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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.

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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.

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

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Q. Doctor, we're having a little bit of trouble I guess hearing you on this end, if you can do a volume control or something.
MR. AUCIELLO: We don't have one of those little devices. 111 just put the microphone nearer.
MR. MESTER: Okay.
A. Can you hear me now?
Q. I guess that's a little better. I can hear you. The court reporter is having a little bit of trouble.
Doctor, are you currently delivering babies in your position with Bethesda Naval Hospital?
A. Yes.
Q. All right. I guess --
A. Let me rephrase that. I have only been there a week, so I haven't really fully started. But in Portsmouth, yes, I was actively delivering babies and I suspect that I will at Bethesda as well. There will be no change in my practice.
Q. Okay. In the year 2001 at Portsmouth, can you tell me how many babies you delivered?
A. Probably by myself about 50, many more than that associated with residents or backing up other

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

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A. Correct.
Q. And again just going through your CV a little bit here, in '92 you did an internship as you said at Portsmouth Naval Hospital?
A. I said I believe I did the internship from '91 to '92. I would have been done with it in '92.
Q. Okay. I'm sorry. All right.
And your fellowship in Los Angeles ended in 1997?
A. Correct.
Q. And I think I may have missed what you said before, where did you go after 1997 when your fellowship was completed?
A. From 1997 to 2002 I was at Portsmouth Naval Hospital.
Q. Okay. Doctor, I take it then you've never been in the private practice of obstetrics during your career?
A. Well, I have never been in a classical model of private practice of having a private physician's office, but I have had during the period of time private patients. Again, I don't bill for them like you would in a private practice, but I do essentially the same as a private practitioner does.

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

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acquire with your recent move?
A. Not that I'm aware of. I think the way the military works is you can actually have a license in any state and there's no specific requirement for a state licensure.
Q. All right. Has your license to practice medicine ever been revoked or suspended in any state?
A. Not that I'm aware of.
Q. And, Doctor, are you Board Certified in any field?
A. I'm Board Certified in obstetrics and gynecology and also Board Certified in maternal-fetal medicine.
Q. When did you become so Board Certified?
A. I believe that I passed on the first attempt the oral examination for general GYN in 1998 and the maternal-fetal exam I would have passed on the first attempt in April of 2000.
Q. All right. What about the written examination, did you also pass those on the first attempt?
A. Yes.
Q. Doctor, would you have any other hospital privileges outside of the naval hospitals?
A. Not currently, no.
Q. Have you ever?

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

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

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

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

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

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

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

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were you reviewing per month or per year?
A. I have no way of knowing that. It's not something I would keep track of. Again, the last three years I've limited it to that. So I know exactly what I'm reviewing. I'll only accept one or two cases a month.
Q. Now with regard to those cases you've reviewed over the last approximately five years, how many of them have been on behalf of the plaintiff as opposed to the defendant?
A. Well, I think it's kind of waxed and waned. I think initially when I first started reviewing, they were mainly on behalf of the defendant. I mean, this is all -- total of all of the cases I review. For some reason lately I've seen more plaintiff cases. Again, they -- I can't remember ever reviewing any GYN cases. So they range the whole range of obstetrics.
Q. As an overall proposition, Doctor, based on the cases that you review as an expert, can you give me the breakdown, plaintiff versus defendant?
A. I think the last couple of -- the last year it's been probably about maybe 60/40 or 70130 as far as, you know, mainly defense. Initially I think the first year or so it was probably 80 to 90

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

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

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Q. Doctor, you're aware that the plaintiffs in this case have retained a few experts, Dr. Ravitz and Dr. Adler, do you know either one of those gentlemen?
A. I don't personally know them, no.
Q. Do you know of them in some way?
A. I believe Dr. Adler may have written a report in other cases that I've seen. I'm not aware that Dr. Ravitz has ever written anything on shoulder dystocia and I have never personally met him.
Q. Doctor, can you give me an idea of how many depositions you've given over the years, the last five years since you've been doing this type of work?
A. Maybe about **30** or so, **30** or 40. Again, about half the cases all total that I would get, you know, I would say that there has been deviation or there has not been a deviation, again, depending on whether that came from a plaintiff or defendant, so about half the cases I end up giving a deposition.
Q. All right. Have you asked -- to your knowledge have you been asked to give a deposition for any cases pending in the State of Ohio?
A. I may have. I don't keep track specifically of

