

1 STATE OF OHIO
2 COUNTY OF CUYAHOGA

3 IN THE COURT OF COMMON PLEAS
4 - - -

5 DAYSHA SHINE, et cetera, et al,)
6 Plaintiffs,)
7 vs.) Case No. 339640
8 UNIVERSITY HOSPITALS OF)
9 CLEVELAND, et al,)
10 Defendants.)

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12
13 DEPOSITION OF
14 HAROLD E. FOX, M.D.
15 BALTIMORE, MARYLAND
16 MARCH 1, 2001
17
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19
20

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REPORTED BY: Belinda Lomax, Professional Reporter

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17 Deposition of HAROLD E. FOX, M.D. was
18 taken on behalf of Defendants at the Johns Hopkins
19 Hospital, 600 North Wolfe Street, Houck-Phipps
20 Building, Room 264, Baltimore, Maryland commencing
21 at 9:35 a.m., Thursday, March 1, 2001, before
22 Belinda Lomax, Professional Reporter.
23
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1 INDEX
2 WITNESS: HAROLD E. FOX, M.D.
3
4 EXAMINATION PAGE
5 By Mr. Moscarino 5
6
7 EXHIBITS: PLAINTIFF'S DESCRIPTION PAGE
8 None
9 DEFENDANTS' DESCRIPTION
10 1 - Report
11 2 - Curriculum vitae
12 3 - Medical file
13 (The exhibits were marked off the
14 record by counsel.)
15 QUESTIONS WITNESS INSTRUCTED NOT TO ANSWER:
16 None
17 INFORMATION TO BE SUPPLIED:
18 None
19
20 CERTIFIED QUESTIONS:
21 NONE
22
23
24
25

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1 APPEARANCES
2
3 ON BEHALF OF THE PLAINTIFFS:
4 BECKER & MISHKIND, CO., L.P.A.
5 BY: MICHAEL F. BECKER, ESQUIRE
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7 Elyria, Ohio 44035
8
9 ON BEHALF OF THE DEFENDANTS UNIVERSITY HOSPITALS OF
10 CLEVELAND AND DR. SEGIL:
11 MOSCARINO & TREU, L.L.P.
12 BY: GEORGE M. MOSCARINO, ESQUIRE
13 The Hanna Building
14 1422 Euclid Avenue
15 Suite 630
16 Cleveland, Ohio 44115
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1 PROCEEDINGS
2 Whereupon --
3 MR. MOSCARINO: The record should
4 reflect that this is the discovery deposition of
5 Dr. Harold Fox, who has been identified as an
6 expert witness in the case of Daysha Shine versus
7 University Hospitals of Cleveland.
8
9 HAROLD E. FOX, M.D.
10 being first duly sworn to tell the truth, the whole
11 truth, and nothing but the truth, testified as
12 follows:
13 DIRECT EXAMINATION
14 BY MR. MOSCARINO:
15 Q. Dr. Fox, we met a minute ago. My
16 name is George Moscarino. I represent the Hospital
17 and Dr. Segil, and I'm obviously here to ask you
18 some questions this morning regarding your report
19 and regarding your opinions in this case. Okay?
20 A. Yes, indeed. Good morning.
21 Q. You, I take it, have had your
22 deposition taken before?
23 A. Yes.
24 Q. Let me tell you what I think the
25 ground rules are and then we will be on the same

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

10 A. Fair enough.

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

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

18 Q. Have you issued any subsequent
19 reports?

20 A. No.

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

24 A. No, I am not.

25 Q. Exhibit 2, I believe you told me,

1 deposition, right?

