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CUYAHOGA COUNTY COMMON PLEAS COURT

GLORIA MASLANKA, AS PARENT AND
GUARDIAN AD LITEM OF SHANE
MASLANKA, A MINOR,

Plaintiff,

vs.

METROHEALTH MEDICAL CENTER,

Defendant.

No. 552424

DEPOSITION OF T. MURPHY GOODWIN, M.D., taken
on behalf of the Plaintiff, at 170 South Euclid Avenue,
Pasadena, California, commencing at 3:17 P.M., on
Tuesday, January 23, 2007, pursuant to Notice, before
KARINA GARCIA, CSR No. 12818, a Certified Shorthand
Reporter in and for the County of San Bernardino,
State of California.

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APPEARANCES:

For the Plaintiff:

BECKER & MISHKIND
BY: MICHAEL BECKER, ESQ.
DAVID KULWICKI, ESQ.
134 Middle Avenue
Elyria, Ohio 44035
(440) 323-7070

For the Defendant:

REMINGER & REMINGER
BY: JAMES MALONE, ESQ.
CHRISTINE S. REID, ESQ.
1400 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115
(216) 687-1311
cred@reminger.com

Also Present:

John Hank, Videographer

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I N D E X

EXAMINATION

WITNESS

T. Murphy Goodwin, M.D. By Mr. Becker

6

PAGE

E X H I B I T S

None.

QUESTIONS INSTRUCTED NOT TO ANSWER

PAGE LINE

85 3

85 20

INFORMATION REQUESTED

None.

1	PASADENA, CALIFORNIA; TUESDAY, JANUARY 23, 2007	
2	3:17 P.M.	
3		
4	THE VIDEOGRAPHER: Good afternoon. My name is	
5	John Hank. I'm a certified legal video specialist here	3:17:32PM
6	today for Jonnell Agnew & Associates, located at	
7	170 South Euclid Avenue, Pasadena, California 91101.	
8	Today is January 23rd, 2007. The time is 3:17 p.m. We	
9	are located, today, at 170 South Euclid in Pasadena.	
10	This deposition of Dr. R. Murphy Goldwin (sic)	3:17:58PM
11	-- Goldwin is being take, today, on behalf of the	
12	plaintiffs, in the case caption Gloria Maslanka as	
13	parent and guardian of Shane Maslanka versus Metro Heart	
14	(sic) Medical Center, Case No. 552424 in the Court of	
15	Common Pleas, Cuyhoga County, Ohio.	3:18:18PM
16	Will counsel for the parties please identify	
17	themselves now.	
18	MR. MALONE: Well, my name is Jim Malone. I	
19	represent MetroHealth Medical Center, not Metro Heart	
20	Medical Center. And the witness sitting to my right is	3:18:25PM
21	Dr. T. Murphy Goodwin, not R. Murphy Goodwin.	
22	MS. REID: Christine Reid, also here on behalf	
23	of MetroHealth Medical Center.	
24	MR. BECKER: Michael Becker on behalf of	
25	Shane Maslanka and Gloria Maslanka.	3:18:42PM

3:19:35PM

3:19:20PM

3:19:06PM

3:18:54PM

3:18:54PM

3:18:45PM

1 MR. KULWICKI: David A. Kulwicksi on behalf of
2 Gloria and Shane Maslanka.
3 THE VIDEOGRAPHER: Thank you.
4 Will the court reporter please swear in the
5 witness.
6 T. MURPHY GOODWIN, M.D.,
7 called as a witness by and on behalf of
8 the Plaintiff, being first duly sworn,
9 was examined and testified as follows:
10
11 EXAMINATION
12 THE VIDEOGRAPHER: We're on the record at 3:19.
13 This is the start of Tape No. 1.
14 BY MR. BECKER:
15 Q. Hi, Doctor. State your full name for the
16 record, please.
17 A. Thomas Murphy Goodwin.
18 Q. Doctor, you've been deposed before; correct?
19 A. Yes, I have.
20 Q. I just want to review the ground rules with
21 you. This is a question-and-answer session under oath.
22 If the question doesn't make sense or isn't artfully
23 phrased, please tell me so, and I'd be happy to attempt
24 to rephrase or restate the question.
25 Fair enough?

3:19:36PM	1	A. Yes.	Q. However, unless you indicate otherwise to me,	3
	2		I'm going to assume that you fully understood the	
	3		question that I've posed and you were giving me your	
3:19:43PM	4		best and most complete answer today.	
	5		Fair enough?	
	6		A. Yes.	
	7		Q. And, Doctor, did you bring your complete file	
	8		with you today?	
3:19:51PM	9	A. Yes, I did.	Q. Okay. And you've just -- before we started,	
	10		you handed it to me, and I passed it off to	
	11		Mr. Kulwicki, and he's looking through it right now;	
	12		correct?	
3:19:59PM	13	A. Yes.	Q. Has anything been removed from your file?	
	14		A. No.	
	15		Q. I'm not sure that you've had an opportunity,	
	16		but we did notice this deposition, duces tecum, and ask	
3:20:09PM	17		you to bring some things.	
	18		Have you had an opportunity to see a copy of	
	19		the duces tecum that we send in this case?	
	20		A. I saw something that was -- I was alerted to by	
	21		Mr. Malone, recently, and I think I have everything that	
3:20:27PM	22		I actually have access to that you've requested as far	

3:21:37PM

3:21:24PM

3:21:12PM

3:20:58PM

3:20:43PM

3:20:30PM

1 as I know.