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where the cases come from.
Q. Can you give any of the names of any other attorneys in Ohio that you've reviewed cases for?
A. I mean, I have reviewed cases for attorneys in Ohio, I don't recall their names.
Q. What about in Cleveland?
A. I believe that I've been asked to look at cases in Cleveland.
Q. You can't remember the names of the lawyers, though?
A. Not specifically, no.
Q. What about trial testimony, Doctor, can you give me an idea of the number of times you've appeared to testify in trial?
A. I'm sorry, what was your question?
Q. Sure. I just asked how many times you've appeared to testify in a trial of a case as an expert witness?
A. I want to say somewhere between five and 10 maybe.
Q. And same question about Ohio, do you know if you've appeared in Ohio in trial?
A. I don't believe I have.
Q. Doctor, it's my understanding that on Friday night you're going to be giving a trial

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deposition in this case?
A. Correct.
Q. The trial in this case is set for next week. Are you unavailable to come to Ohio or is there another reason that you've opted to give a trial deposition?
A. No, that would be the reason. Again, given the short notice and the fact that I just took a month's worth of vacation, my hospital is not going to give me time off.
Q. Doctor, have you personally ever had a claim brought against you for medical malpractice?
A. No, I've not personally been involved. I'm sorry, I've never personally been sued. I was involved in a case as a second resident where a claim was brought against the United States Government but, again, there was another resident involved in that case as well.
Q. And I understand that in your capacity as an employee of the United States Government you probably would not be sued personally. Let me just ask the question again just to make sure.
Can you tell me the number of times to your knowledge that the Government has been sued where there was an allegation that your care

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did not meet acceptable standards of care?
MR. AUCIELLO: Just a generally objection to this line.
A. Again, I don't recall the exact specifics of that case and I don't know whether my care was alleged to have been below the standard of care or not. Again, I was one of the individuals involved in the delivery but I believe that that's the only case that I've ever been part of.
Q. What happened in that delivery?
A. In that delivery there was a shoulder dystocia. The child ended up having a posterior arm brachial plexus injury.
Q. And were you deposed in that case?
A. I would have been, yes.
Q. Can you give me an idea of when that was?
A. '95, '96, somewhere in that time frame.
Q. At that time were you the person in charge of the delivery?
A. No, that would have been the third year resident.
Q. What was your role in that delivery?
A. I would have made the diagnosis of dystocia and I believe I called for assistance from the third year resident who came and completed the delivery.

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Q. Forgive me, Doctor, were you a resident at that time?
A. Correct.
Q. What year were you?
A. I believe I was a second year resident.
Q. So you were the one who was conducting the delivery, you noticed the dystocia and you called for the third year?
A. Correct.
Q. Was that the protocol at that time, that you would look for a senior person to handle it in that situation?
A. I think it would depend on the clinical situation. There was no standard that we had to let a senior know, but I think in general most people would do that.
Q. Why in that particular instance did you opt to bring the third year resident in?
A. Again, I don't specifically recall the facts of that case that would have had me call her in, I don't recall.
Q. Do you recall what maneuvers were done in an effort to relieve the shoulder dystocia in that delivery?
A. I don't recall.

