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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

KAYLA PAYNE, etc., et al.,

Plaintiffs,

-vs-

JUDGE McMonagle
CASE NO. 409044

THE MOUNT SINAI MEDICAL CENTER,
Defendant.

Deposition of ROBERT GHERMAN, M.D., taken as
if upon cross-examination before Susan L. Weiss,
a Registered Professional Reporter and Notary
Public within and for the State of Ohio, at
Kinko's, 6901 Rockside Road, Independence, Ohio,
at 6:00 on Wednesday, August 7, 2002 pursuant to
notice and/or stipulations of counsel, on behalf
of the Plaintiff in this cause.

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On behalf of the Defendant.

SCANNED
9/24/02

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ROBERT GHERMAN, M.D., of lawful age,
called by the Plaintiff for the purpose of
cross-examination, as provided by the Rules of
Civil Procedure, being by me first duly sworn, as
hereinafter certified, deposed and said as
follows:

CROSS-EXAMINATION OF ROBERT GHERMAN, M.D.

BY MR. MESTER:

MR. MESTER: Let the record show
that we are here today via video conference for
the deposition of Dr. Gherman in the case of
Kayla Payne versus Mount Sinai Medical Center.
Before we get started, Ernie, just
one little housekeeping thing. Obviously we're
doing this in a different way by video
conference, I assume any defects in formalities
and so forth are waived?

MR. AUCIELLO: That's correct.

MR. MESTER: Okay.

Q. Doctor, would you please state your name for the
record?

A. Robert Gherman.

Q. And you are a medical doctor, correct?

A. Correct.

Q. What kind of doctor are you?

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A. I'm an obstetrician/gynecologist with a
subspecialty in maternal-fetal medicine.Q. Dr. Gherman, you've been deposed before I take
it?

A. I have.

Q. So you know the ground rules here. I will be
asking you some questions. The most important
rule I guess is if you don't understand my
question, please have me rephrase it. Okay?

A. Sure.

Q. I'll be happy to do so, but if you don't ask me
to, I'm going to assume you've understood my
question and rely on your answer, is that fair?

A. Yes.

Q. And I guess the other thing that's important
especially in the setting that we're doing this
is, let's not talk over each other. There's a
little bit of a delay in the voice, so let me
finish my question and I'll try to do the same.
Okay?

A. That's fair.

Q. Doctor, can I have your current professional
address, please?A. Bethesda Naval Hospital, I think it's 81 -- 8901
Jones Bridge Road, Bethesda, Maryland 20889.

ROBERT GWERMAN, M.D

MOUNT SINAI MEDICAL CENTER

5

- 1 Q. Is your employer then the Bethesda Naval
2 Hospital?
3 A. Technically I believe it's the United States
4 Government.
5 Q. And how long have you been employed with -- well,
6 I should say working at the Bethesda Naval
7 Hospital?
8 A. About a week.
9 Q. One week. Where were you before that?
10 A. At Portsmouth Naval Hospital.
11 Q. And how long were you there?
12 A. Five years.
13 Q. All right. Can you tell me what you do as an
14 obstetrician working for a naval hospital?
15 A. I provide care to active duty and their
16 dependents. I provide almost essentially
17 obstetrics care. My specialty is maternal-fetal
18 medicine. So I practice the full realm of
19 maternal-fetal medicine.
20 Q. Are you also involved in the practice of
21 gynecology?
22 A. I practice some GYN, not much. Mainly when I'm
23 on call, I handle like any kind of GYN emergency,
24 ectopic pregnancies, acute vaginal bleeding,
25 things like that. My main focus is --

6

- 1 Q. Doctor, we're having a little bit of trouble I
2 guess hearing you on this end, if you can do a
3 volume control or something.
4 MR. AUCIELLO: We don't have one of
5 those little devices. I'll just put the
6 microphone nearer.
7 MR. MESTER: Okay.
8 A. Can you hear me now?
9 Q. I guess that's a little better. I can hear you.
10 The court reporter is having a little bit of
11 trouble.
12 Doctor, are you currently delivering
13 babies in your position with Bethesda Naval
14 Hospital?
15 A. Yes.
16 Q. All right. I guess --
17 A. Let me rephrase that. I have only been there a
18 week, so I haven't really fully started. But in
19 Portsmouth, yes, I was actively delivering babies
20 and I suspect that I will at Bethesda as well.
21 There will be no change in my practice.
22 Q. Okay. In the year 2001 at Portsmouth, can you
23 tell me how many babies you delivered?
24 A. Probably by myself about 50, many more than that
25 associated with residents or backing up other

7

- 1 attending.
2 Q. How many physicians, obstetric physicians are
3 there at the Bethesda Naval Hospital with you?
4 A. I'm not really sure. I mean, we have maybe about
5 15 to 20 staff, some of which subspecialize, the
6 majority of which practice general GYN. We also
7 have residents in training. I believe there are
8 six per year.
9 Q. All right. Doctor, I'm going to have your CV
10 here shortly, but could you just briefly take me
11 through your educational background?
12 A. Sure. Actually I have it in front of me, so I
13 can go over that now. I went to college in
14 Pittsburgh. From there I proceeded to medical
15 school in New Orleans at Tulane University.
16 From there I did an internship in
17 obstetrics and gynecology at the naval hospital
18 in Portsmouth. I did the residency at Bethesda.
19 Subsequently did a two year fellowship in
20 maternal-fetal medicine in Los Angeles and then
21 was at Portsmouth the last five years.
22 Q. I got your CV now. Doctor, your date of birth is
23 April 24th, 1965?
24 A. To the best of my knowledge, yes.
25 Q. And you graduated from medical school in 1991?

8

- 1 A. Correct.
2 Q. And again just going through your CV a little bit
3 here, in '92 you did an internship as you said at
4 Portsmouth Naval Hospital?
5 A. I said I believe I did the internship from '91
6 to '92. I would have been done with it in '92.
7 Q. Okay. I'm sorry. All right.
8 And your fellowship in Los Angeles
9 ended in 1997?
10 A. Correct.
11 Q. And I think I may have missed what you said
12 before, where did you go after 1997 when your
13 fellowship was completed?
14 A. From 1997 to 2002 I was at Portsmouth Naval
15 Hospital.
16 Q. Okay. Doctor, I take it then you've never been
17 in the private practice of obstetrics during your
18 career?
19 A. Well, I have never been in a classical model of
20 private practice of having a private physician's
21 office, but I have had during the period of time
22 private patients. Again, I don't bill for them
23 like you would in a private practice, but I do
24 essentially the same as a private practitioner
25 does.

9

- 1 Q. You would agree with me, however, that the
2 majority of the patients that you've seen in your
3 practice as an obstetrician have been those
4 affiliated with the military?
- 5 A. Yes. I mean, the overall majority. The only
6 people who are eligible for care at our hospitals
7 are active duty and their dependents. On the
8 other hand, I see more in the military setting
9 than most maternal-fetal medicine staff because
10 we receive transports from all over the world and
11 I care for the wide range of obstetric patients.
- 12 Q. So you receive transports from all over the world
13 I take it who are military personnel or their
14 family?
- 15 A. Correct. I mean, I'd see in emergency situations
16 where we care for nonmilitary individuals.
- 17 Q. Doctor, are you licensed to practice medicine?
- 18 A. Yes.
- 19 Q. And in which states?
- 20 A. I'm currently licensed in Virginia. I think I
21 also hold a California license, though, I think
22 it's inactive.
- 23 Q. Okay. What about in Maryland?
- 24 A. I don't believe I have a Maryland license.
- 25 Q. Is that something that you're going to have to

10

- 1 acquire with your recent move?
- 2 A. Not that I'm aware of. I think the way the
3 military works is you can actually have a license
4 in any state and there's no specific requirement
5 for a state licensure.
- 6 Q. All right. Has your license to practice medicine
7 ever been revoked or suspended in any state?
- 8 A. Not that I'm aware of.
- 9 Q. And, Doctor, are you Board Certified in any
10 field?
- 11 A. I'm Board Certified in obstetrics and gynecology
12 and also Board Certified in maternal-fetal
13 medicine.
- 14 Q. When did you become so Board Certified?
- 15 A. I believe that I passed on the first attempt the
16 oral examination for general GYN in 1998 and the
17 maternal-fetal exam I would have passed on the
18 first attempt in April of 2000.
- 19 Q. All right. What about the written examination,
20 did you also pass those on the first attempt?
- 21 A. Yes.
- 22 Q. Doctor, would you have any other hospital
23 privileges outside of the naval hospitals?
- 24 A. Not currently, no.
- 25 Q. Have you ever?

11

- 1 A. I believe that I had, yes. In the fellowship we
2 worked at a private hospital. When I was in
3 Portsmouth we also worked at a private hospital
4 as well.
- 5 Q. And have any of those privileges ever been
6 suspended, revoked or in any way altered in any
7 temporary fashion?
- 8 A. Not that I'm aware of.
- 9 Q. I'm looking at your CV here under military
0 honors, it looks like the third page of what I
1 received on your CV. I guess I'm just curious
2 more than anything, there's something that says
3 National Defense Medal and also a Navy Pistol
4 Medal. Could you explain those for me?
- 5 A. What do you specifically want to know?
- 6 Q. I take it those aren't related to the practice of
7 medicine?
- 8 A. Well, in a sense they are. I mean, I do practice
9 medicine in the military and -- well, let me
0 first say the Navy Pistol Medal has no
1 relationship to medicine, you are correct.
- 2 The National Defense Medal, I think the
3 first one was awarded in '91 during Desert Storm
4 and Desert Shield. Again, we care for active
5 duty and their dependents, so it's awarded to all

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- 1 people in the military. My role in that is to
2 provide military support.
- 3 Q. Okay.
- 4 A. I'm sorry, medical support.
- 5 Q. Were you over in Desert Storm?
- 6 A. No.
- 7 Q. Have you -- I'm sorry, go ahead.
- 8 A. But again most likely we would not be and we
9 would care for injured, you know, sailors and
0 marines and other individuals. And, you know,
1 again, usually in the medical field, we mainly
2 function in kind of a supportive role.
- 3 Q. I understand. I just want to make sure or at
4 least come to understand, outside of your role as
5 a doctor within the military, have you ever
6 served in any other capacity in the military?
- 7 A. Well, we are assigned ancillary duties. I'm not
8 just a doctor, an OB/GYN. For example, at
9 Portsmouth I was assigned to a marine unit out of
0 Camp Lejeune. So we actually got called up to go
1 to New York on one of the ships to care for
2 survivors. Now there weren't any, so we didn't
3 go. And here at Bethesda I'm on the comfort,
4 which is a hospital shift. So in reality my
5 primary mission to the military is to serve as a

13

1 physician to treat the troops, mainly because I
 2 have surgical capabilities.
 3 Q. Do you have a military rank, is that something
 4 that's appropriate?
 5 A. Yes.
 6 Q. What is that?
 7 A. I'm currently attending commander, although, I've
 8 been selected for commander.
 9 Q. What does that mean, when will you be a
 10 commander?
 11 A. Well, they only promote a certain amount per
 12 month, so I'm not really sure. It will start in
 13 the new fiscal year, which would be in October.
 14 So it will be sometime after that.
 15 Q. Are you currently doing any teaching in your
 16 field?
 17 A. Yes.
 18 Q. And to what extent?
 19 A. Well, I teach everyday. We have medical students
 20 and residents, so I will teach. I'll teach on
 21 rounds. I also give lectures both on the local
 22 level at the hospital as well as on a national
 23 level. I do many forms of teaching.
 24 Q. All right. Now I've got your CV here. All your
 25 teaching I take it is associated with your role

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1 in the military, you don't teach at any public or
 2 private universities?
 3 A. I'm not certain I understand your question.
 4 Q. Well, let's look at the part of your CV that says
 5 professional background.
 6 A. Okay.
 7 Q. I guess what I'm trying to get at here is the
 8 first entry says Clinical Instructor Uniformed
 9 Services University of the Health Sciences,
 10 what's that?
 11 A. It's actually the military medical school.
 12 Q. And the second one, could you explain the second
 13 entry there?
 14 A. I'm sorry, Clinical Instructor, LA County USC
 15 Medical Center.
 16 Q. Okay.
 17 A. That would have been when I was a fellow.
 18 Q. All right. And that's not military affiliated I
 19 take it?
 20 A. Correct. Actually I don't think I have it listed
 21 on here, but from '97 to 2002 I had clinical
 22 appointments at Eastern Virginia Medical School.
 23 Q. Okay. Doctor, I'm not going to go through all of
 24 your publications and research things here one by
 25 one obviously. Let me just ask you, the CV that

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1 I've been provided with, is that current?
 2 A. I believe it is, yes.
 3 Q. Doctor, give me an idea, I take it this is not
 4 your first time testifying as an expert witness?
 5 A. Correct.
 6 Q. When did you first begin testifying as an expert
 7 witness?
 8 A. I believe it was sometime late in 1997, I believe
 9 November or December of '97. I think that's when
 10 I actually got the first case that was sent to
 11 me.
 12 Q. And who sent you that case, if you can recall?
 13 A. I don't recall.
 14 Q. Do you remember how they got your name?
 15 A. No.
 16 Q. When did you -- I know you've published a lot of
 17 articles on the issue of brachial plexus injury
 18 and shoulder dystocia and we'll probably get into
 19 some of those a little bit here today. Can you
 20 tell me when the first article you published was
 21 on that issue?
 22 A. I want to say '96 or '97. I would have to look
 23 back at the publication. Actually it looks like
 24 it was published in '97.
 25 Q. All right. Doctor, am I correct that you had not

16

1 testified as an expert witness prior to the
 2 publication of your first article regarding
 3 brachial plexus injuries and shoulder dystocia?
 4 A. Again, I don't know what the relation of the
 5 timing of that article was, you know, if that
 6 came out in the latter part of that year. I
 7 don't know when that came out. I mean, most
 8 likely, just looking at the reference number
 9 here, it probably came out in the early part
 10 of '97.
 11 Q. And do you recall whether that came out prior to
 12 the first time you were contacted to review a
 13 case as an expert?
 14 A. I don't recall.
 15 Q. Do you know if one of the reasons you were
 16 contacted for the first time to review a case as
 17 an expert was because of the publication of that
 18 article?
 19 A. I think that's probably how they found me. I
 20 mean, if an Internet search was done, then my
 21 name would come up with Med Line or other
 22 writings, that's probably how they found me.
 23 Q. Doctor, in that first case that you were asked to
 24 review as an expert, were you asked to review it
 25 on behalf of the defense or the plaintiff?