2 Q. Okay. One of the things that I specifically

3 asked about, that you bring with you, is copy of

4 handouts and/or hard copies of your PowerPoint

5 presentation in two seminars you gave in 2006, one in

6 Hawaii and the other in Switzerland.

7 MR. MALONE: I'm going to make an objection to

8 any questioning about this. I'm going to let you ask

9 the questions, but you're asking about presentations in

10 2006 when the question in the lawsuit is the standard of

11 care in August of 2001. You also gave me less than

12 fourteen hours notice for this request, and it's my

13 understanding that the doctor doesn't actually have the

14 material; that the materials that he presents are

15 updated regularly, such that whatever fashion or

16 whatever state they may have existed at the time of

17 those presentations they no longer exist.

18 So we're not going to produce those -- those

19 requested materials, but you can ask him questions about

20 it if you want.

21 BY MR. BECKER:

22 Q. Doctor, I need to hear from you today, and it's

23 true that I didn't give, certainly Mr. Malone much

24 advance notice that seconded-amended request. But not

25 withstanding I --

3:21:38PM	1	MR. MALONE: The first amended wasn't much
	2	better, Michael. I think I got another two hours lead
	3	time on that one.
	4	BY MR. BECKER:
3:21:45PM	5	Q. Do you have, sir, a copy of any handouts or
	6	PowerPoint material available for both of those
	7	seminars?
	8	A. I did not have anything, but it's possible that
	9	the conference organizers have a booklet or something.
3:22:00PM	10	I don't have anything that I've retained -- those talks
	11	come from a pool of material I have, and I pull out
	12	material for that presentation and from my general
	13	background of stuff.
	14	Q. I didn't hear the end of that.
3:22:16PM	15	A. From any general background materials, I pull
	16	out that stuff.
	17	Q. Okay.
	18	A. But the conference organizers -- you know there
	19	was a booklet prepared for both of those. I don't
3:22:27PM	20	retain a hard copy of those, but somebody probably has
	21	them.
	22	Q. Who would I contact to obtain a copy of that
	23	booklet? Whoever put on the --
	24	A. The Ferring Corporation put on the one
3:22:39PM	25	conference in Switzerland and the post graduate division

1	of the Keck School of Medicine put on the course in	3:22:41PM
2	Hawaii.	
3	Q. Doctor, did you create any, or generate any	
4	notes as a result of your review of this case?	
5	A. No. I folded some points in the record and	3:22:54PM
6	some points in depositions, some parts of the chart, but	
7	I did not write anything in there or create any notes.	
8	Q. Okay. So you kind of flagged some parts of the	
9	chart but no notes anywhere therein?	
10	A. No.	3:23:09PM
11	Q. And that applies to depositions as well? No	
12	notes from depositions?	
13	A. That's true.	
14	Q. Now, last deposition I looked at that was by	
15	you, you did about 90 percent defense work and	3:23:20PM
16	10 percent plaintiff's work; is that true?	
17	A. 85, 90 percent defense, 10 to 15 percent on	
18	behalf the patient.	
19	Q. How long have you been doing medical legal	
20	work?	3:23:38PM
21	A. Since the mid 1990s.	
22	Q. And approximately, how many do you -- cases do	
23	you review a year?	
24	A. About 20.	
25	Q. What percentage of your income does your	3:23:51PM

1 medical legal work account for?

2 A. Ten to fifteen percent.

3 Q. Do you review cases all over the country or do

4 you do predominantly in California and, maybe, one or

5 two other states? Can you give me a sense as to --

6 A. Most in California. But I have reviewed cases

7 in -- at one time or another, probably in eight or ten

8 other states.

9 Q. Okay. How many cases have you done on behalf

10 of -- at the request of MetroHealth Medical Center?

11 A. I believe three cases.

12 Q. And what are they, if you recall?

13 A. Jeez, I'm not sure I can remember the names of

14 them. There -- one of them is -- Bahle, is the

15 plaintiff. B-A-H-L-E.

16 Q. Okay.

17 A. And --

18 Q. It's another one named Colon (phonetic) that my

19 office has with you?

20 A. Yes.

21 Q. Any others?

22 A. Yes. There are others. There's one or two

23 others that I don't think I'm going to be able to

24 remember the name of right now.