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

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

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

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

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a brachial plexus, Erb's palsy injury, is that correct?
A. That I've personally been involved in, yes, that would be just one.
Q. All right. Doctor, can you tell me, what are some of the publications or journals that your office subscribes to within the obstetrical field?
A. Actually my office doesn't subscribe to any of them.
Q. Do you personally describe to any, I'm sorry, subscribe to any?
A. I do.
Q. What would those be?
A. I believe that I receive the American Journal of OB/GYN, Obstetrics and Gynecology, The Journal of Reproductive Medicine, The Journal of Maternal-Fetal Medicine, New England Journal. I get many other non-peer review journals as well.
Q. I'm sorry, Doctor, just for the court reporter's sake, would you mind just repeating that one more time?
A. The American Journal of OB/GYN, Obstetrics and Gynecology, New England Journal of Medicine, The Journal of Reproductive Medicine. I think I just

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

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Q. You would agree that the college is certainly an authority in the field of obstetrics?
A. No. I think the college serves, you know, as a guideline but it's not an authority.
Q. Would you agree with me, Doctor, that the materials published by the college and in particular the Precis are at least reliable within the field of obstetrics?
A. No. I think that they -- you know, I think you need a specific Precis. I mean, it tells you right on the front cover, it's a guideline and it's an update of our knowledge. If you look inside the back of the front cover, that's what it tells you that it is. So it's an evolution of our knowledge concerning conditions related to, you know, if this is an obstetrics one, obstetrics.
Q. I want to make sure I understand, Doctor, are you saying that the materials published in the Precis for obstetrics is not reliable?
A. No. I think some of it may be and some of it may not be. I think you would have to look at what the specifics of it were before saying whether I thought it was reliable or not.
Q. Doctor, are you familiar with the 1998 Precis

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

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

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

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

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Q. Have you read the deposition transcript of Justin Lavin, M.D.
A. I don't believe that I have.
Q. What about Dr. Adler's deposition, have you seen that?
A. No, I have not.
Q. And I take it you wouldn't have read the deposition of the vocational expert in this case, Robert Ancell?
A. I don't believe that was sent to me.
Q. Have you reviewed any additional medical records other than the ones you list on your report of July 16, 2002?
A. I don't believe that I have.
Q. All right. Doctor, have you taken any -- did you take any notes on any of the materials that you were provided with?
A. I don't believe that I did.
Q. Have you had any discussions with any other physicians or experts regarding Kayla Payne's case?
A. No.
Q. Have you conducted any additional research, read any additional articles in preparation for this case?

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

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

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

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

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A. Correct.
Q. Doctor, I'm going to have you assume that Dr. Lavin has testified in this case that it was his opinion that a shoulder dystocia was not present in this delivery. I take it you would disagree with that opinion?
A. I would. It is my opinion that, you know, that there was difficulty in delivery. What the midwife had identified as a tight shoulder, I think she described it as a mild dystocia. They did the McRoberts' manuever and episiotomy. The baby quickly delivered after that.
Q. Doctor, I don't know if Mr. Auciello has a copy of the deposition transcript there present, but on page 34 of Dr. Lavin's depo, 111 just quote if for you, he says, and I don't think I would characterize this as sort of a true shoulder dystocia.
And then just so I'm clear, Doctor, you disagree with Dr. Lavin in that regard, correct?
A. Well, I mean, I think, I mean, he may be looking at more in a classical sense of a true shoulder dystocia that may have many maneuvers to be required. I don't know what question you asked

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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lateral traction by an obstetrician in managing shoulder dystocia is a cause of brachial plexus injury in a baby?
A. I think that's a fair statement. Again, I don't think it's the cause. I think it's a possible cause.
Q. And it certainly -- I know you've testified on some plaintiff cases, Doctor, in any of those cases have you provided that opinion, that excessive lateral traction was used and that's what caused the brachial plexus injury?
A. I believe I have, yes.
Q. And, Doctor, what are the mechanics of that, how does that work, how does excessive lateral traction when applied cause a brachial plexus injury?
A. Well, usually if there's a stretching out of the long axis of the fetus, the stretching of a brachial plexus out of the long axis kind of away from the other shoulder, if you will.
Q. Doctor, I have read some of your literature and I'm aware that you believe there are other causes of brachial plexus injuries other than excessive lateral traction?
A. Correct.