17

- 1 A. I believe it was on behalf of the defense.
 2 Q. And was that on an issue of a brachial plexus,
 3 Erb's palsy injury?
 4 A. I believe it was, yes.
 5 Q. Doctor, since 1997 can you give me an idea of the
 6 number of files you have reviewed as an expert?
 7 A. That's not something I would specifically keep
 8 track of. I mean, I can give you a rough guess
 9 but I don't deep track of the number. I usually
 10 look at in total both on behalf of the plaintiff
 11 and the defendant. All total one to two cases a
 12 month because I just don't have time otherwise to
 13 do that.
 14 Q. Has that been fairly constant since 1997?
 15 A. Probably the last two years it's been -- again, I
 16 have self-limited it to that. I will only review
 17 that number of cases per month. I think
 18 initially '97 and '98 I would have looked at less
 19 cases.
 20 Q. When you say you review one to two cases a month,
 21 is that at the present time?
 22 A. Correct. I think it's been that way the last two
 23 years, two to three years or so.
 24 Q. So prior to that from '97 to '99ish, again not
 25 holding you to any specific dates, how many cases

18

- 1 were you reviewing per month or per year?
 2 A. I have no way of knowing that. It's not
 3 something I would keep track of. Again, the last
 4 three years I've limited it to that. So I know
 5 exactly what I'm reviewing. I'll only accept one
 6 or two cases a month.
 7 Q. Now with regard to those cases you've reviewed
 8 over the last approximately five years, how many
 9 of them have been on behalf of the plaintiff as
 10 opposed to the defendant?
 11 A. Well, I think it's kind of waxed and waned. I
 12 think initially when I first started reviewing,
 13 they were mainly on behalf of the defendant. I
 14 mean, this is all -- total of all of the cases I
 15 review. For some reason lately I've seen more
 16 plaintiff cases. Again, they -- I can't remember
 17 ever reviewing any GYN cases. So they range the
 18 whole range of obstetrics.
 19 Q. As an overall proposition, Doctor, based on the
 20 cases that you review as an expert, can you give
 21 me the breakdown, plaintiff versus defendant?
 22 A. I think the last couple of -- the last year it's
 23 been probably about maybe 60/40 or 70/30 as far
 24 as, you know, mainly defense. Initially I think
 25 the first year or so it was probably 80 to 90

19

- 1 percent defense.
 2 Q. Now are all of those matters that you've reviewed
 3 dealing with birth injuries and more specifically
 4 with brachial plexus, Erb's palsy injuries?
 5 A. No. I mean, I review cases, they are -- almost
 6 all of them are obstetrically related, but I look
 7 at cases of uterine rupture, maternal death
 8 related to hemorrhage, you know, undiagnosed
 9 diabetes. You name it, anything on obstetrics I
 0 can review.
 1 Q. Out of all the cases that you've reviewed over
 2 the last five years, can you give me an idea of
 3 what percentage of those cases deal with brachial
 4 plexus, Erb's palsy injuries?
 5 A. Probably all total about 60 percent would be
 6 shoulder dystocia related.
 7 Q. Now limiting this question solely to the field of
 8 those cases of the ones that are shoulder
 9 dystocia related, what's the breakdown between
 0 plaintiff and defendant in that sphere?
 1 A. Again, just an estimate, maybe 75 percent
 2 defense, 25 percent plaintiff. Again, that is
 3 just a complete guess, if you will.
 4 Q. Is that at the present time?
 5 A. It waxes and wanes, I don't know. I mean, people

20

- 1 will call from all over the country both on
 2 behalf of the defendant and the plaintiff.
 3 Q. Has that figure also decreased in terms of
 4 the percentage that you reviewed over the
 5 defense -- for the defense over the years?
 6 A. No. I think, I mean, again, it's not something I
 7 keep track of. I don't know.
 8 Q. How many times have you reviewed cases upon
 9 request of Mr. Auciello or his firm Gallagher,
 0 Sharp, Fulton & Norman?
 1 A. As best I can recall I believe I looked at one
 2 other case.
 3 Q. Is that one currently active?
 4 A. Not that I'm aware of. Again, I don't always
 5 keep track of whether they've been settled or
 6 not.
 7 Q. Were you asked to give a deposition in that case?
 8 A. Not that I'm aware of.
 9 Q. So to your recollection this is the first time
 0 that you've given a deposition where Mr. Auciello
 1 was the attorney who retained you?
 2 A. I believe this is the first time I've ever met
 3 him, yes.
 4 MR. AUCIELLO: He couldn't help me
 5 in that case, Jonathan.

21

1 Q. Doctor, you're aware that the plaintiffs in this
2 case have retained a few experts, Dr. Ravitz and
3 Dr. Adler, do you know either one of those
4 gentlemen?

5 A. I don't personally know them, no.

6 Q. Do you know of them in some way?

7 A. I believe Dr. Adler may have written a report in
8 other cases that I've seen. I'm not aware that
9 Dr. Ravitz has ever written anything on shoulder
10 dystocia and I have never personally met him.

11 Q. Doctor, can you give me an idea of how many
12 depositions you've given over the years, the last
13 five years since you've been doing this type of
14 work?

15 A. Maybe about 30 or so, 30 or 40. Again, about
16 half the cases all total that I would get, you
17 know, I would say that there has been deviation
18 or there has not been a deviation, again,
19 depending on whether that came from a plaintiff
20 or defendant, so about half the cases I end up
21 giving a deposition.

22 Q. All right. Have you asked -- to your knowledge
23 have you been asked to give a deposition for any
24 cases pending in the State of Ohio?

25 A. I may have. I don't keep track specifically of

22

1 where the cases come from.

2 Q. Can you give any of the names of any other
3 attorneys in Ohio that you've reviewed cases for?

4 A. I mean, I have reviewed cases for attorneys in
5 Ohio, I don't recall their names.

6 Q. What about in Cleveland?

7 A. I believe that I've been asked to look at cases
8 in Cleveland.

9 Q. You can't remember the names of the lawyers,
10 though?

11 A. Not specifically, no.

12 Q. What about trial testimony, Doctor, can you give
13 me an idea of the number of times you've appeared
14 to testify in trial?

15 A. I'm sorry, what was your question?

16 Q. Sure. I just asked how many times you've
17 appeared to testify in a trial of a case as an
18 expert witness?

19 A. I want to say somewhere between five and 10
20 maybe.

21 Q. And same question about Ohio, do you know if
22 you've appeared in Ohio in trial?

23 A. I don't believe I have.

24 Q. Doctor, it's my understanding that on Friday
25 night you're going to be giving a trial

23

1 deposition in this case?

2 A. Correct.

3 Q. The trial in this case is set for next week. Are
4 you unavailable to come to Ohio or is there
5 another reason that you've opted to give a trial
6 deposition?

7 A. No, that would be the reason. Again, given the
8 short notice and the fact that I just took a
9 month's worth of vacation, my hospital is not
10 going to give me time off.

11 Q. Doctor, have you personally ever had a claim
12 brought against you for medical malpractice?

13 A. No, I've not personally been involved. I'm
14 sorry, I've never personally been sued. I was
15 involved in a case as a second resident where a
16 claim was brought against the United States
17 Government but, again, there was another resident
18 involved in that case as well.

19 Q. And I understand that in your capacity as an
20 employee of the United States Government you
21 probably would not be sued personally. Let me
22 just ask the question again just to make sure.

23 Can you tell me the number of times
24 to your knowledge that the Government has been
25 sued where there was an allegation that your care

24

1 did not meet acceptable standards of care?

2 MR. AUCIELLO: Just a generally
3 objection to this line.

4 A. Again, I don't recall the exact specifics of that
5 case and I don't know whether my care was alleged
6 to have been below the standard of care or not.
7 Again, I was one of the individuals involved in
8 the delivery but I believe that that's the only
9 case that I've ever been part of.

10 Q. What happened in that delivery?

11 A. In that delivery there was a shoulder dystocia.
12 The child ended up having a posterior arm
13 brachial plexus injury.

14 Q. And were you deposed in that case?

15 A. I would have been, yes.

16 Q. Can you give me an idea of when that was?

17 A. '95, '96, somewhere in that time frame.

18 Q. At that time were you the person in charge of the
19 delivery?

20 A. No, that would have been the third year resident.

21 Q. What was your role in that delivery?

22 A. I would have made the diagnosis of dystocia and I
23 believe I called for assistance from the third
24 year resident who came and completed the
25 delivery.

25

- 1 Q. Forgive me, Doctor, were you a resident at that
2 time?
3 A. Correct.
4 Q. What year were you?
5 A. I believe I was a second year resident.
6 Q. So you were the one who was conducting the
7 delivery, you noticed the dystocia and you called
8 for the third year?
9 A. Correct.
10 Q. Was that the protocol at that time, that you
11 would look for a senior person to handle it in
12 that situation?
13 A. I think it would depend on the clinical
14 situation. There was no standard that we had to
15 let a senior know, but I think in general most
16 people would do that.
17 Q. Why in that particular instance did you opt to
18 bring the third year resident in?
19 A. Again, I don't specifically recall the facts of
20 that case that would have had me call her in, I
21 don't recall.
22 Q. Do you recall what maneuvers were done in an
23 effort to relieve the shoulder dystocia in that
24 delivery?
25 A. I don't recall.

26

- 1 Q. Do you recall the ultimate outcome of that claim
2 that was brought against the Federal Government?
3 A. I believe it went to a non-jury Federal trial and
4 the finding was on behalf of the plaintiff.
5 Q. Were you involved in that trial?
6 A. I would have given testimony. I don't believe I
7 was there for the whole trial.
8 Q. But you did take the witness stand and give
9 testimony?
10 A. Correct.
11 Q. Where was that?
12 A. Somewhere in Maryland.
13 Q. Federal Court in Maryland I take it?
14 A. Correct.
15 Q. Any other claims that we have not talked about
16 where you have given testimony under oath?
17 A. Not that I can recall, no. I'm sorry, I actually
18 may have been involved in one case but, again, it
19 was a similar situation where actually I was the
20 delivering provider but another resident would
21 have cared for the patient after delivery and I
22 had no involvement. But I would have been
23 deposed and I have never heard anything more
24 about the case.
25 Q. When were you deposed in that regard?

27

- 1 A. Around the same time frame, maybe '96, '97.
2 Q. Do you recall what the allegations were in that
3 instance?
4 A. The allegation I think was a breakdown of
5 episiotomy.
6 Q. You, yourself, **did** not perform the episiotomy?
7 A. No. I just delivered the baby and she actually
8 had a breakdown during the postpartum period and
9 I had no involvement with the patient then.
10 Q. Doctor, over the entire course of your practice
11 delivering babies, can you give me an idea of how
12 many shoulder dystocias you personally have
13 encountered?
14 A. I mean, I can only give you an approximate
15 estimate, maybe **50** or **60**. Again, I have always
16 practiced in a tertiary care center and it has
17 always been associated with diabetics or other
18 patients who would be at risk.
19 Q. What about compound presentations, have you
20 encountered those over the course of your
21 practice?
22 A. I have, yes.
23 Q. And can you give me an idea of how many of those
24 you've encountered?
25 A. Probably not that many, maybe a handful, maybe

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- 1 five or so.
2 Q. All right. Starting with the shoulder dystocias
3 that you've encountered, can you tell me to your
4 knowledge how many of those deliveries the child
5 suffered a brachial plexus or Erb's palsy injury?
6 A. I believe only one, the one that we had
7 mentioned.
8 Q. All right. Doctor, in any of the other
9 delivery -- non-shoulder dystocia deliveries that
10 you've done, have there been a brachial plexus,
11 Erb's palsy injury?
12 A. I believe I was present at a delivery room as a
13 fellow and the child had transient brachial
14 plexus during a normal spontaneous delivery.
15 Q. That's the only one?
16 A. As far as I know. I mean, there may have been
17 others. We often don't get neonatal follow-up on
18 all of the children we deliver, but those are the
19 only two I know of.
20 Q. And I may have asked you this earlier, Doctor,
21 but again going back to when you first started
22 delivering babies, can you give me an
23 approximation of how many babies you've delivered
24 to the present time?
25 A. Not really. I mean, I've always practiced in a