25 Q. Fair enough. You had actually come out to

1	MetroHealth and put on a presentation or assisted in a	3:25:17PM
2	seminar at one time?	
3	A. Yes.	
4	Q. And how did that come about?	
5	A. I'm invited to give lectures in different	3:25:26PM
6	places around the country, and I'm -- Dr. Brian Mercer	
7	who is there is a colleague of mine. We served on the	
8	board of Maternal-Fetal Medicine Society and it was at	
9	one of those meetings; he said why don't you come to our	
10	annual conference at Metro.	3:25:38PM
11	Q. How many times have you done that?	
12	A. Once.	
13	Q. And are you -- consider yourself social friends	
14	with Brian Mercer?	
15	A. Well, no. I mean, I -- I know him. He's a	3:25:49PM
16	good guy. I knew him from meetings. That's the only	
17	place I've ever seen him.	
18	Q. Have you ever gone to dinner with him?	
19	A. No, but I -- you know, probably had a cocktail.	
20	MR. MALONE: You would have if you were buying,	3:26:02PM
21	I suppose.	
22	THE WITNESS: He's a -- I know him from a	
23	scientific -- as a scientific colleague, probably	
24	95 percent. And just a few other passing comments.	
25	How's your family doing, that kind of thing.	3:26:15PM

1 BY MR. BECKER:

2 Q. Fair enough. How many cases have you reviewed

3 on behalf of the law firm Reminger & Reminger?

4 A. I think four or so. Yeah, I believe it's four.

5 Q. Because of your relationship, or at least your

6 professional relationship, with Brian Mercer, would you

7 be uncomfortable looking at a case against MetroHealth

8 Medical Center and acting as an expert?

9 A. It -- I'd have to assess it when it came up. I

10 have looked at cases for plaintiffs, and I'm not asked

11 very often. I -- unless I have a specific reason why I

12 can't do it, if the description of the case seems like

13 something I know about, it seems like it's worthy of

14 investigation, I will do it.

15 The fact that one knows someone is involved

16 with the services is an obvious thing that, you know --

17 personal relationships influence these decisions. So I

18 can't say for sure whether I would say out right no.

19 I -- it would probably weigh in the mix of all the

20 factors against that.

21 Q. Fair enough. In the plaintiff's cases that

22 you've done, can you think of the medical subject

23 matters? Have -- have they been shoulder dystocia,

24 Erb's palsy or Klumpke's palsy cases or have they been

25 birth asphyxia? Can you give me a sense as to the

3:27:42PM

3:27:32PM

3:27:19PM

3:27:02PM

3:26:33PM

3:26:18PM

1 plaintiff's cases that you reviewed and actually agreed

2 to act as an expert, given a deposition or made a trial

3 appearance?

4 A. When -- one is -- one was a shoulder dystocia

5 case that I can think of, brachial plexus injury. One

6 was a -- asphyxia related to maternal seizure and

7 preeclampsia the baby was -- sustained some brain

8 damage. Another was a maternal death related to a

9 pulmonary embolism. Another was a maternal injury

10 related to a complicated surgery.

11 Q. Was the PE case, was it alleged that the deep

12 vein thrombosis and pulmonary embolism occurred post

13 deliver, if you remember?

14 A. It was after termination of pregnancy in the

15 middle of a pregnancy, and it was a woman who had

16 significant risk factors and no --

17 Q. Prophylaxis.

18 A. No prophylaxis or appreciation that her medical

19 condition was a significant risk factor that -- I review

20 a number of others. Those are the ones that -- just the

21 spectrum of things that come to mind right now. I do --

22 most of my practice is medical complications of

23 pregnancy, besides intro part of management of preterm

24 labor and stuff of what I see in consultations or women

25 are sick with hypertension, thyroid disease,

1 thrombotic disease, that kind of thing. 3:29:12PM

2 Q. The case involving the shoulder dystocia and Erb's palsy, do you know where that -- the plaintiff's case, where that was venued? 3:29:31PM

3 A. That was in San Diego, California.

4 Q. And do you remember who the name of the plaintiff's lawyer was in that case? 3:29:42PM

5 A. Scott Benjamin.

6 Q. Now, let's talk about your current practice. Can you give me a sense of what your average week is like? 3:30:05PM

7 A. I see my own patients about 20 percent of the time in consultation and practice. I supervise the residents in their care of patients about 20 percent of the time, maybe 30 percent I guess I would say on that account. And then I -- I'm involved in research about 20, 25 percent of the time. And most of the rest is left for administration. I'm in charge of our fellowship program and in charge of the obstetric education for the residents. In other words, the obstetric side of obstetrics and gynecology that residents go through. 3:30:28PM

8 Q. And what percentage of your time is medical/legal work? 3:30:37PM

9 A. It's -- I mean, I'm basically counting there my

3:30:42PM	1	work week, you know, seven in the morning, seven at
	2	night, five days a week.
	3	Q. Okay.
3:30:50PM	4	A. So I -- I never do any other work except on
	5	occasions like this during the waking hours -- daytime
	6	hours.
	7	Q. The depositions that I looked at, Doctor --
	8	maybe this is consistent with what you said is, you
3:31:02PM	9	describe your practice as 15 to 20 percent clinical and
	10	about 25 percent of your time teaching; is that
	11	accurate?
	12	A. Teaching is almost always supervising the
	13	residents and it's teaching at the bedside, yeah.
	14	Q. That's accurate?
3:31:11PM	15	A. Yes.
	16	Q. How many babies do you deliver a year?
	17	A. I don't deliver any that are not just where I'm
	18	supervising the resident. I don't have my own OB
	19	patients. My private practice is only consultation.
3:31:28PM	20	Q. So if you were to actually deliver, it would be
	21	in the act of supervising a resident in the teaching
	22	role?
	23	A. Yes.
	24	Q. And do you have any experience working at a
3:31:41PM	25	prenatal clinic where physician -- well, first of all,