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

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Q. Doctor, can you explain to me how -- well, first of all, you would agree that in this case a nerve injury was diagnosed and occurred to Kayla Payne in this delivery?
A. I'm sorry, what is your question?
Q. Sure. You would agree with me that Kayla Payne sustained a nerve injury in this delivery?
A. Correct.
Q. Can you explain to me if that injury was not caused by excessive lateral traction, how can such a nerve injury occur otherwise?
A. Well, I think specific in this case you had a compound presentation with the hand coming down, you know, along side the head. If it's coming down in such a fashion that it's creating a stretch, you know, along side the neck and, you know, if that shoulder is impacted up underneath the symphysis, that neck is going to be stretched as a consequence or in association with a shoulder dystocia.
Q. By virtue of the compound presentation?
A. Well, the compound presentation is what's giving rise to the shoulder dystocia in this case.
Q. Okay.

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

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to the opinion that a compound Presentation encountered in conjunction with a shoulder dystocia resulted in a brachial plexus injury?
A. Right. And I have looked at cases where you had a compound presentation and that was a case where there was actually an umbilical cord that was kind of wrapped around the arm, again, constricting it as well. Again, they're not common, but it can cause it.
Q. In this case there was no umbilical cord wrapped around the arm, right?
A. Not that I was aware of.
Q. Have you ever seen or reviewed cases with the same or similar set of operative facts as we have here and where it was your opinion that the compound presentation caused the brachial plexus injury?
A. Again, I think, I mean, I have seen other cases. I have again that opinion in this case.
Q. Doctor–
A. They're not common. It's not the most common cause of dystocia but it can occur.
Q. You would agree with me, Doctor, that excessive lateral traction is a more common explanation than compound presentation as a causal agent of

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the brachial plexus injury?
A. Are you talking about in this case?
Q. Generally speaking.
A. No.
Q. So let me be clear, Doctor, about my question. I'm not talking about this case now because I think you've made clear to me what your opinion is in terms of what the causative agent was in this case.
But I asked you before whether excessive lateral traction is the most common cause of brachial plexus injuries and you told me that you do not believe that it is, correct?
A. Correct.
Q. Maybe we should approach that for a second. You said just the normal forces of delivery is the most common?
A. Correct. If you look at large studies of brachial plexus injuries, the majority of these are just associated with normal spontaneous deliveries.
Q. Okay. Let's go to the second most common causative agent of brachial plexus injuries with a shoulder dystocia. Now you've told me the normal forces of delivery, what's the second most

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

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

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A. I think probably the third most common might be excessive traction.
Q. Doctor, I'm going back to the general question I guess, of all cases even those without a shoulder dystocia, you would agree with me that it is certainly more common for excessive lateral traction to cause a brachial plexus injury than for a compound presentation to cause a brachial plexus injury?
A. I don't think anybody has ever looked at them that way. I can't answer that question as you've asked it.
Q. Well, you've told me before you agreed I think that for a compound presentation to cause a brachial plexus injury, that's a relatively rare situation?
A. Well, no, it's not the compound presentation that's causing the brachial plexus. I mean, maybe I can answer your question. It's the compound presentation that's giving rise to the shoulder dystocia. It's the shoulder dystocia that's then injuring the arm. So it's indirectly, the compound presentation gives rise to the dystocia which is much more common than excessive lateral traction.

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Q. Again, you're saying then that injuries with a compound presentation and a shoulder dystocia are more common than injuries just caused by excessive lateral traction by the delivering person?
A. What I'm saying is that the injuries that are caused by dystocia are more common than injuries caused by excessive traction.
Q. Doctor, all I'm trying to get at is this: You would agree that injuries caused by excessive traction are certainly more common than injuries caused by a compound presentation with shoulder dystocia presentation?
MR. AUCIELLO: Objection, I think he's answered that already.
A. Yeah, I think you asked it. No. I think that injuries caused by dystocia are far greater than the injuries caused by traction. Now it's the compound presentation that's causing the shoulder dystocia in this case.
Q. But the question I have, Doctor, is not about just the dystocia. I'm talking about the compound presentation.
MR. AUCIELLO: He said the compound presentation isn't the causative factor.