2 A. Correct.

3 Q. And Dr. Holzheimer's deposition?

4 A. Correct.

5 Q. Both of which are in this red
6 folder?

7 A. Correct.

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

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

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

14 A. Not to the best of my knowledge.

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

17 A. No.

18 Q. Did you read his report?

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

20 Q. Did you read the report of Dr.

21 Justin Lavin, from Akron, Ohio, who is identified
22 as an expert witness for the Defendants?

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

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

3 A. That's correct.

4 Q. Is that current?

5 A. This is the current one.

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

9 A. That's correct.

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

16 A. That's correct.

17 MR. BECKER: Did you mention Dr.
18 Segil?

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

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

24 A. Right.

25 Q. You also read Dr. Segil's

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

3 Q. You don't know him?

4 A. No, I do not.

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

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

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

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

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

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

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

23 A. Yes, I am.

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

1 A. Well, I believe -- is March 19th a
 2 Tuesday?
 3 **Q. I think it's a Monday.**
 4 A. It's a Monday. Then I believe it
 5 would be Tuesday that I have arranged to be there.
 6 **Q. You have reviewed both the prenatal**
 7 **and the hospital records of the pregnancy which is**
 8 **at issue in this case; is that right?**
 9 A. Correct.
 10 **Q. I take it, from the folder of**
 11 **materials that I see, you have also reviewed some**
 12 **records from prior pregnancies?**
 13 A. That may well be.
 14 **Q. You have not reviewed any of the**
 15 **records of Daysha Shine's medical treatment since**
 16 **birth?**
 17 A. Not after the hospital stay,
 18 correct.
 19 **Q. You have not examined her?**
 20 A. No, I have not.
 21 **Q. Am I correct in concluding that you**
 22 **are not going to be giving any opinions on her**
 23 **current state of health?**
 24 A. You're absolutely correct.
 25 **Q. What were you asked to do in this**

1 **care as it pertains to a resident?**
 2 A. Yes, in terms of residency training
 3 programs, residency education, the practice of
 4 residents and their supervision. I am an expert in
 5 that area.
 6 **Q. Do you hold a resident to the same**
 7 **standard of care as that of an attending?**
 8 A. I really hold the resident to be
 9 responsible for using the judgment and applying the
 10 principles that are appropriate for their level of
 11 training, which is not one standard of care. There
 12 is a range, as I said before. So when you use the
 13 term "a standard of care," I don't believe there is
 14 a standard of care. It's a range of good practice.
 15 **Q. Given what you're telling me, then,**
 16 **would you hold a fourth year resident to a**
 17 **different standard of care than a first year?**
 18 A. Not in the same areas that overlap,
 19 but I would expect the fourth year resident to be
 20 able to manage and be credentialed and be
 21 responsible for providing care in areas that a
 22 junior resident would not be responsible for
 23 providing the care. But for the areas where they
 24 are providing the care, I would hold them to the
 25 same criteria.

1 **case?**
 2 A. I was asked to review the records
 3 and render an opinion regarding the care and the --
 4 my opinion regarding the relationship of that care
 5 to the neuro sequelae.
 6 **Q. Do you work with midwives?**
 7 A. Yes, and have extensively in the
 8 past.
 9 **Q. I assume, since you're at Johns**
 10 **Hopkins in the position you're in, that you work**
 11 **with residents and fellows?**
 12 A. Yes, that's correct.
 13 **Q. How do you define the term standard**
 14 **of care?**
 15 A. Well, I think there isn't a standard
 16 of care. There is a range of standard of care that
 17 exists, and that is defined by the benchmarks to
 18 which one is held responsible for the care that one
 19 is delivering.
 20 **Q. Are you familiar with the standard**
 21 **of care for midwives?**
 22 A. I would not hold myself out as an
 23 expert because I'm not a midwife, although I have
 24 worked with midwives extensively in the past.
 25 **Q. You're familiar with the standard of**

1 **Q. What is your position here at Johns**
 2 **Hopkins.**
 3 A. I'm the director of gynecology and
 4 obstetrics, and the obstetrician and gynecologist
 5 in chief for Johns Hopkins Medicine.
 6 **Q. How long have you held that**
 7 **position?**
 8 A. About four and a half years at this
 9 point.
 10 **Q. In the past, were you the medical**
 11 **director of the midwife program?**
 12 A. Not at Hopkins because we don't have
 13 a midwife program here, but I was medical director
 14 at Columbia Presbyterian in New York.
 15 **Q. Are you still on the standards**
 16 **committee of ACOG?**
 17 A. There isn't a standards committee
 18 any more. I'm on the editorial board for
 19 "Guidelines for Women's Health Care."
 20 **Q. What is the difference between those**
 21 **two things?**
 22 A. Well, the "Guidelines for Women's
 23 Health Care" is a publication that is undergoing
 24 review at this point in time, and I'm on that
 25 editorial board that will delineate guidelines for

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

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

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

10 **Q. Have you written articles on**
11 **ultrasound and imaging?**

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

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

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

1 **That's in your yellow folder. That's fine. There**
2 **is also one marked as Exhibit 1.**

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

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

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

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

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

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

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

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

25 A. Three, not including this one. So

1 educational responsibilities.

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

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

5 **Q. How long has that been the case?**

6 A. About the last four years.

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

10 A. About five percent.

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

13 A. Basically the last four, yes.

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

16 A. Correct.

17 **Q. And then 20 percent was?**

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

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

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

25 **Q. You can take this one (indicating).**

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

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

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

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

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

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

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

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

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

25 **Q. Do you simply have the folders at**

1 home, or do you actually have the folders and a
2 list?