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1 tertiary center with a high number of
 2 deliveries. I would have no idea, no way of
 3 knowing that.
 4 Q. Would it be in the thousands?
 5 A. I think that's a fair assessment.
 6 Q. And just so I make sure I understand, of those
 7 deliveries you've encountered a shoulder dystocia
 8 in approximately 50 or 60?
 9 A. That's just a guess. I have no way of knowing.
 10 It's not something I keep track of.
 11 Q. But at any rate, out of the non-shoulder dystocia
 12 deliveries you've been involved in, you can only
 13 recall one instance where there was a brachial
 14 plexus, Erb's palsy injury?
 15 A. Correct.
 16 MR. AUCIELLO: Objection, I don't
 17 know if he limited that to non-shoulder
 18 dystocias.
 19 Q. Did I misunderstand, Doctor?
 20 THE WITNESS: I think he did ask
 21 non-shoulder dystocia.
 22 Q. I'll repeat it in case it wasn't clear. My
 23 question was: Out of the remaining non-shoulder
 24 dystocia deliveries you've done, Doctor, there's
 25 only been one in your experience where there was

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1 a brachial plexus, Erb's palsy injury, is that
 2 correct?
 3 A. That I've personally been involved in, yes, that
 4 would be just one.
 5 Q. All right. Doctor, can you tell me, what are
 6 some of the publications or journals that your
 7 office subscribes to within the obstetrical
 8 field?
 9 A. Actually my office doesn't subscribe to any of
 10 them.
 11 Q. Do you personally describe to any, I'm sorry,
 12 subscribe to any?
 13 A. I do.
 14 Q. What would those be?
 15 A. I believe that I receive the American Journal of
 16 OB/GYN, Obstetrics and Gynecology, The Journal of
 17 Reproductive Medicine, The Journal of
 18 Maternal-Fetal Medicine, New England Journal. I
 19 get many other non-peer review journals as well.
 20 Q. I'm sorry, Doctor, just for the court reporter's
 21 sake, would you mind just repeating that one more
 22 time?
 23 A. The American Journal of OB/GYN, Obstetrics and
 24 Gynecology, New England Journal of Medicine, The
 25 Journal of Reproductive Medicine. I think I just

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1 said I get other non-peer review journals as
 2 well.
 3 Q. And what would those be, Doctor?
 4 A. I think the Female Patient, although that may be
 5 peer reviewed. Contemporary OB/GYN, some other
 6 throw away magazines that I may or may not look
 7 at.
 8 Q. Doctor, are you also familiar with the
 9 publication that is published by ACOG, the
 10 Precis, and I may not be pronouncing that right?
 11 A. It's been a while since I looked at them but,
 12 yes, I have looked at them.
 13 Q. Do you also get the Precis as part of your
 14 subscription?
 15 A. No.
 16 Q. What is the Precis.
 17 A. Well, actually if you look inside the front
 18 cover, it tells you what it is. It's an update
 19 of our clinical knowledge concerning medical
 20 conditions of obstetrics and the conditions
 21 related to that.
 22 Q. And who is it that generates the materials that
 23 are published in the Precis?
 24 A. It's published by the college. I'm not quite
 25 certain who authors it.

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1 Q. You would agree that the college is certainly an
 2 authority in the field of obstetrics?
 3 A. No. I think the college serves, you know, as a
 4 guideline but it's not an authority.
 5 Q. Would you agree with me, Doctor, that the
 6 materials published by the college and in
 7 particular the Precis are at least reliable
 8 within the field of obstetrics?
 9 A. No. I think that they -- you know, I think you
 10 need a specific Precis. I mean, it tells you
 11 right on the front cover, it's a guideline and
 12 it's an update of our knowledge. If you look
 13 inside the back of the front cover, that's what
 14 it tells you that it is. So it's an evolution of
 15 our knowledge concerning conditions related to,
 16 you know, if this is an obstetrics one,
 17 obstetrics.
 18 Q. I want to make sure I understand, Doctor, are you
 19 saying that the materials published in the Precis
 20 for obstetrics is not reliable?
 21 A. No. I think some of it may be and some of it may
 22 not be. I think you would have to look at what
 23 the specifics of it were before saying whether I
 24 thought it was reliable or not.
 25 Q. Doctor, are you familiar with the 1998 Precis

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1 that was published and particularly with respect
 2 to shoulder dystocia?
 3 A. It's been a while since I've looked at it, but I
 4 have looked at it in the past, yes.
 5 Q. And you're familiar with the contents of that?
 6 A. Well, you know, I would refer you quite honestly
 7 to Prices 2000. Prices '98 is far outdated. I
 8 mean, it's four years old and most likely the
 9 material that was written is far older than
 10 that. So, you know, that's outdated information
 11 that you're referring to.
 12 Q. So you don't believe that that information is
 13 reliable I take it?
 14 A. No, I would refer you to Precis 2000 because,
 15 again, I think it clearly tells you that medicine
 16 changes and our belief about medicine changed
 17 and, you know, you're not going to rely on a
 18 textbook from 50 years ago, you're going to rely
 19 on current information.
 20 Q. Was the '98 Precis put out 50 years ago, Doctor?
 21 A. No, sir.
 22 Q. All right. Doctor, you would agree with me that
 23 the '98 Precis, again I know you don't have it in
 24 front of you, but that as a general proposition
 25 it indicated that brachial plexus injuries result

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1 from excessive lateral traction on the fetal
 2 head, is that correct, Doctor?
 3 A. That's something you're reading. I mean, I'm not
 4 going to argue with the fact that you're reading
 5 it. But I think that, you know, when you look at
 6 the research information of the last five to 10
 7 years, that's an invalid opinion and that clearly
 8 was reflected in the change in Precis 2000 as
 9 well as articles that have come out in the last
 10 five years. So, no, I would not rely on that and
 11 I don't think that's a valid opinion.
 12 Q. You would agree with me, Doctor, that there are
 13 still some within the obstetrical field that hold
 14 to that opinion even today?
 15 A. I would have no way of knowing that other than
 16 obviously I think Dr. Ravitz does but, you know,
 17 realistically, I mean, there may be people who
 18 believe that peptic ulcers is caused by stress
 19 when we very well know that the overwhelming
 20 majority of them are caused by bacteria. So our
 21 medical knowledge of situations change.
 22 Q. I understand that, Doctor. I know that you've
 23 told me that obviously outside of your practice
 24 with the military you keep track of the current
 25 literature in this field, correct?

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1 A. I think I read information as it comes out. I
 2 mean, there very well may be articles that come
 3 out that I haven't read. It's an area of
 4 interest of mine. I try and read on this area
 5 when I can.
 6 Q. Doctor, are you familiar with Robert Allen of the
 7 University of Maryland College Park?
 8 A. I read his material in the past, yes.
 9 Q. And you're aware that he has put out studies and
 0 articles with respect to the amount of force
 1 occurring in a delivery?
 2 A. He's tried to measure it, you know, mainly in
 3 models, mechanical-- or bioengineering point of
 4 view and I believe that they actually had a few
 5 patients in association with Dr. Gonik in early
 6 1990s but very, very small series of patients.
 7 Q. But, Doctor, you would agree with me that he is
 8 one of the people currently in the field who
 9 still believes that these types of injuries,
 0 brachial plexus injuries result from excessive
 1 lateral traction on the fetal head?
 2 A. Again, I think you'd have to ask Dr. Allen.
 3 I think that he may believe that. But I
 4 think looking at his data, you know, I think
 5 that -- I'm not certain how he arrives at that

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1 conclusion because his data is flawed.
 2 Q. Doctor, are you familiar with David Acker, M.D.
 3 in Boston, Massachusetts?
 4 A. No.
 5 Q. All right. Doctor, let's talk about the matter
 6 at hand here if we could, the case here involving
 7 young Kayla Payne. Can you tell me what
 8 materials you've reviewed prior to providing your
 9 opinions in this case?
 0 A. I would have looked at --
 1 Q. And let me save a little bit of time, Doctor. I
 2 have your report from July 16, 2002 and you list
 3 on pages one through two, eight things that you
 4 reviewed. Have you reviewed any additional
 5 materials?
 6 A. Yes. I would have looked at the depositions
 7 of Ronna Watson as well as Dr. Cook and just
 8 today I read over very quickly the deposition
 9 of Dr. Ravitz.
 0 Q. Okay. Any other materials that you've read?
 1 A. I'm sorry, I believe over the weekend I did look
 2 at the deposition of Videllia Giles.
 3 Q. Any other deposition transcripts that you've
 4 read, Doctor?
 5 A. Not that I'm aware of.

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1 Q. Have you read the deposition transcript of Justin
 2 **Lavin, M.D.**
 3 A. I don't believe that I have.
 4 Q. What about Dr. Adler's deposition, have you seen
 5 that?
 6 A. No, I have not.
 7 Q. And I take it you wouldn't have read the
 8 deposition of the vocational expert in this case,
 9 Robert Ancell?
 10 A. I don't believe that was sent to me.
 11 Q. Have you reviewed any additional medical records
 12 other than the ones you list on your report of
 13 July 16, 2002?
 14 A. I don't believe that I have.
 15 Q. All right. Doctor, have you taken any -- did you
 16 take any notes on any of the materials that you
 17 were provided with?
 18 A. I don't believe that I did.
 19 Q. Have you had any discussions with any other
 20 physicians or experts regarding Kayla Payne's
 21 case?
 22 A. No.
 23 Q. Have you conducted any additional research, read
 24 any additional articles in preparation for this
 25 case?

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1 A. No.
 2 Q. Doctor, am I correct that you've only authored
 3 one report in this case and that's the one that's
 4 dated July 16th, 2002?
 5 A. To the best of my knowledge, yes.
 6 Q. Can you tell me when you were first approached by
 7 the defense in this case to review this matter?
 8 A. By approached you mean contacted either
 9 electronically or via phone?
 10 Q. First time you heard about this case.
 11 A. It would have been sometime before March the 8th,
 12 2001 because the letter starts out saying thank
 13 you for agreeing to review this case. So I may
 14 have gotten a phone call or e-mail prior to that
 15 asking me to review the case, but I don't recall
 16 the date of that initial correspondence.
 17 Q. Who is the letter from of March 8th, 2001?
 18 A. I believe it's from Mr. Auciello.
 19 Q. And again, unfortunately I'm somewhat handicapped
 20 because I can't see it in front of me there.
 21 Could you just read me the letter please?
 22 Hopefully it's not a long letter.
 23 A. Sure. Dear Dr. Gherman, thank you for agreeing
 24 to review this case on behalf of our client,
 25 Mount Sinai Medical Center, with respect to the

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1 above-captioned matter. I am enclosing for your
 2 review a copy of the Complaint. Also please find
 3 the medical records for your review including,
 4 I'll just condense here, if you will, the records
 5 of Videllia Giles from Mount Sinai and the
 6 records from Kayla Payne from Mount Sinai.
 7 Q. Okay. Thank you, Doctor.
 8 A. Those are from 6-11-99 to 6-13-99.
 9 Q. Is that the full text of the letter?
 10 A. Yes.
 11 Q. Have you received any other correspondence from
 12 Mr. Auciello or his office in this matter?
 13 A. I have, yes.
 14 Q. And how many other letters have you received?
 15 A. I believe I have received several letters and a
 16 couple of e-mails.
 17 Q. Do any of those contain any content other than
 18 just providing you with additional material to
 19 look at in the case?
 20 A. Not that I'm aware of. I think they're all
 21 letters saying that we are sending you something,
 22 please find enclosed.
 23 Q. And, Doctor, I take it you'll have your entire
 24 file with you again on Friday evening when you
 25 testify in this case?

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1 A. Assuming I don't drop anything out of it, yes.
 2 Q. Well, I'd like to request, if you could, Doctor,
 3 if you could keep your entire file that you've
 4 got here together so that when I'm actually there
 5 with you, I can take a look at it. Okay?
 6 A. I make no guarantees, I'm sorry. I will try my
 7 best.
 8 Q. Well, I understand you could inadvertently drop
 9 something, but you won't remove anything from
 10 your file, will you, Doctor?
 11 A. No.
 12 Q. All right. Doctor, turning to the delivery that
 13 occurred in this case, Doctor, can we agree first
 14 of all that a shoulder dystocia was encountered
 15 here by Ronna Watson?
 16 A. It's my belief and understanding looking both at
 17 the note that was written as well as the
 18 deposition, her deposition, that there was a
 19 dystocia.
 20 Q. I'm sorry, just so I heard you, was that was?
 21 A. Correct.
 22 Q. So there was in fact a shoulder dystocia?
 23 A. Again, I think she called it as a tight shoulder,
 24 but people may make that -- use that to
 25 semantically mean the same as a shoulder

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1 dystocia.
 2 Q. How do -- I'm sorry, were you finished?
 3 A. Yes.
 4 Q. How do you personally define the term shoulder
 5 dystocia?
 6 A. I would define it as a failure delivery of the
 7 shoulder after initial attempts at downward
 8 traction and the delivery would require ancillary
 9 obstetric maneuvers to complete.
 10 Q. So by that definition, Doctor, we can agree that
 11 a shoulder dystocia was encountered in this
 12 delivery?
 13 A. Correct.
 14 Q. Doctor, do you know who Justin Lavin is?
 15 A. I don't specifically know him, no.
 16 Q. And I'll just let you know that he was also
 17 retained. He's an obstetrician in Ohio and he
 18 was also retained on behalf of the defendants in
 19 this case to provide an opinion.
 20 I take it then you have not been
 21 provided with his expert report?
 22 A. Well, I looked at it briefly today. I had not
 23 seen it prior to today.
 24 Q. So you did see his report. You told me early,
 25 though, you never read his deposition testimony?

