the institution.

Q. Am I correct that up until the time of the shoulder dystocia presentation, you don't levy any criticisms against Dr. Segil?

A. I think Mr. Segil didn't -- it's unclear whether he informed his chief resident, and I think that's Dr. Hudock -- maybe I'm pronouncing it wrong. I'm sorry -- of his concern of the potential big baby, big babies before, potential big baby, and that he thought there might be an increased risk for shoulder dystocia. I would say Dr. Segil should have communicated that to his senior resident beyond Dr. Schwartz. Dr. Schwartz, I'm viewing that more as a peer resident at this

point in time.
Q. Other than that issue with respect to whether Dr. Hudock was informed by Dr. Segil, you're not critical of him up until the time when the shoulder dystocia presentation --
A. The shoulder dystocia was in the process of presenting when he got to the room, I believe. I'm not absolutely clear as to when he came in, but that became apparent shortly after he arrived. At that point, one should move on with the maneuvers that I have been talking about.
Q. As of 7 a.m., when Ms. Johnson went to University Hospitals of Cleveland, was she a high risk patient?
A. At 7 a.m., she still had intact membranes, if I remember correctly. So they didn't know about meconium stained fluid which incurs some risk for the newborn at that point in time. It was recognized, once her admission was done, that she had a large baby, or they suspected a large baby, and the potential for a shoulder dystocia. Then she became at increased risk for an obstetrical emergency in the birth process. Was she a high risk patient by classic definition, you know, severe preeclampsia or wild diabetes? No, she was

not.
Q. You would agree with me she was not a high risk patient during the prenatal care?
A. Correct.
Q. With respect to Number 6, which we were discussing, have you given me, Dr. Fox, your reasons for the conclusions regarding University Hospitals of Cleveland?
A. Yes, I believe I have.
Q. Now, the final criticism, Number 7, is that University Hospitals of Cleveland deviated from the reasonable standard of care by failing to assure the presence of an experienced obstetrician in this case of an anticipated OB emergency. Did I quote you that correctly?
A. You read that correctly, yes.
Q. Tell me what you mean by that.
A. Well, we have sort of been talking about that. Part of it has to do with the responsibility -- the previous one was the responsibility for supervision of residents. This one is assuring the presence of an experienced obstetrician to deal with a patient who has an increased risk for obstetrical emergency that you cannot accurately predict until it actually

happens.
It is the responsibility of the institution in taking care of this patient globally to assure that a senior experienced person is providing care to that patient like any patient who is receiving their care from their private attending physician.
Q Does this experienced physician or experienced obstetrician have to be an attending?
A. That would be up to the institution. It would be at least a senior resident, at least a senior resident, but optimally, an attending physician. But it should be a physician who has had very substantive obstetrical experience and experience with obstetrical emergencies. So that would be third or fourth year resident in a four-year residency program of OB-GYN.
Q. So is it your opinion that this brachial plexus injury occurred after 8:12 a.m., when Dr. Segil was called into the room?
A. Yes, I believe that is my opinion. Yes, that is my opinion.
Q. Is it your conclusion that it occurred prior to Dr. Holzheimer coming into the

room?
A. As best as I can determine, yes, that is my opinion.
Q. What maneuver did Dr. Holzheimer use?
A. Dr. Holzheimer positioned the patient, cut the episiotomy, and then -- I'd have to review it exactly. He either did a Wood's screw or posterior arm delivery. I don't remember which one it was. Either one is perfectly appropriate.
Q. It's my recall that he used the Wood's maneuver.
A. He may have used the Wood's maneuver. Based on the experience of the individual and how comfortable they feel, either one of those is absolutely appropriate. The Wood's maneuver is probably the best one in a person that doesn't have anesthesia.
Q. What is the Wood's maneuver?
A. Wood's maneuver is determining the position of the shoulders and moving either clockwise or counterclockwise to rotate the shoulders from the anterior posterior to oblique position, allowing there to be a larger space for entry into the pelvis. The pelvis in the