3 A. No, I have folders from the cases
4 and some material. I don't keep a running list of
5 cases.

6 Q. The other thing I'm going to ask you
7 to do is just wait until I'm completely done with
8 my question. Not because I'm not following you,
9 but I want to make sure we're not talking at the
10 same time.

11 THE WITNESS: Can we go off for a
12 second?

13 (A discussion off the record took
14 place.)

15 Q. BY MR. MOSCARINO: Of the three
16 other cases that you have pending now, are those
17 cases where you are acting as a witness for the
18 defendant in the case or the plaintiff?

19 A. Actually defendant.

20 Q. And then over the last four years,
21 how would you break your cases down where you have
22 actually been engaged not just in a review but to
23 serve as an expert?

24 A. Right. To serve as an expert, not
25 just a review but actually serve?

1 hospital?

2 A. Let me see. Did I represent the
3 hospital too? It was definitely for a physician.
4 I don't recall whether the hospital was represented
5 by the same firm or not, but it was certainly a
6 physician.

7 Q. Would it be a time consuming process
8 for you to look in those files for you to be able
9 to tell us the name of that case?

10 A. Well, it would be virtually
11 impossible at this moment.

12 Q. I mean when you went home.

13 A. I could attempt to locate that for
14 you.

15 Q. That wouldn't be an incredibly
16 onerous thing to do?

17 A. No, assuming I've got the file.

18 Q. At Johns Hopkins, is there an
19 accelerated family practice residency?

20 A. No.

21 Q. At the institutions that you have
22 worked at prior to Johns Hopkins, have you worked
23 with accelerated family practice residents?

24 A. No.

25 Q. Are you familiar with the concept or

1 Q. Right.

2 A. I would say it's -- that's a
3 different question than I have been asked before.
4 About 20 percent of the cases that I review are
5 plaintiff cases. In terms of actually serving, I
6 would say it's probably less than that. Ten
7 percent. That is a guess to some degree.

8 Q. So as far as approximation, over the
9 last four years you have been asked to review only
10 20 percent of the cases for the plaintiff?

11 A. That's correct.

12 Q. And of the cases that you have
13 actually signed on to serve as an expert, it's been
14 less than that, in the area of ten percent?

15 A. That is correct.

16 Q. I'm sorry if I asked you this
17 already in one form or the another. Have you ever
18 served as an expert for a plaintiff in a case
19 involving shoulder dystocia?

20 A. No, I have not.

21 Q. The case that you were deposed that
22 you mentioned in Florida, that was for the
23 defendant?

24 A. That is correct.

25 Q. Was that for a physician or

1 the program of accelerated residency programs?

2 A. I have learned about it reading
3 materials in this case.

4 Q. Prior to being engaged by Mr.
5 Becker's firm, did you have a working knowledge of
6 an accelerated residency program?

7 A. Not of accelerated programs, no.

8 Q. Do you consider yourself an expert
9 in the construction, maintenance, protocols, and
10 guidelines for accelerated residency programs?

11 A. Not for accelerated because I have
12 no experience with it. May I qualify that? I have
13 worked in institutions with family practice
14 residency programs in the past, including being on
15 the planning group or the formation group for the
16 family practice program at Columbia Presbyterian
17 where the chair of medicine and myself, as the
18 interim chair of OB-GYN, and chair of pediatrics
19 formed the administrative nidus to begin to develop
20 that family program. But accelerated programs, no.

21 Q. Accelerated programs, at least from
22 my understanding today, is that a four-year medical
23 student spends that year rotating through
24 specialties akin to what a first year intern does.
25 Is that your working understanding?

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

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

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

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

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

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

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

22 **Q. Have you done any research or**
 23 **reviewed any materials other than what has been**
 24 **produced in the discovery of this case regarding**
 25 **this concept of a family practice accelerated**

1 **residency program?**

2 A. No, I haven't, sir.

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

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

14 (Telephone interruption.)

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

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

23 **Q. That's fine.**

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

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

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

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

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

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

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

10 A. At this point in time?

11 **Q. Yes.**

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

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

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

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

1 Kramer, Kramer, Dilloff & Moore.

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

4 A. Defendants.

5 **Q. What were the issues in that case?**

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

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

10 A. This calendar year, no.

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

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

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

20 A. Can you accurately predict?

21 **Q. Yes.**

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

24 **Q. Are there risk factors?**

25 A. Yes.

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

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

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

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

14 A. 2000, yes, once.

15 **Q. Where was that?**

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

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

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

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

24 A. Jim Brown was the defense attorney.

25 The plaintiff attorneys were -- I think it's

1 **Q. Could tell me what those are,**
2 **please?**

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

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

16 A. Yes.

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

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

1 what your actions will be if that occurs.
 2 **Q. If it occurs, and if the OB-GYN team**
 3 **is faced with a dystocia, what are the steps or the**
 4 **methodologies that are used to relieve what you**
 5 **term or what you told me was an obstetrical**
 6 **emergency?**