3:32:50PM

3:32:38PM

3:32:29PM

3:32:17PM

3:32:04PM

3:31:46PM

1 do you have any experience working at a prenatal clinic
2 that it is away from -- physically away from the
3 hospital where delivery would take place?
4 A. You know, we had our own busy private practice
5 for many years that was -- we did prenatal care of 100
6 patients a month, delivered 100 patients a month. It
7 was freestanding and remote. I -- I'm involved in
8 supervising a lot of clinics that send patients into us.
9 But I don't -- I'm not the one actually out there seeing
10 the patients every day.
11 Q. You're -- you supervise some clinics that send
12 some patients in to you where the prenatal care is done
13 off campus?
14 A. Yeah.
15 Q. And the delivery takes place at your hospital?
16 A. Yes.
17 Q. Just so we're in -- on the same page, what is
18 the name of your hospital?
19 A. Los Angeles County University of Southern
20 California Medical Center.
21 Q. Is it referred to as county hospital?
22 A. Yes. Well --
23 Q. What's the breakdown between private versus
24 clinic patients at the county hospital?
25 A. It's one hundred percent clinical patients.

1 Q. When you say you supervise the prenatal clinics

3:33:01PM

2 that ultimately, you know, funnel you patients for

3 delivery, do you play any role in forms that are

4 developed at the clinic -- at the prenatal clinic or the

3:33:18PM

5 policy procedure of those clinics?

6 A. No. They'll often ask us, you know, what

7 should we do in this setting. Sometimes they might --

8 sometimes they'll ask for specific information, like,

9 what kind of a policy should we have in this area. But

3:33:34PM

10 there's no formal way in which we do -- we generate a

11 form that is used by all of the clinics in a certain

12 area or even any one of them.

13 Q. All right. Let's review some definitions,

14 Doctor. What is your understanding, at least in Ohio,

3:33:50PM

15 of the phrase "standard of care"?

16 A. It's what a reasonable physician would do in

17 same or similar circumstances to take care of a patient.

18 Q. Okay. I want you to assume the definition, now

19 in Ohio, is what a reasonable, skillful and diligent

3:34:10PM

20 physician would do in the same or similar circumstances.

21 Would you assume that to be true?

22 A. Yes.

23 Q. Okay. And when I talk later in this

24 deposition, I'm going to be talking about standard of

3:34:23PM

25 care or standard of care violations. You've heard the

3:35:25PM

3:35:15PM

3:34:57PM

3:34:45PM

3:34:34PM

3:34:27PM

1 phrase deviations; correct?
2 A. Yes.
3 Q. Okay. And when I say the word deviations in
4 the balance of this deposition, please, understand that
5 I'm referring to a standard of care violation; is that
6 fair?
7 A. Yes.
8 Q. Okay. Let's start with definitions of PROM
9 P-R-O-M. What does that mean?
10 A. It means premature rupture of membranes.
11 Q. And what is PPROM?
12 A. Preterm premature rupture of membranes.
13 Q. What is -- what are tocolytics?
14 A. Those are drugs to stop uterine contractions.
15 Q. What is something called "rescue tocolytics"?
16 A. That's when tocolytics are used to arrest
17 contractions for a short period of time because there's
18 concern for fetal well-being. Actually, that term
19 "rescue tocolytics" is a -- a popular term that I doubt
20 has any formal definition, but that's what I mean by it
21 and that's what most of my colleagues mean by that.
22 Q. Okay. I didn't get that. Tell me that again?
23 A. It's not -- rescue tocolytics is not something
24 one could look up in a --
25 Q. No. But I -- I didn't get your definition.

1 A. Oh, it's a -- what it means to me, and this is

2 based on my conversations with colleagues and

3 understanding of the literature is, the use of

4 tocolytics to arrest uterine contractions usually for a

5 short period of time. Most often in response to the

6 perception that the uterine activity is not being

7 tolerated by the fetus. In other words, there's usually

8 an -- an abnormality of the fetal heart tracing or you

9 can anticipate that there will be an abnormality to

10 fetal heart rate tracing and you try to stop the

11 contractions for the next few minutes. Whereas

12 tocolysis, in general, is something you might hope to

13 continue for hours or days. It's not me. Is that

14 yours?

15 MS. REID: It's not me.

16 BY MR. BECKER:

17 Q. Doctor, if you need to take a break during the

18 deposition, take a call, feel free to do so.

19 A. It's not me, sorry.

20 MR. MALONE: I swear to God, it's coming from

21 this library. Isn't it?

22 BY MR. BECKER:

23 Q. And the term "therapeutic tocolytics"?

24 A. I don't know what that term would mean. That's

25 the -- not one that I commonly use.