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1 A. Correct.
 2 Q. Doctor, I'm going to have you assume that
 3 Dr. Lavin has testified in this case that it was
 4 his opinion that a shoulder dystocia was not
 5 present in this delivery. I take it you would
 6 disagree with that opinion?
 7 A. I would. It is my opinion that, you know, that
 8 there was difficulty in delivery. What the
 9 midwife had identified as a tight shoulder, I
 10 think she described it as a mild dystocia. They
 11 did the McRoberts' maneuver and episiotomy. The
 12 baby quickly delivered after that.
 13 Q. Doctor, I don't know if Mr. Auciello has a copy
 14 of the deposition transcript there present, but
 15 on page 34 of Dr. Lavin's depo, if I just quote
 16 if for you, he says, and I don't think I would
 17 characterize this as sort of a true shoulder
 18 dystocia.
 19 And then just so I'm clear, Doctor,
 20 you disagree with Dr. Lavin in that regard,
 21 correct?
 22 A. Well, I mean, I think, I mean, he may be looking
 23 at more in a classical sense of a true shoulder
 24 dystocia that may have many maneuvers to be
 25 required. I don't know what question you asked

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1 him or what he was exactly thinking. But my
 2 interpretation of the case I believe there was a
 3 shoulder dystocia present.
 4 Q. Doctor, can we agree that it is a deviation --
 5 Doctor, do you need a moment to review something?
 6 A. No, I'm just thinking, go ahead.
 7 Q. Okay. Doctor, can we agree that when a shoulder
 8 dystocia is encountered such as you've opined was
 9 encountered here, that it would not conform with
 10 the standard of care to apply excessive lateral
 11 traction to the fetal head?
 12 A. I think in the absence of --
 13 Q. Doctor, unfortunately when you're shuffling your
 14 papers, you're hitting the microphone.
 15 A. Again, I would only recommend using excessive
 16 lateral traction as far as a life saving maneuver
 17 on behalf of the child.
 18 Q. And, Doctor, you would agree with me from all of
 19 the materials you've reviewed in this case, that
 20 there was no need for a life saving maneuver in
 21 this delivery, am I correct?
 22 A. Correct.
 23 Q. So can we agree, Doctor, that if Ronna Watson
 24 applied excessive lateral traction during this
 25 delivery, that she deviated from the standard of

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1 care?
 2 A. Well, I think it would depend at what point in
 3 time and, you know, how she did it.
 4 Q. All right. Under what circumstance would
 5 applying excessive lateral traction in this
 6 delivery conform with the standard of care?
 7 MR. AUCIELLO: I'm just going to
 8 object generally because there's no evidence
 9 she applied excessive lateral traction, but
 10 since this is a hypothetical, you can go
 11 ahead and answer it.
 12 A. Again I think it would depend on the clinical
 13 situation. You know, you'd have to give me more
 14 of a specific rather than just saying under what,
 15 you know, general circumstances.
 16 Q. And I didn't mean to phrase it that way, Doctor.
 17 What I was really saying was, you've reviewed all
 18 the materials in this case, is there any point in
 19 this delivery based on the materials you've
 20 reviewed where the use of excessive lateral
 21 traction would have been appropriate?
 22 A. Not in this delivery, no.
 23 Q. So again, Doctor, my question is: In this
 24 specific delivery if Ms. Watson applied excessive
 25 lateral traction during the delivery, that would

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- 1 be a deviation from the standard of care?
- 2 A. Again, assuming that's a hypothetical because I
- 3 do not see any evidencethat she did, I would say
- 4 that's a deviation of standard care.
- 5 Q. I understand that, Doctor, and I am giving you
- 6 that as a hypothetical.
- 7 Doctor, you've told me that you had
- 8 an opportunity to review the testimony of
- 9 Videllia Giles that was given in this case?
- 10 A. Correct.
- 11 Q. And I take it then you saw in the material where
- 12 Ms. Giles indicated that prior to employing
- 13 McRoberts' or cutting an episiotomy, Ms. Watson
- 14 grabbed the baby by the head and arm I believe
- 15 and attempted to pull it out?
- 16 A. I did see that and again that would be the normal
- 17 way to do it when you conduct a delivery even
- 18 according to my definition. You would exert
- 19 downward traction and with failure delivery of
- 20 the shoulder you would then proceed with other
- 21 maneuvers.
- 22 Q. Doctor, I'm going to ask you, and I know it's
- 23 difficult, can you lean forward while you're
- 24 testifying or at least not lean back?
- 25 A. I'm sorry.

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- 1 Q. That's okay. Unfortunately, Doctor, I'm not sure
- 2 we got that whole answer. I guess let me repeat
- 3 my question.
- 4 I think my question is: You've
- 5 reviewed the materials of -- you've reviewed
- 6 Ms. Giles' deposition and I guess my question
- 7 is: If Ms. Giles' deposition testimony is
- 8 accurate, would that be a deviation from the
- 9 standard of care?
- 10 MR. AUCIELLO: I'm going to just
- 11 interpose an objection because another
- 12 witness from the plaintiff has contradicted
- 13 that already. I don't have the transcript
- 14 yet to show him, but just with an objection
- 15 because that will differ that --
- 16 A. Well, maybe you can refer me to a specific
- 17 question and answer and a specific line and page
- 18 number and, you know, I'll tell you what I think
- 19 of it.
- 20 Q. Sure.
- 21 A. And unfortunately I think when I read this over
- 22 the weekend, I think I left every other page at
- 23 home when I re-stapled it. So you might have to
- 24 bear with me. But if you give a line and a page
- 25 number, hopefully I'll have it.

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- 1 Q. Doctor, do you have page 30?
- 2 A. I don't think that I do because I think for some
- 3 reason I -- I don't think I do.
- 4 MR. MESTER: Ernie, do you have that
- 5 by any chance?
- 6 MR. AUCIELLO: Unfortunately I
- 7 didn't bring any other transcripts because I
- 8 knew he had them all, so I don't have them
- 9 with me. Let me double-check. No, I don't
- 10 have any other transcripts.
- 11 MR. MESTER: All right.
- 12 Q. Doctor, let me just read a short passage then
- 13 from Ms. Giles' deposition to you and I'll do
- 14 this as slow as possible for everyone involved.
- 15 She's talking about on page 30 about the delivery
- 16 and she says, she told me to stop pushing. I
- 17 stopped pushing. She grabbed her by her neck and
- 18 her arm and pulled and when she pulled them for a
- 19 few seconds, she was like indicating and then it
- 20 goes on.
- 21 Doctor, again, assuming that
- 22 testimony is true, would that be a deviation from
- 23 the standard of care?
- 24 A. No. Again, I think what she's describing is the
- 25 normal traction that would be an inherent part of

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- 1 any delivery process.
- 2 Q. When a shoulder dystocia is encountered, Doctor,
- 3 is it proper to attempt to pull the baby by her
- 4 head and arm?
- 5 A. Well, after you've done a maneuver, yes. A
- 6 general maneuver is done and then traction is
- 7 applied and the vertex is delivered. The
- 8 traction will be applied before that.
- 9 Q. And, Doctor, I apologize because the testimony
- 10 goes on to say that subsequent to pulling the
- 11 neck and arm the nurse midwife grabbed her leg
- 12 and held it up, essentially applying an
- 13 McRoberts' I guess, and then did the episiotomy.
- 14 A. Again, I think what she would be describing is
- 15 the traction that would be part of a normal
- 16 delivery. The midwife attempts traction,
- 17 shoulder won't deliver, she then goes into her
- 18 maneuvers and then exerts traction again. It's
- 19 an inherent part of how you do a delivery. You
- 20 do a maneuver, then you have to go back to
- 21 traction. The child is just not going to fall
- 22 out once you do the maneuver.
- 23 Q. Doctor, I know that unfortunately you don't have
- 24 the benefit of having her deposition transcript
- 25 in front of you, so I'm just going to give this

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- 1 question to you as my own hypothetical, okay?
- 2 A. Sure.
- 3 Q. Doctor, if in this case Ms. Watson encountered
- 4 the shoulder dystocia, at that point told
- 5 Ms. Giles to stop pushing and then reached in and
- 6 grabbed the baby by her neck and arm without
- 7 doing any maneuvers beforehand and then
- 8 subsequently did a McRoberts' and cut an
- 9 episiotomy afterward, under that hypothetical,
- 10 Doctor, would that be a deviation from the
- 11 standard of care?
- 12 MR. AUCIELLO: Objection, go ahead.
- 13 A. Again, I think what you're describing is the way
- 14 that she's going to diagnose the dystocia is
- 15 after her attempts at traction had been
- 16 unsuccessful. Again, the -- initially after
- 17 that, after those initial attempts had been
- 18 unsuccessful, she should resort to a maneuver and
- 19 then exert traction again.
- 20 Q. Doctor, the excerpt that I read you, Ms. Giles
- 21 indicated that Ms. Watson told her to stop
- 22 pushing, would that be an appropriate order after
- 23 a shoulder dystocia is encountered?
- 24 A. Yes.
- 25 Q. So if we assume that Ms. Watson encountered the

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- 1 shoulder dystocia, in other words, realized it
- 2 was there, told Ms. Giles to stop pushing and
- 3 then pulled on the neck and arm, would that be a
- 4 deviation from the standard of care?
- 5 A. No, because again it's my interpretation in this
- 6 case that she did the maneuver and then exerted
- 7 her traction.
- 8 Q. But, Doctor --
- 9 A. You need to specifically define when she would
- 10 have exerted traction.
- 11 Q. And I thought I had, but let me try it again and
- 12 I think it would be clear by the deposition
- 13 transcript, but let's just do it in a
- 14 hypothetical.
- 15 Let's take it in a hypothetical in
- 16 this order of events, Doctor, Ms. Watson
- 17 encounters the shoulder dystocia and realizes
- 18 it and tells Ms. Giles to stop pushing, that's
- 19 No. 1, okay?
- 20 A. Okay.
- 21 Q. No. 2, before doing any maneuvers, before putting
- 22 in a McRoberts' and before doing an episiotomy
- 23 she reaches in and tries to pull the baby out
- 24 with the neck -- by the neck and arm, okay?
- 25 A. Okay.

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- 1 Q. Under that hypothetical, Doctor, would that be a
- 2 deviation from the standard of care?
- 3 A. Well, again, I think as you've described it
- 4 hypothetically, that's not the appropriate way to
- 5 handle the situation. But it's my evaluation
- 6 that's not what happened in this case.
- 7 Q. Does that evaluation come from your reading of
- 8 the deposition of Videllia Giles?
- 9 A. Yes. It would be also incorporated in my
- 0 interpretation of what occurred.
- 1 Q. So it's your recollection that Ms. Giles -- well,
- 2 strike that.
- 3 What is your recollection of
- 4 Ms. Giles' testimony?
- 5 A. Well, again, I think first in the context in
- 6 which it is taken, again, it can be difficult for
- 7 the patient to observe what is happening and
- 8 these things are happening quickly and they're
- 9 very fluid movements. So, again, I think that
- 0 needs to be looked at within that context.
- 1 Q. Doctor, is there ever a time when you are
- 2 delivering a baby after a shoulder dystocia is
- 3 encountered where you would want to apply
- 4 excessive lateral traction and now I'm asking you
- 5 in the general sense?

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- 1 A. I think if all of your other maneuvers have not
- 2 worked and you're going to use that as a life
- 3 saving maneuver, in that situation I would go to
- 4 excessive lateral traction.
- 5 Q. Outside of a life saving maneuver, Doctor, is
- 6 there any time where you would apply excessive
- 7 lateral traction when a shoulder dystocia has
- 8 been encountered?
- 9 A. I guess let me also add, I mean, there is no
- 0 standard nomogram for what is considered
- 1 excessive. You know, we really don't even know,
- 2 you know, there's no normal nomogram in labor.
- 3 But again using the subjective word excessive,
- 4 you normally would not use that, but only in a
- 5 life threatening situation.
- 6 Q. Doctor, how would you determine I guess whether
- 7 the lateral traction applied is excessive, how
- 8 might one determine that?
- 9 A. Well, that goes back to the clinical experience
- 0 and the training that one receives doing
- 1 deliveries. That's something that you learn by
- 2 doing normal deliveries, you know, what it feels
- 3 like.
- 4 Q. You train residents I take it still at the
- 5 present time in doing deliveries, correct?