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

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

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dystocia is present or not.
Q. Well, I understand that, Doctor, and unfortunately I guess you don't have her deposition, the appropriate page but having you --
MR. AUCIELLO: Nowhere in the deposition did she say there was a shoulder dystocia.
MR. MESTER: Well, I thinkthat's obviously beyond her realm of expertise, Ernie.
MR. AUCIELLO: Right.
Q. But, Doctor, let's have you assume the same hypothetical I gave you earlier, that Ms. Giles testified on page 30 of her deposition that the midwife told her to stop pushing, that immediately after that the midwife reached in and grabbed the baby by the neck and arm and pulled and then after that at that point the nurse only then did McRoberts', cut an episiotomy and was able to conclude the delivery.
If we assume those set of facts, Doctor, would you agree with me that to a reasonable degree of medical probability Ms. Watson's actions in that aspect would have

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been the cause of Kayla's injury?
A. No. I think in this case you had a shoulder dystocia. What you're reading to me doesn't even define a shoulder dystocia and it's my interpretation as well as the interpretation of nurse midwife Watson that there was a dystocia. So I think you're just going in a roundabout way of it. So, no, I wouldn't agree with that.
Q. And, Doctor, I'm going to read a portion of Dr. Lavin's testimony to you because I know you don't have the deposition. My question to Dr. Lavin was: Doctor, having you assume that Ms. Giles' testimony is accurate, would you agree with me that that would be a deviation from the standard of care? Answer: If it was accurate, yes. Question: Doctor, if that testimony is accurate, would you agree with me that that would be the cause of Kayla Payne's brachial plexus injury? Answer: Probably, yes.
My question is, Doctor, if what I'm reading of Dr. Lavin's deposition is correct, in other words, if I'm reading it correctly, am 1to assume you disagree with Dr. Lavin in that respect also?
A. Well, I think if you asked him the same exact

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questions you asked me, and I don't know that you did, I don't know what you asked him or what you read to him because I don't have his deposition.
Q. Having you assume that what I just read you is an accurate reading of his deposition.
A. And, again, you're reading to me something out of his deposition. I don't know what you're asking him in the context in which you're asking him. I can't really comment on that.
Q. You can't comment on it based on the way I read it to you, Doctor?
A. Well, again, you're reading me one little line out of there. I don't know if you read to him the exact words that you read to me in the exact context in which you read it to me. It's more of just simply reading those lines.
MR. AUCIELLO: It's also a matter of interpreting Videllia Giles' testimony which is hardly --
Q. Well, Doctor, let me ask you this. Is there any -- you've read Ms. Giles' testimony. Again, just based on your recollections of what you read from Ms. Giles' testimony, if what she says is true to a reasonable degree of medical probability, is that the cause of Kayla's injury?

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A. I think you've asked that and I think I've answered it. The answer is no because it's my interpretation that the injury occurred with the shoulder dystocia and would have been present irregardless.
Q. And if Dr. Lavin opines otherwise, that based on his reading of Ms. Giles' deposition, that it's his opinion that that would have been the cause of Kayla's injuries, again if Ms. Giles' deposition is taken as true, you would disagree with him in that regard, correct?
A. Again I think I would have to know what he specifically said before I agreed or disagreed.
Q. All I'm asking you, Doctor, is based on a reading of Videllia Giles' deposition.
A. But again, you're asking about specifics of what occurred when.
Q. I'm really not. I read you Dr. Lavin's deposition where I asked him, having you assume that Ms. Giles' testimony is accurate, and he said based on that, that that would have been in all probability the cause of Kayla Payne's injury. I just want to confirm what I think is obvious, Doctor. You disagree with that, right?
A. If you ask me specifically on page 30, the