1	Q. Prophylactic tocolytics?	3:36:41PM
2	A. That probably is meant to describe the use of	
3	drugs to prevent contractions before they've actually	
4	occurred.	
5	Q. What is clinical chorioamnionitis?	3:36:54PM
6	A. That's -- clinical chorioamnionitis, an	
7	infection of the membranes inside the uterine cavity	
8	that can be detected by some clinical means. Usually,	
9	meaning, physical examination or observation of the	
10	patient.	3:37:13PM
11	Q. Preterm labor?	
12	A. That's labor before 37 weeks gestation.	
13	Q. And how do you define labor?	
14	A. That's used -- the most common definition is,	
15	regular uterine contractions with progressive cervical	3:37:25PM
16	change.	
17	Q. Can you distinguish, for me, contractions from	
18	uterine irritability?	
19	A. There's no specific way to tell those apart	
20	that I know of. The general way is, people would do it	3:37:49PM
21	is, by how regularly they're occurring. If there is a	
22	distinct, discrete pattern to them and whether they can	
23	be distinguished discretely on a monitor. And often,	
24	you can only tell in retrospect, as they progress. You	
25	have to look at the whole clinical setting to tell if	3:38:06PM

3:39:29 PM

MR. MALONE: Objection. Read that again.

3:39:14 PM

3:38:56 PM

3:38:41 PM

3:38:21 PM

3:38:10 PM

1 it's, like, irritability or breech in contractions, if
2 there is doubt.
3 Q. What is an induction of labor?
4 A. Induction of labor is beginning of labor
5 when -- is giving medication to begin labor when a woman
6 does not have any uterine activity, or has only
7 background normal uterine activity, with the goal of
8 getting her into labor.
9 Q. And how is that to be distinguished from an
10 augmentation of labor?
11 A. If a person -- a woman already has regular
12 uterine contractions, and if you give medication to
13 increase her intensity or frequency, that's augmentation
14 of labor.
15 Q. And it doesn't matter whether one is in latent
16 or active labor for there to be an augmentation --
17 latent phase or active phase?
18 A. It can be used equally in either phase.
19 Q. I want to talk about some medical principals,
20 Doctor, see if we can agree on some things.
21 Can we agree that a patient -- obstetrical
22 patient, has a clear interest in delivering and relaying
23 the most accurate history and best information she can
24 to the obstetrics team?
25 MR. MALONE: Objection. Read that again.

1 BY MR. BECKER: 3:39:30 PM

2 Q. Can we agree that the obstetrical patient has a 3

4 clear interest in delivering and relaying the most 4

5 accurate information in history that she can to her 5

6 obstetrical team? 3:39:42 PM

7 MR. MALONE: Objection. I'm not sure what it 6

8 has to do with anything. But if you understand it, can 7

9 we agree that the patient wants to tell us the best she 8

10 can tell us, I think is the about the size of it. I'm 9

11 not sure what that has to do with anything. 3:39:55 PM

12 THE WITNESS: If I understood you correctly, 11

13 I -- I believe it's in the best interest of the patient 12

14 to relay that information. BY MR. BECKER: 14

15 Q. And have you found that patients generally try 15

16 to give the best history and information they can to the 16

17 obstetrical team? 17

18 MR. MALONE: Well, objection to "try." What 18

19 does that have to do with anything, "try." Doctor's try 19

20 to do the best they can all the time too. Is that -- 3:40:17 PM

21 want to make an agreement on that? 21

22 BY MR. BECKER: 22

23 Q. Can you answer, Doctor? 23

24 A. Generally, I believe they do. 24

25 Q. Okay. Can we agree, Doctor, that on a physical 3:40:24 PM

1 exam or even by ultrasound, it should be readily
2 apparent to an obstetrical caregiver whether or not he's
3 taking of care of 1,000-gram baby versus a 3,000-gram
4 baby?
5 A. Generally, it -- in the aggregate, if someone
6 has a setting where there is a baby normal, near term
7 size, versus one that is 1,000 grams. It would normally
8 be apparent on the clinical exam.
9 Q. Can we agree that one of the factors
10 influencing the success of tocolytics is the gestational
11 age of the fetus?
12 A. No. I don't think that that is known. It's
13 debated, and there may be certain tocolytics that are
14 more effective at some gestational ages.
15 Q. Would the factor of whether or not the mom is
16 truly in labor impact the success of tocolytics?
17 A. If the membranes are intact, then the use of
18 tocolytics in patients who are not truly in labor --
19 it's much more likely to suppress contractions than in
20 those who have established labor whether the membranes
21 are ruptured. There is no data one way or the other.
22 Q. What are the factors or tests available for the
23 obstetrician that he can utilize in a PPRM patient to
24 predict that labor will likely ensue?
25 A. The main tools that you have is your experience