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- 1 A. Yes.
- 2 Q. And as part of that training you watch them
- 3 conduct deliveries?
- 4 A. Yes.
- 5 Q. Can you tell by simply watching the resident
- 6 whether the amount of traction he is applying is
- 7 appropriate?
- 8 A. I think that you can. I think that they also
- 9 learn with the hands-on approach as well and the
- 10 feeling, but you usually can tell by watching.
- 11 Q. Tell me from your position as an observer
- 12 watching deliveries, can you characterize for me
- 13 what would be in excess of the normal traction
- 14 you'd want to apply?
- 15 A. Well, again, I don't think you can specifically
- 16 tell really. I mean, the only person who can
- 17 truly comment on that is the person who has their
- 18 hands on the head because, you know, excessive
- 19 implies the fact that you're going to measure it
- 20 and it's not something that we routinely do.
- 21 Q. Okay. But you told me before that that's
- 22 something that you say as an observer you are
- 23 able to at least be able to tell somewhat whether
- 24 it's excessive, correct?
- 25 A. No, not necessarily. I mean, I think that as a

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- 1 trained observer, someone who does countless
- 2 deliveries, you might have an idea. But clearly
- 3 even at C-section we put enormous forces on a
- 4 child's head often times trying to get it out or
- 5 other parts of the body, we may put a lot of
- 6 traction on it.
- 7 Q. Doctor, do you have the deposition of Ms. Watson
- 8 handy?
- 9 A. I do.
- 10 Q. All the pages?
- 11 A. One can only hope. Yes, I think that I do.
- 12 Q. All right. Could you turn to page 78, if you
- 13 would, in her deposition?
- 14 A. Sure.
- 15 Q. Okay?
- 16 A. Okay.
- 17 Q. And I'd like if you could, not out loud, but just
- 18 read the Question starting on line 7 and the
- 19 Answer on line 11?
- 20 A. I'm sorry, line?
- 21 Q. My Question beginning on line 7 on page 78.
- 22 A. Going down to where?
- 23 Q. Her Answer on line 11.
- 24 A. How about line 13 and 14 too?
- 25 Q. Sure. My question is really going to be directed

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- 1 to just lines 7 through 11 but, I mean, you can
- 2 read whatever you like.
- 3 A. Well, I mean, I think it's a continuation. I
- 4 think that she's telling you quite clearly she
- 5 didn't apply excessive traction.
- 6 Q. I see that, Doctor.
- 7 A. I think you ask her in line 7 to 9 a hypothetical
- 8 question and she says, yeah, it's a possibility.
- 9 But here she's telling you when you specifically
- 0 ask her, do you recall that, she tells you, I
- 1 didn't apply excessive traction.
- 2 Q. I understand, Doctor, but let me ask what my
- 3 question is. My question is: If Ms. Watson has
- 4 indicated in line 11 that there are instances
- 5 where you might have to apply a little bit more
- 6 pressure than normal in a delivery involving a
- 7 shoulder dystocia, would you agree with that
- 8 statement?
- 9 A. Sure. But, again, that wouldn't be excessive.
- 10 You might have to exert a little bit more, but
- 11 it may be a gradation. And she's telling you,
- 12 when you continue on in your questioning you say,
- 13 you recall it did happen and she tells you
- 14 point-blank it didn't happen.
- 15 Q. I understand, Doctor. Now my questions are

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- 1 really geared more towards you as an expert in
- 2 instructing on how we do these deliveries, not on
- 3 what happened in this case. Okay?
- 4 A. Well, again, you asked me to review a specific
- 5 part of the deposition which, you know, again,
- 6 you need to take in the general context of the
- 7 questions that you're asking. You're asking her
- 8 kind of a hypothetical situation and then trying,
- 9 you know, to apply it to this case and she's
- 10 telling you that, which I think what -- you're
- 11 doing the same thing to me.
- 12 Q. Doctor, let me ask it even more generally, maybe
- 13 that will get us on the same page. I believe if
- 14 I heard your answer correct, you said that there
- 15 are times where a shoulder dystocia is
- 16 encountered and it's not a life threatening
- 17 situation where it would be appropriate to apply
- 18 a little bit more pressure, it's a gradation I
- 19 think you said?
- 20 A. Right. I mean, again, it's not something that we
- 21 measure. But, you know, you may -- you very well
- 22 may fall into the realm of not excessive but a
- 23 little bit more than normal.
- 24 Q. What is your definition of excessive lateral
- 25 traction?

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- 1 A. I don't have a standard definition because there
2 is no standard objective definition of what is
3 excessive.
4 Q. And again, Doctor, all I'm trying to do here is
5 to understand your opinion in this regard. If
6 I'm understanding you, you're telling me that
7 there is an amount of traction that would be
8 normal and then there is -- we know that there is
9 something called -- and a point where you would
10 consider it to be excessive, but you're saying
11 there is a gray area in between there where you
12 can apply a little bit more than normal and that
13 would be appropriate?
14 A. It very well may, yes.
15 Q. Well, that's what I'm asking. I mean, is there a
16 yes, that's your opinion?
17 A. Yes, it is my opinion.
18 Q. So it's okay when encountering a shoulder
19 dystocia to apply a little bit more traction than
20 you normally would?
21 A. In some situations you may have to do that, yes.
22 Q. And again, other than a life threatening
23 situation, Doctor?
24 A. And I'm restating that even in a non-life
25 threatening shoulder dystocia, the provider may

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- 1 exert a little bit more traction than they
2 normally would but it wouldn't be classified as
3 excessive.
4 Q. Doctor, by applying more traction than normal
5 wouldn't that be putting the baby at risk for an
6 Erb's palsy injury?
7 A. Not necessarily because we don't know what the
8 fetal threshold for injury is, meaning each fetus
9 may have their own individual threshold. We
10 actually tried to look at that to see if there
11 is -- we're trying to figure out why kids get
12 injured at the time of shoulder dystocia and we
13 can't figure that out. The majority of kids
14 don't get injured. You would anticipate a much
15 higher injury rate.
16 Q. But, Doctor, haven't studies been done about the
17 amount of --
18 A. I'm sorry, may I also add, the only reason why
19 you're claiming excessive traction is because you
20 have an injury in this case. If there was no
21 injury but yet the traction was still what you
22 define as excessive, then you wouldn't be saying
23 that.
24 Q. Doctor, I appreciate your editorializations but
25 I'm just going to ask you questions here today,

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- 1 okay?
2 Doctor, haven't studies been done
3 with regard to the amount of force that is
4 applied in deliveries by Robert Allen?
5 A. Well, I think when you look at -- I'm sorry. I
6 think he's tried but when look at his specific
7 data, for example, in his study of 29 patients,
8 there were two patients that had the same amount
9 of force and one wasn't injured and one had a
0 transient injury. So how do you draw any kind of
1 causation argument from that?
2 Q. Do you know the amount of force that is needed to
3 induce a temporary brachial plexus stretch
4 injury?
5 A. I don't think anybody knows that because each
6 fetus may have their own individual threshold.
7 There is no number above which where we think
8 that that force is present.
9 Q. Do you recall a letter to the editor that was
10 written by Robert Allen in response to your
11 article with other authors entitled Brachial
12 Plexus Palsy on In Utero Injury?
13 A. I don't specifically recall it, I think it's been
14 a couple of years since he wrote it and I would
15 have obviously written back.

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- 1 Q. You don't recall that specifically, though?
2 A. No. I mean, it's been several years since that
3 article came out, I think three to four years
4 ago, and he wrote the article right after it came
5 out.
6 Q. Mr. Allen indicates in that -- Dr. Allen
7 indicates, I should say, in that letter that the
8 force needed to induce a temporary brachial
9 plexus stretch injury is roughly 22 pounds of
0 traction applied rapidly. Is that something that
1 you disagree with, Doctor?
2 A. I would, yes. Again, I don't think that he from
3 the few patients that he's described can make
4 that giant leap to say that. He hasn't studied a
5 huge number of patients to draw that because my
6 suspicion is, is that, you know, we exert that
7 amount of force, for example, in doing C-sections
8 or forceps or other things and yet those children
9 are uninjured. You know, he's measured in a few
0 cases and now generalizing for the entire
1 population. I don't think that's correct.
2 Q. Doctor, while we're on the subject of causation
3 let me switch gears a little bit here.
4 Would you agree with me, Doctor,
5 that generally speaking the use of excessive

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- 1 lateral traction by an obstetrician in managing
 2 shoulder dystocia is a cause of brachial plexus
 3 injury in a baby?
 4 A. I think that's a fair statement. Again, I don't
 5 think it's the cause. I think it's a possible
 6 cause.
 7 Q. And it certainly -- I know you've testified on
 8 some plaintiff cases, Doctor, in any of those
 9 cases have you provided that opinion, that
 10 excessive lateral traction was used and that's
 11 what caused the brachial plexus injury?
 12 A. I believe I have, yes.
 13 Q. And, Doctor, what are the mechanics of that, how
 14 does that work, how does excessive lateral
 15 traction when applied cause a brachial plexus
 16 injury?
 17 A. Well, usually if there's a stretching out of the
 18 long axis of the fetus, the stretching of a
 19 brachial plexus out of the long axis kind of away
 20 from the other shoulder, if you will.
 21 Q. Doctor, I have read some of your literature and
 22 I'm aware that you believe there are other causes
 23 of brachial plexus injuries other than excessive
 24 lateral traction?
 25 A. Correct.

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- 1 Q. Doctor, would you at least agree with me that
 2 excessive lateral traction is the most common
 3 cause of the brachial plexus injury?
 4 A. No, I would not.
 5 Q. If excessive lateral traction is not the most
 6 common cause, Doctor, in your opinion what is the
 7 most common cause?
 8 A. My opinion the most common cause would be normal
 9 labor delivery itself since we clearly know that,
 10 you know, on average I think it's about 55
 11 percent or so of these injuries are associated
 12 with normal spontaneous delivery.
 13 Q. Doctor, you would agree with me, of course, that
 14 in those studies you would have to account for a
 15 certain percentage of deliveries where there was
 16 a shoulder dystocia that went unrecognized?
 17 A. Sure. I think we acknowledge that, but when you
 18 go back to pull many studies looking at these,
 19 there are studies that rate at as high as 75
 20 percent. So, again, we're not arguing the fact
 21 that you couldn't have some cases under
 22 recognition but those studies all totaled, you
 23 know, some of which are the studies done by
 24 Gilbert was a huge study of about sixteen hundred
 25 cases, I think it's unlikely that that's going to

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- 1 account for much change.
 2 Q. Doctor, can you explain to me how -- well, first
 3 of all, you would agree that in this case a nerve
 4 injury was diagnosed and occurred to Kayla Payne
 5 in this delivery?
 6 A. I'm sorry, what is your question?
 7 Q. Sure. You would agree with me that Kayla Payne
 8 sustained a nerve injury in this delivery?
 9 A. Correct.
 10 Q. Can you explain to me if that injury was not
 11 caused by excessive lateral traction, how can
 12 such a nerve injury occur otherwise?
 13 A. Well, I think specific in this case you had a
 14 compound presentation with the hand coming down,
 15 you know, along side the head. If it's coming
 16 down in such a fashion that it's creating a
 17 stretch, you know, along side the neck and, you
 18 know, if that shoulder is impacted up underneath
 19 the symphysis, that neck is going to be stretched
 20 as a consequence or in association with a
 21 shoulder dystocia.
 22 Q. By virtue of the compound presentation?
 23 A. Well, the compound presentation is what's giving
 24 rise to the shoulder dystocia in this case.
 25 Q. Okay.

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- 1 A. Again, as that arm is coming down, that may be
 2 increasing that angle in between the head and
 3 neck, if you will, thereby stretching the nerve
 4 roots on that side.
 5 Q. Well, Doctor, you're suggesting then that that's
 6 a possibility of what occurred?
 7 A. No, I think it's my opinion of what occurred in
 8 this case.
 9 Q. So if I understand, the compound presentation is
 10 the reason that she sustained this nerve injury?
 11 A. I think in an overall sense, yes. Again, that
 12 compound presentation led to dystocia which, you
 13 know, again, that compound presentation, the way
 14 that arm is, again, most likely was creating an
 15 abnormal angle between the head and neck.
 16 Q. Doctor, in your practice over the years
 17 delivering babies with compound presentations
 18 have you ever seen a compound presentation cause
 19 a brachial plexus injury?
 20 A. I haven't specifically seen it, no. But on the
 21 other hand, I've never seen it in association
 22 with shoulder dystocia in any clinical practice.
 23 I've seen it upon my review of cases, yes. I
 24 haven't seen it thank goodness.
 25 Q. So you've reviewed other cases where you've come

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- 1 to the opinion that a compound Presentation
 2 encountered in conjunction with a shoulder
 3 dystocia resulted in a brachial plexus injury?
 4 A. Right. And I have looked at cases where you had
 5 a compound presentation and that was a case where
 6 there was actually an umbilical cord that was
 7 kind of wrapped around the arm, again,
 8 constricting it as well. Again, they're not
 9 common, but it can cause it.
 10 Q. In this case there was no umbilical cord wrapped
 11 around the arm, right?
 12 A. Not that I was aware of.
 13 Q. Have you ever seen or reviewed cases with the
 14 same or similar set of operative facts as we have
 15 here and where it was your opinion that the
 16 compound presentation caused the brachial plexus
 17 injury?
 18 A. Again, I think, I mean, I have seen other cases.
 19 I have again that opinion in this case.
 20 Q. Doctor—
 21 A. They're not common. It's not the most common
 22 cause of dystocia but it can occur.
 23 Q. You would agree with me, Doctor, that excessive
 24 lateral traction is a more common explanation
 25 than compound presentation as a causal agent of

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- 1 the brachial plexus injury?
 2 A. Are you talking about in this case?
 3 Q. Generally speaking.
 4 A. No.
 5 Q. So let me be clear, Doctor, about my question.
 6 I'm not talking about this case now because I
 7 think you've made clear to me what your opinion
 8 is in terms of what the causative agent was in
 9 this case.
 10 But I asked you before whether
 11 excessive lateral traction is the most common
 12 cause of brachial plexus injuries and you told me
 13 that you do not believe that it is, correct?
 14 A. Correct.
 15 Q. Maybe we should approach that for a second. You
 16 said just the normal forces of delivery is the
 17 most common?
 18 A. Correct. If you look at large studies of
 19 brachial plexus injuries, the majority of these
 20 are just associated with normal spontaneous
 21 deliveries.
 22 Q. Okay. Let's go to the second most common
 23 causative agent of brachial plexus injuries with
 24 a shoulder dystocia. Now you've told me the
 25 normal forces of delivery, what's the second most

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- 1 common?
 2 A. The second most common would be a shoulder
 3 dystocia. Again, that would then be broken down
 4 either to impaction of the anterior shoulder or
 5 impaction of the posterior shoulder.
 6 Q. And, Doctor, I may not have been clear before in
 7 my question. In cases where a shoulder dystocia
 8 is encountered, would you agree with me that
 9 excessive lateral traction is the most common
 0 cause of brachial plexus injuries?
 1 A. No.
 2 Q. What's the most common cause in cases where a
 3 shoulder dystocia is encountered?
 4 A. It's my opinion that the shoulder dystocia
 5 process itself. Again, I think it depends on
 6 which shoulder is injured. Usually it's going to
 7 be the anterior one but, you know, the studies
 8 have shown that the clinician applied forces are
 9 far less than the shoulder dystocia forces.
 0 I guess another way of saying that
 1 is that shoulder dystocia forces, impaction
 2 forces on the neck area are nearly ten-fold
 3 higher than the clinician applied forces in the
 4 shoulder dystocia.
 5 Q. So with impaction forces then being the most

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- 1 common cause of a brachial plexus injury when a
 2 shoulder dystocia is encountered, what would be
 3 the second most common cause?
 4 A. I think you asked me in general what the number
 5 one cause was and I told you normal spontaneous
 6 delivery and then the second most common would be
 7 shoulder dystocia usually of the anterior arm
 8 where you have impaction of it.
 9 Q. Can I clarify? I'm talking about within the
 0 realm of delivery where a shoulder dystocia is
 1 encountered, okay, let's just talk about that.
 2 You've told me that the normal impaction forces
 3 would be the most common cause of injury,
 4 correct?
 5 A. Of the shoulder dystocia related, yes.
 6 Q. That's what I'm asking, yes. Again, staying in
 7 the family of cases where shoulder dystocia is
 8 encountered, what I want to know is what's the
 9 second most common cause?
 0 A. I think it would be impaction usually of the
 1 posterior arm.
 2 Q. Would you mind repeating that answer?
 3 A. I think it would be a stretch or compression of
 4 the posterior arm on sacral promontory.
 5 Q. What would be the third most common cause?