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lines.
Q. Here's what I asked him before that question, Doctor. Did you read in her, meaning Ms. Giles' testimony, where she indicated that upon delivery nurse midwife Watson grabbed the baby's head and neck and pulled?
A. Okay.
Q. And based upon that excerpt he went on to say that, yeah, he believed that that would have probably been the cause of injury?
A. Well, I think you asked that in a general fashion and I would agree with that too in a sense. But you're asking about the specifics of this case and when she pulled or didn't pull and so in a sense I agree and in a sense I disagree.
Q. Can you explain further, in what sense do you agree?
A. Well, I mean, you're asking him simply if she had done no maneuvers and she had just pulled, would that have been a deviation of standard of care and think that's what Dr. Lavin's getting at, but you can ask him specifically. I would agree with that. Again, not doing any maneuvers and just pulling is a deviation.
Now reading what you have read to me

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and looking at causation, it's my opinion that that injury would have occurred irrespective and I don't think you asked that to Dr. Lavin. So I can't agree one way or the other with what he said. You're reading something to me that's just out of context.
Q. Let's assume --
A. You're not reading to me the same information that you're reading to Dr. Lavin. You're not asking us the same questions. So I'm not going to get into a conflicting discussion with him.
Q. Doctor, I've read it to you word for word, other than the fact that you haven't seen it, there's nothing more I can do.
MR. AUCIELLO: Jonathan, I think you've made your point. I think we can --
MR. MESTER: Well, let me just finish it and I'll move on.
Q. Doctor, if what you said is true, if let's just take as a general proposition, if upon encountering this shoulder dystocia Ms. Watson reached in and pulled and didn't do any other maneuvers, you believe that if that happened in this case, that that still would not be the cause of this injury, correct?

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A. Correct.
Q. If Dr. Lavin believes otherwise, you would disagree with him?
A. I think in a general sense, yes.
Q. Okay. I'll move on.
Doctor, did you see anywhere in the medical record where Ms. Watson documented the amount of traction that she applied in this delivery?
A. No, that's not something that you would normally document.
Q. Is that something that in the course of your teaching medical students and so forth you would recommend be done?
A. Not necessarily. I mean, I think ideally you would like to have it done but it's not going to be routinely done. I think you would like to have it done but there's no standard of care that says it has to be done or it does not have to be done.
Q. Let me repeat my question, Doctor.
Do you recommend that the delivering person document the amount of traction done in a delivery?
A. I think, yeah, you'd like to recommend it. But

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there is no standard that it has to be done. Yeah, I mean, I'd like to see it done. I'd like to see a lot of other things documented but they're not always documented.
Q. And why is it that you'd like that to be documented, Doctor?
A. Well, I think, you know, again, if excessive traction was used, that would be a deviation of standard care and, again, I think I would like to see it. Clearly this is a litigious area. If I'm being asked to review it and I see that, then I might say it's a deviation of standard of care.
You know, again, there's plenty of things that I would like to see, for example, presentation of the head, how long the shoulder dystocia was, you know, the sequence in type of maneuvers, but those aren't -- not everything is always there. Most of it is, but not all of it.
Q. So, Doctor, you would agree that medical records particularly with respect to documenting shoulder dystocia deliveries often fail to record what occurred?
A. No. I think the standard of care, you know, that's just a minimum and that's to document dystocia or the maneuvers that were done.