3:42:13PM

3:41:40PM

3:41:19PM

3:40:58PM

3:40:41PM

3:40:29PM

1 in clinical observation. There are not really very many
2 other tools that I know of for the patient who has
3 ruptured membranes to predict which are going to
4 progress in labor, at least that are not commonly
5 applied.
6 Q. There's something about a fibro- -- fetal
7 fibronectin test?
8 A. Yes. But that's only if the membranes are
9 intact. Because if -- if membranes are ruptured, it's
10 always positive, because there is a lot of fibronectin
11 in the amniotic fluid.
12 Q. So that wouldn't apply to PPRM?
13 A. Right.
14 Q. And you did some research on another drug or
15 something. Is that also only when the membranes are
16 intact? I forgot what the question was.
17 A. Yes. A drug that we would use to arrest labor,
18 and if a patient -- if it didn't work, you could say,
19 well, this probably is more substantial labor. That
20 would be a very indirect way of figuring it out. That
21 would only be in -- usually, in intact membranes.
22 Q. Salivary estriol?
23 A. Salivary estriol has never been studied in
24 ruptured membranes. It would be used in cases of intact
25 membranes. It's not currently available clinically.

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1 But if it were available -- it's never been studied in
2 ruptured membranes.

3 Q. So in your clinical experience, when you have a
4 patient, hypothetically, comes in PPRM, what do you
5 look for to give you a sense as to whether or not this
6 patient will -- labor will ensue, and how quickly the
7 labor will progress? What are the factors that you look
8 for?

9 A. If -- if they're rupt- -- many patients who
10 have ruptured membranes have no uterine activity at all

11 or minimal, and those patients have the highest
12 likelihood of remaining without progressing in labor,

13 even though the majority of them do develop contractions
14 within 24 to 48 hours. Some of them will stay pregnant

15 for a long period of time, depending on how far along
16 they're in gestation. And if a patient is having

17 regular uterine activity when they rupture membranes, in
18 my experience, they rarely stay pregnant for a long

19 period of time. Most of them progress to -- to deliver.
20 Q. Within a matter of seven days?

21 A. It depends on other circumstances. But if the
22 patient has regular uterine activity, and has gross

23 ruptured membranes, it depends mostly on the gestational
24 age of the patient as to -- I would say that, if that

25 happens anywhere near term, virtually, all of the

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1 patients will progress to deliver within, you know, a
2 day.
3 Q. 36 weeks, same answer?
4 A. Yes.
5 Q. 34 weeks?
6 A. Same answer. I would take that answer probably
7 back down to 32 weeks or so. If a patient comes on with
8 contractions and ruptured membranes -- regular
9 contractions and ruptured membranes -- before 32 weeks,
10 sometimes -- although, it's relatively infrequent, the
11 contractions will abate with or without tocolysis. No,
12 there's never been a study done where half the patients
13 were given tocolysis and half of them were given a
14 placebo after ruptured membranes with regular
15 contractions to see if tocolysis makes a difference.
16 And the only studies were -- made -- patients with
17 ruptured membranes were included and tocolysis was
18 given, you can't really draw the conclusion that it does
19 anything.
20 So most of us are skeptical that tocolysis does
21 anything in ruptured membranes. Although, sometimes if
22 we think we can limit the harm, we do use it. So -- now
23 I'm going off and forgot what your question was, but --
24 MR. BECKER: Can you help me? I forgot my
25 question as well.

1 THE WITNESS: I must have been rambling for
 2 awhile.
 3 (The previous question was read back.)
 4 BY MR. BECKER:
 5 Q. Oh, I remember, Doctor. I asked you about 36
 6 weeks with PROM, when do you expect delivery and you
 7 said within a day or -- or so. And then you said same
 8 answer to 34 weeks. And you said same answer to 32
 9 weeks; right?
 10 A. Yes.
 11 Q. When we go under 32 weeks, the chances are
 12 increased that you have a greater latency period?
 13 A. That's correct. Most of what's known about
 14 latency period is known from patients who ruptured
 15 membranes before 32 weeks and have -- don't have
 16 contractions when they rupture, or have very infrequent
 17 contractions. And from that, we know that the earlier
 18 in gestation you are, the longer the latent period.
 19 Q. Okay.
 20 A. For those patients who rupture membranes and
 21 have regular contractions, it's far fewer the patients
 22 that stay pregnant. And I don't know exactly what the
 23 number is. I would say that it's a lot less than
 24 50 percent stay pregnant for more than two days, if they
 25 have regular contractions when they come in ruptured.

1	Q. Well, what does regular contractions mean, and	3:47:39PM
2	how is that different than infrequent contractions?	
3	What's a regular contraction?	
4	A. Regular contractions meaning -- means	
5	contractions that looks like they could be labor	3:47:48PM
6	contractions, if they're occurring every three to four	
7	minutes. There isn't really a definition -- a specific	
8	definition of regular contractions. It's the pattern	
9	that looks consistent with labor.	
10	Now, as we already discussed, labor has other	3:48:04PM
11	components to the definition. But everybody who is	
12	going to change their cervix and progress in labor, so	
13	that you can give them that name, has to start	
14	contracting at some point when they haven't yet changed.	
15	So many times you're in the situation of	3:48:21PM
16	saying, does this look like labor, and you have to make	
17	the initial assessment just on the basis of the uterine	
18	contraction pattern. So in the case we're discussing,	
19	the patient had regular uterine activity. That's my	
20	opinion.	3:48:37PM
21	Q. This case has regular uterine --	
22	A. Yes.	
23	Q. -- activity?	
24	A. Yes.	
25	Q. What about the intensity of the contractions in	3:48:42PM

1 this case?