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

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

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

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

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

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

17 So those combined three things, the
 18 McRobert's, episiotomy and McRobert's and
 19 suprapubic pressure will successfully deliver 30 to
 20 40 percent, in my experience, of shoulder
 21 dystocias. You also -- I teach my residents think,
 22 plan, and then do.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 **Q. What is a Klumpke's palsy?**

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

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

1 delivery process.

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

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

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

8 A. That's correct.

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

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

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

17 A. That's correct. That's absolutely
18 correct.

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

21 A. Not that I recall. No, sir.

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

1 A. It can.

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

6 A. Just by the fact that it occurred?

7 **Q. Yes.**

8 A. No. I would agree with you.

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

11 A. Not in my opinion, sir.

12 **Q. Was this a fast labor?**

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

17 **Q. Would you describe it as**
18 **precipitous?**

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

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

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

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

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

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

22 (A discussion off the record took
23 place.)

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

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

3 A. I believe that is the statement,
4 yes.

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

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

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

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

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

13 **Q. How does an OB-GYN like yourself**
14 **have this data that would suggest a baby at this**
15 **4500 level?**

16 A. Well, you would do clinical
17 estimates of fetal weight, which are plus or minus
18 about 200 grams per kilogram. So that gets to be a
19 pretty wide range. You can think the baby is 48,
20 4900 grams and it could be 4,000. You are
21 perfectly aware of that.

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

1 shoulder dystocia. I just wanted to clarify that
2 terminology.

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

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

9 **Q. What do you go by?**

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

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

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

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

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

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

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

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

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

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

7 MR. BECKER: Objection. You can
8 answer.

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

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

16 A. Certainly.

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

23 A. That's correct, sir.

24 **Q. You stand by that statement today?**

25 A. Yes, I do.

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

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

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

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

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

1 **Q. Your reason for that is what?**

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

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

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

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

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

6 A. They certainly can, absolutely.

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

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

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

19 A. That can happen.

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

25 A. It becomes a very difficult task to

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

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

18 A. No, not on its face value.

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

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

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

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

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

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

15 A. That was my recollection. Thank
16 you.

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

21 A. No, I'm not.

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

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

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

12 A. I believe so. Yes, sir.

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

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

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

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

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

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

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

1 position. That wasn't done.
 2 So I envision the patient up on the
 3 bed as you describe, McRobert's position,
 4 suprapubic pressure being applied, and no posterior
 5 space being available. One of the things Dr.
 6 Holzheimer describes is going through the process
 7 of moving the patient down on the bed, cutting the
 8 episiotomy, and executing the delivery.

9 **Q. So you're telling me that she was in**
 10 **a McRobert's position with suprapubic pressure**
 11 **being applied, but it's not effective because of**
 12 **lack of posterior space?**

13 A. Correct, it's not going to be as
 14 effective because of lack of posterior space.

15 **Q. Are you telling me that it's**
 16 **useless?**

17 A. No, I would not go so far as to say
 18 it's useless. One of the, as I mentioned a couple
 19 of times before, the important factors are to move
 20 through methodically in a logical manner, to
 21 position the patient appropriately, get the
 22 posterior space, cut an episiotomy in order to
 23 allow for the posterior shoulder to descend.

24 You can have the patient in
 25 McRobert's maneuver, putting suprapubic pressure on

1 not a McRobert's maneuver. I have to be clear
 2 about this. The McRobert's maneuver is flexing the
 3 thighs up onto the abdomen. It changes pelvic tilt
 4 and architecture. That helps to reduce the
 5 shoulder dystocia. It does not provide posterior
 6 space. Moving the patient down on the table,
 7 getting the patient positioned appropriately
 8 combined with the McRobert's maneuver, et cetera.

9 In a situation where you have a
 10 shoulder dystocia and you have no way of turning
 11 the patient sideways on the bed, bringing her
 12 perineum to the edge of the bed, and getting a
 13 posterior space, as I mentioned before. Moving her
 14 into even a knee/chest position can be a very
 15 useful maneuver in that circumstance. It becomes
 16 anterior space at that point, but you get the room
 17 to deliver the baby. With the patient in a
 18 knee/chest position, she is in McRobert's position
 19 by virtue of the fact that she's crouching.