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1 A. I think probably the third most common might be
 2 excessive traction.
 3 Q. Doctor, I'm going back to the general question I
 4 guess, of all cases even those without a shoulder
 5 dystocia, you would agree with me that it is
 6 certainly more common for excessive lateral
 7 traction to cause a brachial plexus injury than
 8 for a compound presentation to cause a brachial
 9 plexus injury?
 10 A. I don't think anybody has ever looked at them
 11 that way. I can't answer that question as you've
 12 asked it.
 13 Q. Well, you've told me before you agreed I think
 14 that for a compound presentation to cause a
 15 brachial plexus injury, that's a relatively rare
 16 situation?
 17 A. Well, no, it's not the compound presentation
 18 that's causing the brachial plexus. I mean,
 19 maybe I can answer your question. It's the
 20 compound presentation that's giving rise to the
 21 shoulder dystocia. It's the shoulder dystocia
 22 that's then injuring the arm. So it's
 23 indirectly, the compound presentation gives rise
 24 to the dystocia which is much more common than
 25 excessive lateral traction.

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1 Q. Again, you're saying then that injuries with a
 2 compound presentation and a shoulder dystocia are
 3 more common than injuries just caused by
 4 excessive lateral traction by the delivering
 5 person?
 6 A. What I'm saying is that the injuries that are
 7 caused by dystocia are more common than injuries
 8 caused by excessive traction.
 9 Q. Doctor, all I'm trying to get at is this: You
 10 would agree that injuries caused by excessive
 11 traction are certainly more common than injuries
 12 caused by a compound presentation with shoulder
 13 dystocia presentation?
 14 MR. AUCIELLO: Objection, I think
 15 he's answered that already.
 16 A. Yeah, I think you asked it. No. I think that
 17 injuries caused by dystocia are far greater than
 18 the injuries caused by traction. Now it's the
 19 compound presentation that's causing the shoulder
 20 dystocia in this case.
 21 Q. But the question I have, Doctor, is not about
 22 just the dystocia. I'm talking about the
 23 compound presentation.
 24 MR. AUCIELLO: He said the compound
 25 presentation isn't the causative factor.

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1 Q. But, Doctor, am I correct that your opinion in
 2 this case with respect to this delivery is that
 3 but for the compound presentation, this injury
 4 would not have occurred?
 5 A. No. I think in this case even without a compound
 6 presentation, even if you had a shoulder dystocia
 7 without a compound presentation, you still could
 8 have had an injury. But it's the compound
 9 presentation that's giving rise to the shoulder
 10 dystocia which then gives rise to the injury.
 11 Q. The court reporter has to change paper.
 12 A. Can I take a restroom break?
 13 Q. Of course.
 14 - - - -
 15 (Thereupon, a recess was had.)
 16 - - - -
 17 Q. Doctor, moving on, would you agree with me that
 18 having you assume that if Ms. Watson did apply
 19 excessive lateral traction in this delivery that
 20 to a reasonable degree of medical probability
 21 that would be the cause of Kayla's injury?
 22 A. Not necessarily, no, because again most probably
 23 it would have been injured by the shoulder
 24 dystocia.
 25 Q. So just so I'm clear, your opinion in this case

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1 is that even if Ms. Watson did apply what you
 2 would characterize and define as excessive
 3 lateral traction, that your opinion to a
 4 reasonable degree of medical probability is that
 5 that excessive lateral traction was not the cause
 6 of Kayla's injury?
 7 A. Correct. I think you had asked what I believe
 8 was the most common causes and I listed them and
 9 the lateral traction was down along the lines of,
 10 you know, causation. Again, I think in this case
 11 that arm most likely would already have been
 12 injured anyway because of the shoulder dystocia
 13 being present.
 14 Q. Doctor, I'd like you to assume for this question
 15 the testimony of Videllia Giles that you read and
 16 that I recounted to you a little bit before.
 17 Would you agree with me, Doctor, to a reasonable
 18 degree of medical probability that if Ms. Giles'
 19 testimony is true, that Ms. Watson would have
 20 been in that instance the cause of Kayla's
 21 injuries?
 22 A. I'm not certain I quite understand your question.
 23 Q. Sure. Let me repeat it.
 24 A. Well, I mean, I don't think that Videllia Giles
 25 is commenting on the fact that a shoulder

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1 dystocia is present or not.

2 Q. Well, I understand that, Doctor, and
3 unfortunately I guess you don't have her
4 deposition, the appropriate page but having
5 you --

6 MR. AUCIELLO: Nowhere in the
7 deposition did she say there was a shoulder
8 dystocia.

9 MR. MESTER: Well, I think that's
10 obviously beyond her realm of expertise,
11 Ernie.

12 MR. AUCIELLO: Right.
13 Q. But, Doctor, let's have you assume the same
14 hypothetical I gave you earlier, that Ms. Giles
15 testified on page 30 of her deposition that the
16 midwife told her to stop pushing, that
17 immediately after that the midwife reached in and
18 grabbed the baby by the neck and arm and pulled
19 and then after that at that point the nurse only
20 then did McRoberts', cut an episiotomy and was
21 able to conclude the delivery.

22 If we assume those set of facts,
23 Doctor, would you agree with me that to a
24 reasonable degree of medical probability
25 Ms. Watson's actions in that aspect would have

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1 been the cause of Kayla's injury?

2 A. No. I think in this case you had a shoulder
3 dystocia. What you're reading to me doesn't even
4 define a shoulder dystocia and it's my
5 interpretation as well as the interpretation of
6 nurse midwife Watson that there was a dystocia.
7 So I think you're just going in a roundabout way
8 of it. So, no, I wouldn't agree with that.

9 Q. And, Doctor, I'm going to read a portion of
10 Dr. Lavin's testimony to you because I know you
11 don't have the deposition. My question to
12 Dr. Lavin was: Doctor, having you assume that
13 Ms. Giles' testimony is accurate, would you agree
14 with me that that would be a deviation from the
15 standard of care? Answer: If it was accurate,
16 yes. Question: Doctor, if that testimony is
17 accurate, would you agree with me that that would
18 be the cause of Kayla Payne's brachial plexus
19 injury? Answer: Probably, yes.

20 My question is, Doctor, if what I'm
21 reading of Dr. Lavin's deposition is correct, in
22 other words, if I'm reading it correctly, am I to
23 assume you disagree with Dr. Lavin in that
24 respect also?

25 A. Well, I think if you asked him the same exact

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1 questions you asked me, and I don't know that you
2 did, I don't know what you asked him or what you
3 read to him because I don't have his deposition.

4 Q. Having you assume that what I just read you is an
5 accurate reading of his deposition.

6 A. And, again, you're reading to me something out of
7 his deposition. I don't know what you're asking
8 him in the context in which you're asking him. I
9 can't really comment on that.

10 Q. You can't comment on it based on the way I read
11 it to you, Doctor?

12 A. Well, again, you're reading me one little line
13 out of there. I don't know if you read to him
14 the exact words that you read to me in the exact
15 context in which you read it to me. It's more of
16 just simply reading those lines.

17 MR. AUCIELLO: It's also a matter of
18 interpreting Videllia Giles' testimony which
19 is hardly --

20 Q. Well, Doctor, let me ask you this. Is there
21 any -- you've read Ms. Giles' testimony. Again,
22 just based on your recollections of what you read
23 from Ms. Giles' testimony, if what she says is
24 true to a reasonable degree of medical
25 probability, is that the cause of Kayla's injury?

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1 A. I think you've asked that and I think I've
2 answered it. The answer is no because it's my
3 interpretation that the injury occurred with the
4 shoulder dystocia and would have been present
5 irregardless.

6 Q. And if Dr. Lavin opines otherwise, that based on
7 his reading of Ms. Giles' deposition, that it's
8 his opinion that that would have been the cause
9 of Kayla's injuries, again if Ms. Giles'
10 deposition is taken as true, you would disagree
11 with him in that regard, correct?

12 A. Again I think I would have to know what he
13 specifically said before I agreed or disagreed.

14 Q. All I'm asking you, Doctor, is based on a reading
15 of Videllia Giles' deposition.

16 A. But again, you're asking about specifics of what
17 occurred when.

18 Q. I'm really not. I read you Dr. Lavin's
19 deposition where I asked him, having you assume
20 that Ms. Giles' testimony is accurate, and he
21 said based on that, that that would have been in
22 all probability the cause of Kayla Payne's
23 injury. I just want to confirm what I think is
24 obvious, Doctor. You disagree with that, right?

25 A. If you ask me specifically on page 30, the

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1 lines.

2 Q. Here's what I asked him before that question,

3 Doctor. Did you read in her, meaning Ms. Giles'

4 testimony, where she indicated that upon delivery

5 nurse midwife Watson grabbed the baby's head and

6 neck and pulled?

7 A. Okay.

8 Q. And based upon that excerpt he went on to say

9 that, yeah, he believed that that would have

10 probably been the cause of injury?

11 A. Well, I think you asked that in a general fashion

12 and I would agree with that too in a sense. But

13 you're asking about the specifics of this case

14 and when she pulled or didn't pull and so in a

15 sense I agree and in a sense I disagree.

16 Q. Can you explain further, in what sense do you

17 agree?

18 A. Well, I mean, you're asking him simply if she had

19 done no maneuvers and she had just pulled, would

20 that have been a deviation of standard of care

21 and think that's what Dr. Lavin's getting at, but

22 you can ask him specifically. I would agree with

23 that. Again, not doing any maneuvers and just

24 pulling is a deviation.

25 Now reading what you have read to me

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1 and looking at causation, it's my opinion that

2 that injury would have occurred irrespective and

3 I don't think you asked that to Dr. Lavin. So I

4 can't agree one way or the other with what he

5 said. You're reading something to me that's just

6 out of context.

7 Q. Let's assume --

8 A. You're not reading to me the same information

9 that you're reading to Dr. Lavin. You're not

10 asking us the same questions. So I'm not going

11 to get into a conflicting discussion with him.

12 Q. Doctor, I've read it to you word for word, other

13 than the fact that you haven't seen it, there's

14 nothing more I can do.

15 MR. AUCIELLO: Jonathan, I think

16 you've made your point. I think we can --

17 MR. MESTER: Well, let me just

18 finish it and I'll move on.

19 Q. Doctor, if what you said is true, if let's just

20 take as a general proposition, if upon

21 encountering this shoulder dystocia Ms. Watson

22 reached in and pulled and didn't do any other

23 maneuvers, you believe that if that happened in

24 this case, that that still would not be the cause

25 of this injury, correct?

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1 A. Correct.

2 Q. If Dr. Lavin believes otherwise, you would

3 disagree with him?

4 A. I think in a general sense, yes.

5 Q. Okay. I'll move on.

6 Doctor, did you see anywhere in the

7 medical record where Ms. Watson documented the

8 amount of traction that she applied in this

9 delivery?

10 A. No, that's not something that you would normally

11 document.

12 Q. Is that something that in the course of your

13 teaching medical students and so forth you would

14 recommend be done?

15 A. Not necessarily. I mean, I think ideally you

16 would like to have it done but it's not going to

17 be routinely done. I think you would like to

18 have it done but there's no standard of care that

19 says it has to be done or it does not have to be

20 done.

21 Q. Let me repeat my question, Doctor.

22 Do you recommend that the delivering

23 person document the amount of traction done in a

24 delivery?

25 A. I think, yeah, you'd like to recommend it. But

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1 there is no standard that it has to be done.

2 Yeah, I mean, I'd like to see it done. I'd like

3 to see a lot of other things documented but

4 they're not always documented.

5 Q. And why is it that you'd like that to be

6 documented, Doctor?