2 A. I think the intensity was listed as one plus or

3 not very strong --

4 Q. Okay.

5 A. -- by the nurses.

6 Q. Is that a marker, whether or not you're having

7 regular contractions, the intensity? Is that a factor

8 to consider?

9 A. It is a factor. If a patient is, you know,

10 very uncomfortable or groaning in pain, then the

11 patient, under those circumstances, is virtually

12 one-hundred percent to likely deliver in a short period

13 of time. If the patient is not very uncomfortable and

14 they're low intensity, sometimes those contractions will

15 abate, and, you know, she could stay pregnant longer,

16 which is relatively infrequent.

17 Q. You write that the only unequivocal effect from

18 tocolytics, from randomized control trials, is a delay

19 in delivery of 48 hours; right?

20 A. Yes.

21 Q. That just means, no question, you're going to

22 get 48 hours with tocolytics?

23 A. No, what that means is -- first of all, that

24 applies only to patients with intact membranes, not with

25 ruptured membranes. But if you -- what it means is, if

1 there is any unequivocal -- if there is any effect, the
 2 only one we know of is that in more patients who receive
 3 a drug than placebo are still pregnant 48 hours later,
 4 if they come in with preterm labor and contractions
 5 within intact membranes.
 6 Q. Are you aware of any literature that stands to
 7 the proposition that: in a PPRM, use of tocolytics
 8 under 32, generally, will buy you at least three or four
 9 days? Are you aware of any literature that stands for
 10 that proposition?
 11 A. I can't say that there is no literature. I can
 12 say that the vast majority of the literature is
 13 supportive that there is no known benefit of tocolysis
 14 with ruptured membranes. Con- -- many conscientious
 15 doc- -- some conscientious doctors never use it. There
 16 are many medical centers in the country that just don't
 17 use tocolysis in ruptured membranes. Some do thinking
 18 that if it has a benefit in intact membranes, it might
 19 have a benefit even in ruptured membranes. If it's not
 20 too risky, let's give it a try. That's the extent of
 21 the logic. But we -- I'm always careful to point out to
 22 the residents, don't tell anybody that you can look it
 23 up; that's it actually going to be beneficial. That's
 24 why you should never administer it if you think it has
 25 any downside.

1 Q. I think we earlier established that there are a
2 number of factors that you look at to determine whether
3 or not this mom is going to go on to actual labor. One
4 is, how frequently there is contractions; two is, the
5 strength of the contractions; correct?
6 A. That would be one factor.
7 Q. Okay. What other factors are there, if any?
8 A. Other factors that -- in general, or in this
9 cases?
10 Q. In general.
11 A. In general --
12 Q. We'll talk about this case, in a moment. In
13 general.
14 A. In general, other evidence of whether it would
15 progress in labor is if there's associated vaginal
16 bleeding. That is not uncommon. And if you have that,
17 then the patient is much more likely to progress.
18 Q. Any other factors?
19 A. Uterine tenderness or fever.
20 Q. Signs of clinical chorio?
21 A. Yes.
22 Q. Any other --
23 A. That would strongly suggest that you're going
24 to progress in labor.
25 Q. Any other factors? Just -- let's talk about

1 all of them that you can think of?

2 A. Others are laboratory tests and so forth, which

3 one would not get back for hours. You know, such as

4 high white blood cell count, evidence of infection and

5 so forth. I think the clinical factors that tell the

6 obstetrician whether somebody is likely to progress in

7 labor are really mostly at your finger tips when the

8 patient first presents, and those are the ones that

9 we've already described.

10 Q. Bleeding, strength of the contractions,

11 frequency of contractions. Have I missed anything?

12 Clinical chorio.

13 A. Signs of clinical chorio.

14 Q. Right.

15 A. Uterine tenderness.

16 Q. Uterine tenderness.

17 A. Yes.

18 Q. We covered it?

19 A. I think that -- I mean, if something else

20 occurs to me I'll let you know. But I think those are

21 most of the things you use clinically to make an

22 assessment. You can do laboratory assessments, you can

23 do amniocentesis and other things to draw amniotic fluid

24 out and do tests on it, but these are infrequently used.

25 So for the vast majority of patients with preterm

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1 premature ruptured membranes, I think those are the

2 tools that you would use.

3 Q. I think we've already agreed to this, but the

4 lower the gestational age the likely greater the latency

5 period?

6 A. In general.

7 Q. In general.

8 A. As I said, most of the information is obtained

9 from people when they contract -- when they rupture

10 membranes, are not in labor, they don't have regular

11 contractions.

12 Q. Can we agree that with PPRM, an accurate

13 diagnosis of PPRM is critical on the management of this

14 patient?