20 **Q. Was the bed broken down?**

21 A. At some point it became broken down,
 22 and I believe the bed was broken but she pushed up
 23 on the bed. The mattresses in fact -- and I don't
 24 know what bed was being used here. The mattresses
 25 are pretty firm on these birthing beds and they

1 and attempting to rotate the shoulder off of the
 2 anterior/posterior to an oblique, and no space for
 3 it to rotate if the patient is not positioned
 4 properly. You never say never it wouldn't work,
 5 but it certainly is not optimal by any means.

6 **Q. I forgot to ask you one thing, by**
 7 **the way. Have you been furnished with the**
 8 **deposition of Rosalie Johnson, the mother? I did**
 9 **not see it in your materials.**

10 A. Let me see if I listed it here.

11 **Q. I know you would not have listed it,**
 12 **Doctor, because it was taken after your report.**

13 A. Then I don't believe so.

14 **Q. Okay. The effort by Dr. Segil to**
 15 **have this patient in the McRobert's position and to**
 16 **have Dr. Schwartz assist with suprapubic pressure,**
 17 **in and of themselves, those are standard of care**
 18 **maneuvers or methodologies when faced with a**
 19 **shoulder dystocia presentation, correct?**

20 A. Those are appropriate maneuvers to
 21 pursue.

22 **Q. I think what you told me before,**
 23 **those would be the first two in conjunction with**
 24 **the episiotomy?**

25 A. Correct. Position the patient is

1 have a cutout into the lower component of the
 2 mattress actually to facilitate that posterior
 3 space development when you are bringing the patient
 4 down and still support the posterior thigh.

5 **Q. The breaking down of the bed, is**
 6 **that an appropriate decision?**

7 A. It's an appropriate decision to
 8 make, yes.

9 **Q. Did Dr. Segil attempt to do an**
 10 **episiotomy?**

11 A. I would have to go back and look. I
 12 don't recall that being written in the records, but
 13 I would have to go back and look at that
 14 specifically.

15 **Q. If he planned to do an episiotomy or**
 16 **he was doing that or that was his next step, that**
 17 **would be an appropriate step in this presentation?**

18 A. An episiotomy would be one of the
 19 first things that one would do in this
 20 circumstance. She didn't have an episiotomy and
 21 they weren't going to be enlarging it. I believe
 22 he said -- I mean one of the early things he did
 23 was bring the patient down and cut an episiotomy.
 24 Those are the appropriate things to do.

25 **Q. Have you given me your reasons for**

1 **your Conclusion Number 3 on Page 2?**
 2 A. Let me just read it once more, sir.
 3 Yes.
 4 **Q. Turning to the next page, you**
 5 **conclude that, "Caregiver Segil deviated from**
 6 **within the standard of care by failing to safely**
 7 **and adequately perform maneuvers to execute**
 8 **delivery of a shoulder dystocia." You stand by**
 9 **that statement today, correct?**

10 A. Yes, that's correct, sir.

11 **Q. What did Dr. Segil do?**

12 A. What did Dr. Segil do?

13 **Q. Yes.**

14 A. Dr. Segil, I believe was attempting
 15 to deliver the shoulders by getting Dr. Schwartz to
 16 administer suprapubic pressure by doing a
 17 McRobert's maneuver. This is not successful. So
 18 these were the maneuvers he was doing.

19 I believe there is testimony or data
 20 to show that he had tried to rotate shoulders at
 21 some point in time. But at no time do I see that
 22 the patient was positioned appropriately and an
 23 episiotomy being done to expedite the delivery of
 24 the shoulder dystocia.

25 **Q. All I want to do is find out exactly**

1 A. He was attempting to deliver the
 2 shoulders without taking those actions, which, in
 3 this case, we had a large baby. But even in a
 4 normal size baby, by not having the appropriate
 5 space to deliver the baby, you can end up with
 6 complications associated with shoulder dystocia
 7 such as neuro trauma. So I think moving ahead to
 8 attempt to execute the delivery of the shoulders
 9 without taking appropriate actions was outside of
 10 the standard of care.

11 **Q. What did he do to attempt to deliver**
 12 **or attempt to remove the impacted shoulder or**
 13 **shoulders?**

14 A. He was attempting for a period of
 15 time. I think when we go through the record it
 16 says 2 minutes or 4 minutes, and then 30 seconds of
 17 that would have been Dr. Holzheimer trying to get
 18 the time line together here. But for at least a
 19 couple of minutes, perhaps up to three and a half
 20 minutes, he was attempting to deliver the shoulders
 21 without the patient being appropriately managed.