7 A. Well, I think, you know, again, if excessive

8 traction was used, that would be a deviation of

9 standard care and, again, I think I would like to

10 see it. Clearly this is a litigious area. If

11 I'm being asked to review it and I see that, then

12 I might say it's a deviation of standard of care.

13 You know, again, there's plenty of

14 things that I would like to see, for example,

15 presentation of the head, how long the shoulder

16 dystocia was, you know, the sequence in type of

17 maneuvers, but those aren't -- not everything is

18 always there. Most of it is, but not all of it.

19 Q. So, Doctor, you would agree that medical records

20 particularly with respect to documenting shoulder

21 dystocia deliveries often fail to record what

22 occurred?

23 A. No. I think the standard of care, you know,

24 that's just a minimum and that's to document

25 dystocia or the maneuvers that were done.

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- 1 Q. Doctor, I--
- 2 A. There's no standard of care that says that you
- 3 have to diagnose the other things that you would
- 4 like see, **for** example, who was in the room, how
- 5 long the dystocia lasted, you know, what the
- 6 traction that you used **was**. There's no standard
- 7 of care that says you have to document that.
- 8 Q. Doctor, I'm not asking you a standard of care
- 9 question right now. All I'm asking is would you
- 10 agree that as a general proposition the medical
- 11 records in shoulder dystocia cases often failed
- 12 to record everything that occurred in the
- 13 delivery room?
- 14 A. No, I would not agree with that.
- 15 Q. Doctor, would you agree with me that, again as a
- 16 general proposition, the delivering personnel
- 17 will sometimes minimize their actions in terms of
- 18 the way they report it on the medical record?
- 19 A. I haven't seen that, no. I wouldn't agree with
- 20 that general statement.
- 21 Q. All right. Doctor, let's talk a little bit more
- 22 specifically about compound presentations.
- 23 Doctor, you've read in this case that Ms. Watson
- 24 artificially ruptured the membranes?
- 25 A. Correct.

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- 1 Q. That was done I believe at plus one station?
- 2 A. Correct.
- 3 Q. Just so I understand, what is plus one station?
- 4 A. Will be approximately one centimeter past the
- 5 ischial spine.
- 6 Q. And, Doctor, when the delivering person ruptures
- 7 the membranes at plus one station as Ms. Watson
- 8 did in this case, if there is a compound
- 9 presentation at that point in time, is that
- 10 something the delivering person would be able to
- 11 know when rupturing the membranes at plus one
- 12 station?
- 13 A. If it was present, yes. But, again, it may occur
- 14 after that.
- 15 Q. All right. But there are times where certainly
- 16 you would acknowledge that during that process
- 17 the delivering person would be able to recognize
- 18 the compound presentation at that point?
- 19 A. Well, I think it depends on where it occurs. I
- 20 mean, compound presentation where you scoop the
- 21 hand up by the head and if you're feeling the top
- 22 of the head, you may not feel that but it still
- 23 could be compound by definition.
- 24 Q. But sometimes -- I'm sorry.
- 25 A. It could still be there and they might not be

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- 1 able to diagnose it.
- 2 Q. Doctor, there are compound presentation
- 3 deliveries where the hand is on top of the head?
- 4 A. Correct.
- 5 Q. In those circumstances where there is an
- 6 artificial rupture of the membranes at plus one
- 7 station, would the delivering person potentially
- 8 be able to diagnose the compound presentation at
- 9 that point?
- 0 A. Potentially they could.
- 1 Q. Okay. Doctor, could you turn in Ms. Watson's
- 2 deposition to page 61, please?
- 3 A. Yes.
- 4 Q. Are you there?
- 5 A. Yes.
- 6 Q. And **look** at lines 4 through 7.
- 7 A. Okay.
- 8 Q. Do you agree with Ms. Watson the answer to my
- 9 question in that respect?
- 0 A. I do. I agree with her answer.
- 1 Q. How so?
- 2 A. Well, again, I don't think it was present. It
- 3 very well -- well, she didn't diagnose it and she
- 4 wouldn't have been able to notice it if it was
- 5 just along side the cheek or up against the ear

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- 1 or, you know, a little bit higher up, you
- 2 wouldn't have been able to diagnose it.
- 3 When you asked her on page 62, lines
- 4 21 to 24, and she says it's either, you know, you
- 5 ask her if you recall it being next to the head,
- 6 she says, I recall it either being next to the
- 7 head or folded up like against the shoulder.
- 8 There was no way she could have diagnosed it at
- 9 plus one stage given that clinical situation.
- 0 Q. Doctor, as a general proposition, however, if
- 1 Ms. Watson's statement on page 61, line 6, of oh,
- 2 no, of course not, the baby is still inside then,
- 3 if that is to be interpreted as her indication
- 4 that you cannot recognize a compound presentation
- 5 at plus one station, you would disagree with her
- 6 there I assume?
- 7 A. Again, I don't know what she means by the baby is
- 8 still inside there. You're reading into it. I
- 9 mean, she says -- I mean this is yes, no -- what
- 0 you asked her was a yes, no question, you said,
- 1 do you know if you noticed it, she says, no, of
- 2 course not.
- 3 Q. The baby is still inside then?
- 4 A. Again, I don't know, you would have to ask her
- 5 what she means by that.

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- 1 Q. Okay. Doctor, did you read in Ms. Giles'
2 deposition where she indicated that after
3 traction was applied the baby's arm flopped
4 against her leg?
5 A. What page are you referring to?
6 Q. Unfortunately I think that was on page 30.
7 A. I mean, I would have read it. I would have read
8 it over the weekend, yes.
9 Q. Do you recall that being part of her testimony?
10 A. I don't specifically recall it.
11 Q. Is that something that you've encountered in your
12 practice, that scenario that I've described?
13 A. I'm sorry, can you reask that again just so that
14 I'm clear?
15 Q. Sure. Again, having you assume, and I really
16 don't want to get into reading into her depo
17 again, that Ms. Giles' testimony was that after
18 traction was applied and before the McRoberts'
19 maneuver was employed, the baby's arm flopped
20 against her leg, is that something you've
21 encountered in delivery?
22 A. With a compound presentation that's described
23 there, yes. Again, that compound presentation,
24 as the head is coming out, that compound
25 presentation is going to be released.

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- 1 Q. Would that be consistent also with the delivering
2 person pulling on that arm?
3 A. I don't think so, no. I think it would be quite
4 unusual to pull on the arm, just pull the arm
5 out.
6 Q. So that would not be consistent with the
7 delivering person pulling on the arm?
8 A. No.
9 Q. So if Dr. Lavin also indicated in his deposition
10 that in a compound presentation if the delivering
11 person were to pull on the arm, that would cause
12 the arm to come out, you would disagree with him
13 in that regard as well?
14 A. No. That's not what I'm saying.
15 Q. Well, what are you saying?
16 A. Well, I think if the provider was just going to
17 pull on the arm, it could come out. But it's my
18 interpretation that that's not what happened
19 here.
20 Q. I apologize if you misunderstood. That was all I
21 was asking. It would be consistent generally
22 speaking if the delivering person pulled on the
23 arm in a compound presentation, it would come out
24 and hit her in the leg, right?
25 A. No, not necessarily. It's a possibility. It's

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- 1 also a possibility that, you know, the provider
2 did the maneuver, they relieved the dystocia and
3 as the dystocia was being released, that arm came
4 out, that's another possibility.
5 Q. I understand there are all kinds of
6 possibilities, Doctor. I just want to make sure
7 that we're on the same page. That would be
8 consistent, that would be one possible
9 possibility, correct?
10 A. It would be a possibility.
11 Q. All right.
12 A. That's not my interpretation of what happened
13 here.
14 Q. I understand that. How else would the baby's arm
15 come out and strike the mom's leg other than if
16 the delivering person had pulled on it?
17 A. Well, as the shoulder dystocia is being
18 alleviated, as the McRoberts' maneuver is being
19 done, it converts the shoulder to an oblique
20 diameter, the shoulder is free, the head is able
21 to come out and the arm is next to it and it just
22 comes out.
23 Q. You're talking about after the shoulder dystocia
24 is relieved?
25 A. Correct.

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- 1 Q. What about prior the time the shoulder dystocia
2 is relieved?
3 A. Again, I don't think that it could have come out
4 on its own. It's causing the dystocia, it's
5 what's obstructing. I think it would be highly
6 unlikely it would come out by the provider just
7 pulling on it.
8 Q. Doctor, switching gears, would you agree with me
9 that the diagnosis and need for additional
10 maneuvers in the realm of a shoulder dystocia
11 case is directly affected by the experience of a
12 delivering person?
13 A. Not necessarily. I mean, I think in a general
14 sense that's fair but, you know, if the provider
15 has been in shoulder dystocia and they've been
16 trained to do that, no.
17 Q. Let me read it again. I'd like an answer of
18 whether it's accurate or not if you can give it
19 to me, but I understand you may not have caught
20 it all.
21 Would you agree with the statement
22 that the diagnosis and need for additional
23 maneuvers is directly affected by the experience
24 of the delivering person?
25 A. I think in a general sense. I don't know if I

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1 would necessarily agree with that.
 2 Q. So you would not agree with that?
 3 A. No, not in the context in which you've said it.
 4 Q. Okay. Doctor, in this case Ms. Watson testified
 5 in her deposition that she encountered 10 prior
 6 shoulder dystocias before this one, do you
 7 remember that?
 8 A. I don't specifically recall that. I mean, it's
 9 been awhile since I looked at it. I remember
 10 recollecting that she had been in the situation
 11 before and having encountered that.
 12 Q. Maybe I can find the page for you quickly. Look
 13 at page 40, Doctor.
 14 A. Okay.
 15 Q. The question on line 20.
 16 A. Well, she said at least 10.
 17 Q. Okay.
 18 A. She said maybe more.
 19 Q. All right. Would you agree with me, Doctor, that
 20 given that number that Ms. Watson would be less
 21 capable of making a diagnosis and handling
 22 additional maneuvers than one who is more
 23 experienced in doing those deliveries?
 24 A. No. Again, I think that, you know, 10 is a
 25 reasonable number. I don't think you ever asked

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1 her what maneuvers that she did. I mean, the
 2 first one she may have ever encountered may have
 3 been the worst one in her life.
 4 She may have done other maneuvers.
 5 Again, it's part of her training, you know, in
 6 handling shoulder dystocia. You even asked her
 7 on page 41, is she trained in it, yes.
 8 Q. Moving on. Would you agree that shoulder
 9 dystocias attended by a midwife are at three to
 10 four-fold increased risk of neonatal brachial
 11 plexus injury?
 12 A. Again, it sounds like something I wrote and came
 13 from an article. I don't know that I would
 14 necessarily agree with that as a general blanket
 15 statement.
 16 Q. You don't agree with the stuff that's in your
 17 articles?
 18 A. Again, I took that from another article, you
 19 know, that is 20 years old. I don't think I
 20 would necessarily agree with that. I would have
 21 to go back and look at the specifics of how they
 22 got that information.
 23 Q. Well, Doctor, I'm taking this, as I believe
 24 you're aware, from your article entitled Brachial
 25 Plexus Palsy on In Utero Injury and the sentence

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1 that you've written is, and it's under the -- I
 2 take it you don't have that article with you?
 3 A. No.
 4 Q. It's under the section heading of risk factors
 5 and your sentence is, although there has been no
 6 correlation with the physician's level of
 7 obstetric experience, shoulder dystocias attended
 8 by either a midwife, nurse, corpsman or osteopath
 9 are at three to four-fold increased risk of
 10 neonatal brachial plexus injury?
 11 A. And, again, I would agree with that statement as
 12 I wrote it. But, again, I don't think you can
 13 correlate from there to the general midwife or
 14 general osteopath population, you can't do that.
 15 I quoted a specific study and they may have
 16 looked at it in that fashion.
 17 Q. Do you disagree with that study?
 18 A. I have to go back and look at it, parts of it. I
 19 could do that between now and Friday and tell you
 20 whether I agree with it or disagree with it.
 21 MR. AUCIELLO: I don't think he
 22 wants you to do that.
 23 Q. Well, I mean, obviously you'll have that
 24 opportunity.
 25 Doctor, do you know whether

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1 residents or doctors were available to perform
 2 deliveries at Mount Sinai in June of 1999?
 3 A. I don't specifically know that.
 4 Q. Would you agree with me, Doctor, that there is at
 5 least some increased risk of neonatal brachial
 6 plexus injury when a non-physician is conducting
 7 the delivery?
 8 A. No. Again, I think as a general blanket
 9 statement, no, I don't think that they are
 10 necessarily because again, if we go back and look
 11 at that specific article, whether they're
 12 specifically comparing midwives to the general
 13 population, again, I think there is other
 14 information out there that state irregardless of
 15 the level of experience period. And, again, this
 16 is a provider who is experienced in handling
 17 dystocia. She's not really at an increased
 18 risk. That same injury could have occurred if a
 19 resident had been there or if a staff physician
 20 had been there.
 21 Q. I know, but my only question, Doctor, and I think
 22 you've answered it, though, is as a general
 23 proposition is there an increased risk with
 24 having a non-physician handle a delivery in a
 25 hospital setting?