anterior/posterior position is narrowest.
So you move the shoulders and you move the anterior shoulder posterior, and that brings the posterior shoulder down and delivers it over the perineum and allows the rotated shoulder to deliver. That's the Wood's screw maneuver.
Q. Can an infant or a fetus sustain a brachial plexus injury during a standard of care Wood's maneuver?
A. It can.
Q. During a Wood's maneuver itself?
A. No, I would say not during the Wood's maneuver itself.
Q. Would it be prior to?
A. That would be very difficult mechanically because you have done -- the way you do the maneuver, it's maintaining the baby in the plane. It could have been prior to, related to maneuvers done prior to moving to the Wood's screw maneuver or the Wood's maneuver. It could even incur afterwards, you know, if down and out traction is used to deliver the now anterior shoulder after the posterior shoulder has been manipulated into a more oblique position.
Q. Are you ruling out that the injury

occurred after Dr. Holzheimer came into the room?
A. In my opinion, from the description we have, it is extremely unlikely that it happened then. This delivery with the -- as described when Dr. Holzheimer was there, is one that was executed relatively easily with appropriate positioning of the mother and the appropriate actions by the experienced obstetrician.
Q. But can you rule that out 100 percent that the injury occurred after the time that Dr. Holzheimer came into the room?
MR. BECKER: Objection. You can answer, Doctor. He's asking you 100 percent. You have answered in terms of probability.
THE WITNESS: My answer is it's my opinion related to the probability, you know, the likelihood. Nothing is 100 percent.
Q. BY MR. MOSCARINO: And regarding your last sentence in your report where you say it's your opinion that it's more probable than not that the injury would have most likely not occurred if an obstetrician with appropriate experience and training supervised the birth, I take it by my multiple questions to you regarding 1 through 7, you have already given us the reasons for that?

A. That is correct, sir.
Q. I want to ask you if you agree or disagree with this sentence from Dr. Goodwin's report: "In a patient who progresses very rapidly to delivery, it is reasonable to attempt ancillary maneuvers prior to cutting the episiotomy, especially in a multi-para who may have a laxed endroitis." (Phonetically spelled.)
A. I believe this is, in the context of this, this is after shoulder dystocia is diagnosed, to my recollection. I do not agree with that.
Q. Why not?
A. Because when you have the shoulder dystocia, you have evidence of no space to deliver the shoulders. You must create additional space. And doing an episiotomy is immediately -- that and positioning the patient, calling for help are the primary actions.
MR. MOSCARINO: I'm almost done, Doctor. I'm just going through my notes here.
THE WITNESS: All right. Take your time.
(Pause in proceedings.)
Q. BY MR. MOSCARINO: Are there any ACOG practice patterns or other guidelines that you

feel are pertinent to this matter?
A. That are pertinent to this matter, no, I don't believe so.
Q. You're not relying on any particular medical texts, journal articles, or abstracts in giving your opinions that you have told me about today; is that right?
A. No, I'm not.
Q. Doctor, I have your report which we have marked as Exhibit 1. I have asked you questions over the last almost two hours. My question to you is do I have all of your opinions in this matter so that when I go out the door, I know that you have told me what your opinions are regarding the case of Daysha Shine versus University Hospitals of Cleveland?
A. Yes, sir.
MR. MOSCARINO: I have no further questions at this point. I'm going to mark his file, and with your permission, I'm going to remove the medical records from the file so I can have the other parts marked as an exhibit. So the record is clear, I think the only exhibits we have are Number 1, which is Dr. Fox' report; 2, which is the --
THE WITNESS: Are you taking the

whole file?
MR. MOSCARINO: I'm going to ask her to Xerox it or have you Xerox it and give it to her.
MR. BECKER: You don't need the depositions?
MR. MOSCARINO: No. I'm going to remove the depositions and the medical records.
MR. BECKER: How about if we have the doctor's office photocopy it and then send it to the Court Reporter?
MR. MOSCARINO: That's absolutely fine.
MR. BECKER: That's fine.
MR. MOSCARINO: Thank you.
(The deposition concluded at 11:20 a.m.)
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