22 So I don't know. I was not there.
 23 I can't say what type of maneuver was being done at
 24 that time to do -- to accomplish that delivery.
 25 But it can be virtually impossible to do that

1 **what your opinions are here so that when we meet**
 2 **again in Cleveland, if we do, I understand what**
 3 **you're saying.**

4 A. No problem. If I didn't answer it,
 5 ask again.

6 **Q. If I wrap up and I have asked you**
 7 **the same question before, just bear with me. I'm**
 8 **not here to take up more time than I have to.**

9 A. No problem.

10 **Q. You told me, and I think you made it**
 11 **clear that he didn't have her, in your opinion, in**
 12 **the right position?**

13 A. Correct.

14 **Q. You have also made it clear to me**
 15 **that it's your opinion that he should have been**
 16 **able to cut an episiotomy, and that is one of the**
 17 **first things you would have done, correct?**

18 A. Correct.

19 **Q. Those are two things that you're**
 20 **saying he did not do, correct?**

21 A. Correct, absolutely.

22 **Q. Did he do things, in your opinion,**
 23 **that were inappropriate? Did he take affirmative**
 24 **action in any form or fashion that you find to be**
 25 **negligent?**

1 safely without the patient being positioned
 2 appropriately.

3 **Q. You are not of the opinion that he**
 4 **was applying excessive or improper traction for**
 5 **three and a half minutes, are you?**

6 A. I'm not saying three and a half
 7 minutes. I think that it's my opinion, to a
 8 reasonable degree of the medical certainty, that
 9 the injury that this baby has evidence of, the
 10 neuro deficits, is related to the timing, the
 11 process during that period of time attempting to
 12 deliver the shoulders without the patient being
 13 appropriately prepared for that maneuver. That's
 14 my opinion.

15 **Q. I'm sorry if I asked you this before**
 16 **and I didn't understand your answer. What exactly**
 17 **did he do, if you know, to attempt to deliver the**
 18 **baby?**

19 A. Well, recalling the depositions,
 20 which I have not immediately reviewed prior to this
 21 deposition, et cetera --

22 MR. BECKER: Doctor, if you want to
 23 look at the depositions, you're free to do that.

24 THE WITNESS: I understand that.
 25 There were maneuvers applied and attempts to

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

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

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

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

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

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

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

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

21 A. No, sir.

22 **Q. If the patient was in the**
23 **appropriate position, gentle traction is**
24 **appropriate?**

25 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

25 **Q. Have we discussed your opinions and**

1 your basis for your opinions for Number 4?

2 A. Yes.

3 Q. Moving on to Number 5, the focus
4 here is Dr. Schwartz?

5 A. Yes.

6 Q. Dr. Schwartz, in your opinion,
7 deviated from the standard of care?

8 A. Yes, from within the standard of
9 care.

10 Q. What was her role here?

11 A. Caregiver Segil was the person that
12 was hands-on with this delivery. She had come as
13 the resident physician to be with him in this
14 process, and had, I think, six months more
15 experience. She was a PGY-1 in OB.

16 She, as Mr. Segil's supervisor,
17 should have held off on any maneuvers or encouraged
18 him to hold off on these maneuvers, if she had the
19 wisdom to do that at her young state in maturing in
20 obstetrical experience, until the patient was
21 positioned appropriately, episiotomy was cut, et
22 cetera. I think that was a failure on her part to
23 supervise Dr. Segil adequately in performing this
24 delivery. That's the basis for that.

25 (Pause in proceedings.)

1 as required by the special requirements for
2 residency training?

3 A. Correct.

4 Q. What is the phrase "by the special
5 requirements for residency training" mean?

6 A. We are all -- our residency programs
7 are all governed by the specific residency review
8 criteria put forth by the ACGME, the certifying
9 group for residency education programs. I believe
10 the family practice program is also an ACGME.
11 There is also the ABMS, which is another
12 certification program. These are all ACGME.

13 As educators, we are required to
14 assure the adequate supervision of residents for
15 their level of training. Both of these documents
16 have wording to this effect. The specific wording,
17 I'm not exactly sure of at that time, but it is to
18 assure adequate education and to assure patient
19 safety.

20 A first year -- six-month, first
21 year residents in OB supervising a fourth year
22 medical student, a first year residency participant
23 in family medicine, you know, the accelerated
24 program position doesn't provide adequate
25 supervision for a patient who is at risk for an

1 Q. BY MR. MOSCARINO: Dr. Fox, then
2 your opinions regarding Dr. Schwartz are confined
3 to supervision. You're not saying that she did
4 anything affirmatively that was incorrect or below
5 the standard of care?