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- 1 A. Again, I think, you know, yeah, I may have wrote
2 it but I'm not certain I quite agree with that as
3 a general blanket statement.
4 Q. So, again, I'm just trying to understand, now
5 that you've revised-- revisiting the issue you
6 may not agree with what you wrote in 1999?
7 A. Yeah, I think in a general sense, I mean, as a
8 general statement saying that by having the
9 patient delivered by a midwife is she at an
10 increased risk, not necessarily, no.
11 Q. Doctor, are there any other opinions that you'll
12 be providing in your testimony, in your trial
13 testimony on Friday that aren't contained in your
14 report or that we have not discussed tonight?
15 A. I don't believe so. I mean, I don't believe
16 you've asked me today about the antepartum care,
17 but I believe that I had addressed in my report
18 that the prenatal care was within the standard of
19 care.
20 Q. The prenatal care that was done at Metro
21 Hospital?
22 A. Correct.
23 Q. Metro Hospital is not a defendant in this case,
24 Doctor.
25 A. I'm sorry?

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- 1 Q. Metro is not a defendant in this case.
2 Doctor, you don't have any opinions
3 I take it regarding the permanency of Kayla's
4 injury?
5 A. No.
6 Q. And you don't have any opinions regarding
7 whether, you know, physical therapy had it been
8 done on a more extensive basis would have changed
9 her ultimate outcome?
10 A. No, I do not have an opinion about that.
11 MR. AUCIELLO: Jonathan, I'm not
12 going to ask him questions relating to that,
13 I'll stipulate to that.
14 MR. MESTER: All right. And, of
15 course, that would apply to future surgeries
16 and so forth?
17 MR. AUCIELLO: All of that. He's a
18 standard of care liability expert, not a
19 damage expert.
20 MR. MESTER: I understand.
21 Q. Doctor, have you had an opportunity to review
22 notes that were taken by Dr. Lavin in his reading
23 of the materials in this case?
24 A. No, I have not.
25 Q. I'd like to read you a note that Dr. Lavin took

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- 1 concerning his reading of the deposition of Ronna
2 Watson, okay?
3 A. Okay.
4 Q. And it's not long so it will just take a moment.
5 Dr. Lavin in his reading of Ms. Watson's
6 deposition wrote, and I'm quoting, I get the
7 impression she wasn't sure initially what was
8 happening, end quote. I guess my question,
9 Doctor, is: Do you agree with that statement?
10 MR. AUCIELLO: Objection.
11 A. Again, I'm not going to comment on what
12 Dr. Lavin thinks. Again, my reading of her
13 deposition and my review of the records, it's my
14 interpretation that she had handled it with a
15 well recognized maneuver and that she identified
16 dystocia and she knew what she was doing.
17 Q. So, Doctor, I take it that it's not your
18 impression that she wasn't sure initially what
19 was happening?
20 A. Well, again, I think that -- I mean, in a general
21 sense she may not have known. I mean, she may
22 not have known there was a compound presentation
23 until later. I don't know what he specifically
24 meant by that, you have to ask him.
25 Q. I know and that's absolutely true. But what I'm

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- 1 asking you now is: Do you have the impression
2 that Ms. Watson wasn't sure initially what was
3 happening?
4 A. I didn't get that exact impression, no.
5 Q. Did you have any impression at all that there
6 was, you know, ever a period after the dystocia
7 and compound presentation presented that she
8 didn't know what was happening?
9 A. No. It's my interpretation that she went to a
10 recognized maneuver, did the maneuver, dystocia
11 was alleviated.
12 Q. So if Dr. Lavin holds that opinion, you would
13 disagree with him in that regard?
14 A. Again, that's his opinion. Yeah, I think that
15 the facts in this case are that she used the
16 McRoberts' and the episiotomy that alleviated the
17 dystocia. If it was a compound presentation, she
18 may not have known that there was a compound
19 presentation and maybe that's what he meant by
20 that.
21 And, again, she very well may not
22 have known that there was a compound presentation
23 and may not have been aware that that was present
24 and so may not have known in that sense there was
25 a compound presentation. But as far as her

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1 management of this acute obstetric event I feel
 2 that she handled it in an appropriate and timely
 3 fashion.
 4 Q. Doctor, I know you told me that you had an
 5 opportunity to read Dr. Ravitz' deposition.
 6 A. No, actually what I said was I briefly skimmed
 7 it. I did not review it in its entirety.
 8 Q. All right. Fine. He indicated in his deposition
 9 that everything else being equal, I think he said
 10 you have seven to nine minutes while a baby will
 11 be well oxygenated and not have any risk of brain
 12 damage once the dystocia is encountered. Roes
 13 that sound correct to you?
 14 A. Well, yes and no. I mean, there are studies that
 15 have looked at that and the median time is about
 16 seven minutes. On the other hand there is other
 17 information out there that suggests that when
 18 they looked at cases of death associated with
 19 dystocia and the median time was about five
 20 minutes. So I think it depends on what the baby
 21 is like going into dystocia. You know, the time
 22 frame is probably about four to five minutes I
 23 would suspect, somewhere in there.
 24 Q. Doctor, would you agree with the statement that a
 25 normal term fetus can endure up to 10 minutes of

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1 asphyxia before permanent neurologic injury
 2 occurs?
 3 A. I think that they could, yes.
 4 Q. And in this case-- I'm sorry, I didn't mean to
 5 interrupt.
 6 A. I think, yes, it sounds like something I wrote
 7 but when you look at other studies that have come
 8 out like within the last one to two years that
 9 suggest that maybe that's not --that that time
 10 frame is a little bit different.
 11 Q. And, again, this is something that you wrote in a
 12 paper called Shoulder Dystocia from 1998 that you
 13 wrote with Dr. Goodwin. Just so I understand,
 14 are you now saying that four years later your
 15 opinion with regard to that passage I read is now
 16 different?
 17 A. Absolutely. I mean, it's just like the thing you
 18 read from Precis. We get new information all the
 19 time that looks at this and I would refer you,
 20 for example, I wrote something in Clinic Obstet
 21 GYN, it was published in June of 2002 that looked
 22 at the -- that addressed that question. So,
 23 again, these are things that we're always
 24 constantly evaluating.
 25 Now if you want to read something

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1 from 10 years ago, that's fine. If you want to
 2 read an article from 20 years ago. We're always
 3 reevaluating these things as new information
 4 comes out.
 5 Q. And your statement that a normal term fetus can
 6 endure up to 10 minutes of asphyxia before
 7 permanent neurologic injury occurs is something
 8 you revisited?
 9 A. Absolutely, yes.
 10 Q. And you no longer feel that that's true?
 11 A. Absolutely, yes.
 12 Q. Okay. Doctor, in this case I think Ms. Watson
 13 indicated that from the time that dystocia was
 14 first encountered it was less than a minute?
 15 A. I believe I remember reading that.
 16 Q. So you would agree with me that regardless of
 17 whether you're using four to five minutes or 10
 18 minutes, she had at least a period of two to
 19 three minutes still before there was going to be
 20 any possible asphyxia for this baby, correct?
 21 A. I think that's a fair statement.
 22 Q. Okay. Doctor, I'd like to refer you to the last
 23 paragraph in your report.
 24 A. Okay. I'm sorry, I need to pull the report.
 25 Q. Sure.

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1 A. Okay.
 2 Q. It's the paragraph that begins with research has
 3 shown, the last sentence.
 4 A. Okay.
 5 Q. Doctor, what research are you alluding to there?
 6 A. I mean, one of the better studies was done. It's
 7 a recent article that came out in the American
 8 Journal I think in 2000 or 2001. There's also
 9 articles by Sam Meyer in the Green Journal as
 10 well as also an article called Birth that have
 11 addressed those things.
 12 Q. Doctor, did you read Dr. Adler's report in this
 13 case?
 14 A. I would have, yes.
 15 Q. Did you see where he diagnosed a shoulder
 16 separation?
 17 A. I believe I did see that, yes.
 18 Q. Does that diagnosis influence your opinions in
 19 any way in this case in terms of the opinions
 20 you're presenting?
 21 A. Not specifically, no.
 22 Q. All right. Doctor, have you ever spoken to Ronna
 23 Watson about this case?
 24 A. I don't know who Ronna Watson is.
 25 Q. But you know she was the delivery person?

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- 1 A. Correct, but I've never spoken to her. I don't
2 believe I've ever met her. I mean, I meet a lot
3 of people giving lectures but I don't
4 specifically recall her.
- 5 Q. Doctor, I think I'm pretty much done here but I
6 want to be sure I understand one thing. Your
7 opinion regarding the cause of Kayla's injuries
8 in this case I think we've discussed it at length
9 here, is that it was due to the natural delivery
10 process coupled with the compound presentation?
- 11 A. No, I believe it was due to the shoulder dystocia
12 and the shoulder dystocia was due to the compound
13 presentation.
- 14 Q. All right. What other possible causes of Kayla's
15 injury are there in this case?
- 16 A. Actually in this case I think that's the cause.
- 17 Q. Are there any other possible causes, Doctor?
- 18 A. Well, sure. I mean, every time I review a case
19 I would go, you know, along the lines of
20 differential diagnosis of all the potential
21 causes that we've talked about.
- 22 Q. And in this case as part of your differential
23 diagnosis, what other potential causes were you
24 looking at?
- 25 A. Well, I looked to see whether there was an

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- 1 intrauterine cause, I mean, you know,
2 long-standing causes, septums, fibroids, viral
3 causes, you know, could potentially, as you've
4 mentioned, excessive traction may cause, yes.
5 There are many causes of brachial plexus injury.
6 Again, I don't -- and again, I go for each one of
7 those and kind of check it off mentally and
8 that's how I arrive at the conclusions that I do.
- 9 Q. Doctor, I'm not going to have you repeat that
10 answer. The court reporter didn't get the whole
11 thing, but suffice it to say you'll get a chance
12 to read this and you can make any corrections.
- 13 Well, maybe, though, just to be safe
14 here I think where the court reporter lost you
15 was after you mentioned excessive traction as a
16 potential cause. What were the other potential
17 causes? If you could repeat it slowly.
- 18 A. An intrauterine abnormality, myomas, septums,
19 fibroids, viral cases, those could be other
20 potential causes, impaction on the sacral
21 promontory.
- 22 Q. And out of those other potential causes, Doctor,
23 in a scheme of things where would excessive
24 traction rank in your view in terms of likelihood
25 as opposed to the others?

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- 1 MR. AUCIELLO: In this case he
2 already testified that it was -- he has an
3 opinion. You're now asking him to rank it?
- 4 MR. MESTER: Right.
- 5 MR. AUCIELLO: In this case or in
6 general?
- 7 MR. MESTER: In this case.
- 8 A. Again, I think it's unlikely. I saw no objective
9 evidence of excessive traction being applied in
10 this case and that she handled this -- I think
11 you specifically even asked her that. She said,
12 I didn't do it.
- 13 Q. I understand, Doctor.
- 14 With respect to the other potential
15 causes that you listed, however, the intrauterine
16 problems, et cetera, where does the excessive
17 lateral traction rank in that list as a
18 possibility?
- 19 A. I think it ranks right along with all of them. I
20 give them equal weight and I try and -- I mean,
21 one of the things I do when I look at these
22 cases, I try and, you know, attempt to the best
23 of my abilities to see what a cause is. In, you
24 know, doing this I don't put weight one over the
25 other.

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- 1 Q. Okay. Doctor, I think this is my last question.
2 What is your charge for the deposition testimony
3 here today?
- 4 A. Three fifty an hour.
- 5 Q. Okay. And is that the same charge that you have
6 for trial testimony or is that different?
- 7 A. That will be different.
- 8 Q. What's your charge for trial testimony?
- 9 A. Three thousand dollars.
- 10 Q. And is that confined to where you actually make a
11 live appearance at trial?
- 12 A. No.
- 13 Q. So on Friday for your trial testimony, is that a
14 three thousand dollar charge?
- 15 A. Yes.
- 16 Q. And what is your charge for chart review and
17 deposition review and so forth?
- 18 A. Three hundred an hour.
- 19 Q. And have those rates increased at all within the
20 last five years since you've been doing this?
- 21 A. I don't think so. I think maybe the first year I
22 was charging two fifty an hour for medical and
23 chart review and I increased it to three hundred
24 I think roughly the first year but since then
25 it's been stable.

105

1 Q. Okay. Doctor, I believe that is all I have.
 2 Thank you.
 3 MR. AUCIELLO: Okay. He'll read
 4 it.

6 ROBERT GHERMAN, M.D.

106

1 CERTIFICATE

2 The State of Ohio) SS:
 3 County of Cuyahoga.)

5 I, Susan L. Weiss, a Notary Public within
 6 and for the State of Ohio, authorized to
 7 administer oaths and to take and certify
 8 depositions, do hereby certify that the
 9 above-named ROBERT GHERMAN, M.D., was by me,
 10 before the giving of his deposition, first duly
 11 sworn to testify the truth, the whole truth, and
 12 nothing but the truth; that the deposition as
 13 above-set forth was reduced to writing by me by
 14 means of stenotypy, and was later transcribed
 15 into typewriting under dictation; that this is
 16 a true record of the testimony given by the
 17 witness, and was subscribed by said witness in my
 18 presence; that said deposition was taken at the
 19 aforementioned time, date and place, pursuant to
 20 notice or stipulations of counsel; that I am not
 21 a relative or employee or attorney of any of the
 22 parties, or a relative or employee of such
 23 attorney or financially interested in this
 24 action. I am not, nor is the court reporting firm
 25 with which I am affiliated, under a contract as
 defined in Civil Rule 28(D).

17 IN WITNESS WHEREOF, I have hereunto set my
 18 hand and seal of office, at Cleveland, Ohio, this
 19 ____ day of ____, A.D. 20 ____.

20 Susan L. Weiss, Notary Public, State of Ohio
 21 14237 Detroit Avenue, Cleveland, Ohio 44107
 22 My commission expires May 19, 2007

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 5 BY MR. MESTER

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