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

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Q. That was done I believe at plus one station?
A. Correct.
Q. Just so I understand, what is plus one station?
A. Will be approximately one centimeter past the ischial spine.
Q. And, Doctor, when the delivering person ruptures the membranes at plus one station as Ms. Watson did in this case, if there is a compound presentation at that point in time, is that something the delivering person would be able to know when rupturing the membranes at plus one station?
A. If it was present, yes. But, again, it may occur after that.
Q. All right. But there are times where certainly you would acknowiedge that during that process the delivering person would be able to recognize the compound presentation at that point?
A. Well, I think it depends on where it occurs. I mean, compound presentation where you scoop the hand up by the head and if you're feeling the top of the head, you may not feel that but it still could be compound by definition.
Q. But sometimes -- I'm sorry.
A. It could still be there and they night not be

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

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

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Q. Okay. Doctor, did you read in Ms. Giles' deposition where she indicated that after traction was applied the baby's arm flopped against her leg?
A. What page are you referring to?
Q. Unfortunately I think that was on page 30.
A. I mean, I would have read it. I would have read it over the weekend, yes.
Q. Do you recall that being part of her testimony?
A. I don't specifically recall it.
Q. Is that something that you've encountered in your practice, that scenario that I've described?
A. I'm sorry, can you reask that again just so that I'm clear?
Q. Sure. Again, having you assume, and I really don't want to get into reading into her depo again, that Ms. Giles' testimony was that after traction was applied and before the McRoberts' maneuver was employed, the baby's arm flopped against her leg, is that something you've encountered in delivery?
A. With a compound presentation that's described there, yes. Again, that compound presentation, as the head is coming out, that compound presentation is going to be released.

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Q. Would that be consistent also with the delivering person pulling on that arm?
A. I don't think so, no. I think it would be quite unusual to pull on the arm, just pull the arm out.
Q. So that would not be consistent with the delivering person pulling on the arm?
A. No.
Q. So if Dr. Lavin also indicated in his deposition that in a compound presentation if the delivering person were to pull on the arm, that would cause the arm to come out, you would disagree with him in that regard as well?
A. No. That's not what I'm saying.
Q. Well, what are you saying?
A. Well, I think if the provider was just going to pull on the arm, it could come out. But it's my interpretation that that's not what happened here.
Q. I apologize if you misunderstood. That was all I was asking. It would be consistent generally speaking if the delivering person pulled on the arm in a compound presentation, it would come out and hit her in the leg, right?
A. No, not necessarily. It's a possibility. It's

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also a possibility that, you know, the provider did the maneuver, they relieved the dystocia and as the dystocia was being released, that arm came out, that's another possibility.
Q. I understand there are all kinds of possibilities, Doctor. I just want to make sure that we're on the same page. That would be consistent, that would be one possible possibility, correct?
A. It would be a possibility.
Q. All right.
A. That's not my interpretation of what happened here.
Q. I understand that. How else would the baby's arm come out and strike the mom's leg other than if the delivering person had pulled on it?
A. Well, as the shoulder dystocia is being alleviated, as the McRoberts' maneuver is being done, it converts the shoulder to an oblique diameter, the shoulder is free, the head is able to come out and the arm is next to it and it just comesout.
Q. You're talking about after the shoulder dystocia is relieved?
A. Correct.

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Q. What about prior the time the shoulder dystocia is relieved?
A. Again, I don't think that it could have come out on its own. It's causing the dystocia, it's what's obstructing. I think it would be highly unlikely it would come out by the provider just pulling on it.
Q. Doctor, switching gears, would you agree with me that the diagnosis and need for additional maneuvers in the realm of a shoulder dystocia case is directly affected by the experience of a delivering person?
A. Not necessarily. I mean, I think in a general sense that's fair but, you know, if the provider has been in shoulder dystocia and they've been trained to do that, no.
Q. Let me read it again. I'd like an answer of whether it's accurate or not if you can give it to me, but I understand you may not have caught it all.
Would you agree with the statement that the diagnosis and need for additional maneuvers is directly affected by the experience of the delivering person?
A. I think in a general sense. I don't know if I