6 A. That is correct, sir.

7 Q. Do you know any of the OB-GYN
8 physicians, the attending physicians at University
9 Hospitals of Cleveland?

10 A. I'm sure I know some, sure.

11 Q. Have you ever been to the University
12 Hospitals of Cleveland to lecture?

13 A. I have been to Cleveland but not
14 University Hospitals. I have been to -- gosh.
15 What's it called -- Metro years ago. I'm talking
16 many, many years ago. I was there once. Then I
17 did a perinatal education program at one of the
18 large community hospitals in the area. For the
19 life of me, I can't remember what it was. That was
20 a long time ago. It was probably 15 years ago.

21 Q. Number 6 is directed at the
22 institution. Your opinion here is that the
23 hospital failed to assure the adequate supervision
24 of Dr. Schwartz and Dr. Segil in the performance of
25 their task in supervising the birth of Daysha Shine

1 obstetrical emergency.

2 A fourth year resident, a third year
3 or fourth year resident may be delegated that
4 responsibility, primary responsibility, by the
5 attending that is in charge of the obstetrical
6 service depending on their experience and what
7 experience they have had in dealing with
8 obstetrical emergencies. By the third or fourth
9 year of a residency, most everyone had has
10 considerable experience and they can supervise the
11 junior residents.

12 The attending who is responsible for
13 the patients in a resident practice, which is what
14 this seemed to be, is ultimately responsible for
15 that. That, I see as the responsibility of the
16 educational institution, to ensure that appropriate
17 supervision is available. That's my basis.

18 Q. So the answer that you gave to me
19 just now is based on your understanding as to the
20 standard of care at teaching hospitals for the
21 supervision of residents?

22 A. As indicated by the standards for
23 having approved residency programs, correct.

24 Q. You're not specifically saying that
25 this hospital failed to comply with the accelerated

1 **residency program guidelines?**

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

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

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

20 By the time they have had
21 substantive obstetrical experience, they will
22 develop the skill of recognition of this emergency,
23 and then the need to coordinate care and to
24 intervene in a reasonable manner. So I would say
25 an ending second year resident could sub-supervise a

1 obstetrical emergency.

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

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

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

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

1 PGY-1.

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

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

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

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

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

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

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

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

1 point in time.

2 **Q. Other than that issue with respect**
3 **to whether Dr. Hudock was informed by Dr. Segil,**
4 **you're not critical of him up until the time when**
5 **the shoulder dystocia presentation --**

6 A. The shoulder dystocia was in the
7 process of presenting when he got to the room, I
8 believe. I'm not absolutely clear as to when he
9 came in, but that became apparent shortly after he
10 arrived. At that point, one should move on with
11 the maneuvers that I have been talking about.

12 **Q. As of 7 a.m., when Ms. Johnson went**
13 **to University Hospitals of Cleveland, was she a**
14 **high risk patient?**

15 A. At 7 a.m., she still had intact
16 membranes, if I remember correctly. So they didn't
17 know about meconium stained fluid which incurs some
18 risk for the newborn at that point in time. It was
19 recognized, once her admission was done, that she
20 had a large baby, or they suspected a large baby,
21 and the potential for a shoulder dystocia. Then
22 she became at increased risk for an obstetrical
23 emergency in the birth process. Was she a high
24 risk patient by classic definition, you know,
25 severe preeclampsia or wild diabetes? No, she was

1 not.

2 **Q. You would agree with me she was not**
3 **a high risk patient during the prenatal care?**

4 A. Correct.

5 **Q. With respect to Number 6, which we**
6 **were discussing, have you given me, Dr. Fox, your**
7 **reasons for the conclusions regarding University**
8 **Hospitals of Cleveland?**

9 A. Yes, I believe I have.

10 **Q. Now, the final criticism, Number 7,**
11 **is that University Hospitals of Cleveland deviated**
12 **from the reasonable standard of care by failing to**
13 **assure the presence of an experienced obstetrician**
14 **in this case of an anticipated OB emergency. Did I**
15 **quote you that correctly?**

16 A. You read that correctly, yes.

17 **Q. Tell me what you mean by that.**

18 A. Well, we have sort of been talking
19 about that. Part of it has to do with the
20 responsibility -- the previous one was the
21 responsibility for supervision of residents. This
22 one is assuring the presence of an experienced
23 obstetrician to deal with a patient who has an
24 increased risk for obstetrical emergency that you
25 cannot accurately predict until it actually

1 happens.

2 It is the responsibility of the
3 institution in taking care of this patient
4 globally to assure that a senior experienced person
5 is providing care to that patient like any patient
6 who is receiving their care from their private
7 attending physician.