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

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

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

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

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A. Again, I think, you know, yeah, I may have wrote it but I'm not certain I quite agree with that as a general blanket statement.
Q. So, again, I'm just trying to understand, now that you've revised -- revisiting the issue you may not agree with what you wrote in 1999?
A. Yeah, I think in a general sense, I mean, a5 a general statement saying that by having the patient delivered by a midwife is she at an increased risk, not necessarily, no.
Q. Doctor, are there any other opinions that you'll be providing in your testimony, in your trial testimony on Friday that aren't contained in your report or that we have not discussed tonight?
A. I don't believe so. I mean, I don't believe you've asked me today about the antepartum care, but I believe that I had addressed in my report that the prenatal care was within the standard of care.
Q. The prenatal care that was done at Metro Hospital?
A. Correct.
Q. Metro Hospital is not a defendant in this case, Doctor.
A. I'm sorry?

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Q. Metro is not a defendant in this case.
Doctor, you don't have any opinions I take it regarding the permanency of Kayla's injury?
A. No.
Q. And you don't have any opinions regarding whether, you know, physical therapy had it been done on a more extensive basis would have changed her ultimate outcome?
A. No, I do not have an opinion about that.
MR. AUCIELLO: Jonathan, I'm not going to ask him questions relating to that, I'll stipulate to that.
MR. MESTER: All right. And, of course, that would apply to future surgeries and so forth?
MR. AUCIELLO: All of that. He's a standard of care liability expert, not a damage expert.
MR. MESTER: I understand.
Q. Doctor, have you had an opportunity to review notes that were taken by Dr. Lavin in his reading of the materials in this case?
A. No, I have not.
Q. I'd like to read you a note that Dr. Lavin took

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

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asking you now is: Do you have the impression that Ms. Watson wasn't sure initially what was happening?
A. I didn't get that exact impression, no.
Q. Did you have any impression at all that there was, you know, ever a period after the dystocia and compound presentation presented that she didn't know what was happening?
A. No. It's my interpretation that she went to a recognized maneuver, did the maneuver, dystocia was alleviated.
Q. So if Dr. Lavin holds that opinion, you would disagree with him in that regard?
A. Again, that's his opinion. Yeah, I think that the facts in this case are that she used the McRoberts' and the episiotomy that alleviated the dystocia. If it was a compound presentation, she may not have known that there was a compound presentation and maybe that's what he meant by that.
And, again, she very well may not have known that there was a compound presentation and may not have been aware that that was present and so may not have known in that sense there was a compound presentation. But as far as her

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

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

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

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

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

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

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

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Q. Okay. Doctor, I think this is my last question. What is your charge for the deposition testimony here today?
A. Three fifty an hour.
Q. Okay. And is that the same charge that you have for trial testimony or is that different?
A. That will be different.
Q. What's your charge for trial testimony?
A. Three thousand dollars.
Q. And is that confined to where you actually make a live appearance at trial?
A. No.
Q. So on Friday for your trial testimony, is that a three thousand dollar charge?
A. Yes.
Q. And what is your charge for chart review and deposition review and so forth?
A. Three hundred an hour.
Q. And have those rates increased at all within the last five years since you've been doing this?
A. I don't think so. I think maybe the first year I was charging two fifty an hour for medical and chart review and I increased it to three hundred I think roughly the first year but since then it's been stable.

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Q. Okay. Doctor, I believe that is all I have. Thank you.

MR. AUCIELLO: Okay. He'll read it.

ROBERT GHERMAN. M.D.

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CERTIFICATE

The State of Ohio) SS:
County of Cuyahdga.)

I, Susan L. Weiss, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named ROBERT GHERMAN, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth. the whole truth. and nothingbut the truth; that the deposition'as above-set forth was reduced to writing by me by means of stenotypy, a n was later transcribed into typewriting under r ctio ı; that this is a true record of the tes give n by the witness, and was s lbs by s id witne in my presence; that said de n wa taken a e aforementioned time, ate and place, purs ant to notice or stipulations counsel; that I am ıot a relative or employee r attornev of anv o the parties, o r a relative or employee of such attorney or financially interested in this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ___ day of _____, A.D. 20 __.

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

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