8 **Q Does this experienced physician or**
9 **experienced obstetrician have to be an attending?**

10 A. That would be up to the
11 institution. It would be at least a senior
12 resident, at least a senior resident, but
13 optimally, an attending physician. But it should
14 be a physician who has had very substantive
15 obstetrical experience and experience with
16 obstetrical emergencies. So that would be third or
17 fourth year resident in a four-year residency
18 program of OB-GYN.

19 **Q. So is it your opinion that this**
20 **brachial plexus injury occurred after 8:12 a.m.,**
21 **when Dr. Segil was called into the room?**

22 A. Yes, I believe that is my opinion.
23 Yes, that is my opinion.

24 **Q. Is it your conclusion that it**
25 **occurred prior to Dr. Holzheimer coming into the**

1 room?

2 A. As best as I can determine, yes,
3 that is my opinion.

4 **Q. What maneuver did Dr. Holzheimer**
5 **use?**

6 A. Dr. Holzheimer positioned the
7 patient, cut the episiotomy, and then -- I'd have
8 to review it exactly. He either did a Wood's screw
9 or posterior arm delivery. I don't remember which
10 one it was. Either one is perfectly appropriate.

11 **Q. It's my recall that he used the**
12 **Wood's maneuver.**

13 A. He may have used the Wood's
14 maneuver. Based on the experience of the individual
15 and how comfortable they feel, either one of those
16 is absolutely appropriate. The Wood's maneuver is
17 probably the best one in a person that doesn't have
18 anesthesia.

19 **Q. What is the Wood's maneuver?**

20 A. Wood's maneuver is determining the
21 position of the shoulders and moving either
22 clockwise or counterclockwise to rotate the
23 shoulders from the anterior posterior to oblique
24 position, allowing there to be a larger space for
25 entry into the pelvis. The pelvis in the

1 anterior/posterior position is narrowest.
 2 So you move the shoulders and you
 3 move the anterior shoulder posterior, and that
 4 brings the posterior shoulder down and delivers it
 5 over the perineum and allows the rotated shoulder
 6 to deliver. That's the Wood's screw maneuver.
 7 **Q. Can an infant or a fetus sustain a**
 8 **brachial plexus injury during a standard of care**
 9 **Wood's maneuver?**
 10 A. It can.
 11 **Q. During a Wood's maneuver itself?**
 12 A. No, I would say not during the
 13 Wood's maneuver itself.
 14 **Q. Would it be prior to?**
 15 A. That would be very difficult
 16 mechanically because you have done -- the way you
 17 do the maneuver, it's maintaining the baby in the
 18 plane. It could have been prior to, related to
 19 maneuvers done prior to moving to the Wood's screw
 20 maneuver or the Wood's maneuver. It could even
 21 incur afterwards, you know, if down and out
 22 traction is used to deliver the now anterior
 23 shoulder after the posterior shoulder has been
 24 manipulated into a more oblique position.
 25 **Q. Are you ruling out that the injury**

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

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

1 **feel are pertinent to this matter?**
 2 A. That are pertinent to this matter,
 3 no, I don't believe so.
 4 **Q. You're not relying on any particular**
 5 **medical texts, journal articles, or abstracts in**
 6 **giving your opinions that you have told me about**
 7 **today; is that right?**
 8 A. No, I'm not.
 9 **Q. Doctor, I have your report which we**
 10 **have marked as Exhibit 1. I have asked you**
 11 **questions over the last almost two hours. My**
 12 **question to you is do I have all of your opinions**
 13 **in this matter so that when I go out the door, I**
 14 **know that you have told me what your opinions are**
 15 **regarding the case of Daysha Shine versus**
 16 **University Hospitals of Cleveland?**
 17 A. Yes, sir.
 18 MR. MOSCARINO: I have no further
 19 questions at this point. I'm going to mark his
 20 file, and with your permission, I'm going to remove
 21 the medical records from the file so I can have the
 22 other parts marked as an exhibit. So the record is
 23 clear, I think the only exhibits we have are Number
 24 1, which is Dr. Fox' report; 2, which is the --
 25 THE WITNESS: Are you taking the

1 whole file?
2 MR. MOSCARINO: I'm going to ask
3 her to Xerox it or have you Xerox it and give it to
4 her.
5 MR. BECKER: You don't need the
6 depositions?
7 MR. MOSCARINO: No. I'm going to
8 remove the depositions and the medical records.
9 MR. BECKER: How about if we have
10 the doctor's office photocopy it and then send it
11 to the Court Reporter?
12 MR. MOSCARINO: That's absolutely
13 fine.
14 MR. BECKER: That's fine.
15 MR. MOSCARINO: Thank you.
16 (The deposition concluded at 11:20 a.m.)
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