15 A. Yes.

16 Q. Why?

17 A. Well, if a patient does not have ruptured

18 membranes, the natural history of the whole condition is

19 different than if they have ruptured membranes. Just as

20 we are pointing out, tocolytics -- there's reasonable

21 evidence that with intact membranes and the same uterine

22 ac- -- contractions you -- more patients who receive a

23 tocolytic -- some tocolytics -- will still be pregnant

24 in 48 hours than those who receive placebo; we know

25 that. But if you have -- missed the diagnosis and they

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1 really have ruptured membranes, then you don't have a
2 good reason to expect that benefit because you -- it's
3 never been shown.
4 Q. I didn't hear the end.
5 A. It's never -- you don't have a good reason to
6 expect the same benefit if they have ruptured membranes,
7 because it's never been known. So that's just one
8 example of the kind of thinking that is influenced by
9 whether the patient has -- has ruptured membranes or
10 not. You have to -- you have to be able to confirm
11 that.
12 Q. Would you agree with this statement, that an
13 accurate assessment of gestational age and knowledge of
14 maternal, fetal and neonatal risks are essential to
15 appropriate evaluation, counseling and management of a
16 patient with PPRM?
17 A. Yes.
18 Q. Are you familiar with something called an epic
19 system?
20 A. Not by that name.
21 Q. Do you have a computerized record keeping
22 system at county hospital?
23 A. No.
24 Q. Do you have a computerized -- is that the only
25 hospital you have privileges at, county hospital?

1 A. No. I have privileges at a number of hospitals
2 where we consult.
3 Q. Do any of them have computerized charting?
4 A. None of them have computerized charting. Some
5 of them have computerized doctors' orders and so forth.
6 Actually, none of them have computerized charting, at
7 the present time.
8 Q. Do you have an understanding of what the
9 Epic -- Epic System is?
10 A. No.
11 Q. Can Depo-Provera -- if a woman is taking that
12 as a birth control, can that lead to an inaccurate last
13 menstrual period?
14 A. Well, if you're taking Depo-Provera, you may
15 not have any menstrual periods at all. And the -- the
16 time you get pregnant is your first ovulation and you
17 were destined to have a period but you got pregnant on
18 that first ovulation, then there will be no last
19 menstrual period.
20 Q. I was under the impression that Depo-Provera
21 causes women for, at least a short term, the next three
22 or four or six months, to have an irregular period?
23 A. It can. So even though most women have no
24 bleeding, if you have some bleeding and then you get
25 pregnant on one of those early ovulations, as you're

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1 escaping from the Depo-Provera, it could certainly be

2 confusing to figure out the due date from the last

3 menstrual period.

4 Q. Could the amniotic fluid index, as observed

5 through ultrasound, influence how long a PPRM patient

6 will stay pregnant?

7 A. It can give some general -- actually, I don't

8 know that there is any data on that. Most people have

9 the impression that if there is no fluid seen on the

10 ultrasound, you're more likely to deliver sooner than if

11 there is some fluid. That depends somewhat on how far

12 you are from the time of rupture, because the process of

13 the fluid actually leaking out takes, you know, some

14 hours. But there can be some association in chronic

15 ruptured membranes.

16 Q. Now, I want to talk about the duty and

17 responsibilities of the obstetrical caregivers in 2001,

18 or the standard of care by some of the agents of

19 MetroHealth.

20 In 2001 can we -- and in all these questions,

21 so you understand, on standard of care, are directed to

22 what the standard of care was in 2001, understood?

23 A. Yes.

24 Q. Okay. Can we agree that care -- the

25 obstetrical care providers at outlying community

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neighborhood clinics, who are rendering prenatal care, have a duty to keep the prenatal chart, including the ACOG flow sheet current and up to date?

A. I agree with that, in general.

Q. Can we agree that keeping a prenatal chart up to date is critically important when there is a system where the prenatal care -- caregivers are not the ones that deliver, the pregnant mom, so that they're assuming hypothetical in a different site.

A. Yeah, it's true. Yes, I agree to that. That's actually true of almost all practices, even most private practices. Unless, you're a solo practitioner who remembers every patient, the prenatal care record is what the doctor who is in the hospital doing the delivery has to consult for continuity of care. So keeping it up to date, to the extent that's feasible, is an important part of the duty of the obstetrician.

Q. And the reason -- the purpose behind keeping these ACOG flow sheets and prenatal care records up to date is to ensure continuity of care, correct?

A. Yes.

Q. Can we agree that it would be the responsibility of an -- a practicing obstetrician at a prenatal clinic to follow all of that particular clinic's policy and procedure relative to obstetrical

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comes to your notice that other practitioners might want

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something that is material to the patient's care that

judgment of the doctor to do it. But if you have

information signifies is, something that's within the

conclusion is drawn as to what any bit of laboratory

you get other bits of information. So when the

sometimes, draw a conclusion about that until you get --

you, it should be noted in the chart. You can't,

that the dates might not be correct is made available to

A. When the information that makes one suspect

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chart in a timely fashion?

to indicate his perceived discrepancy in dates on the

he's taking care of a patient, he has a responsibility

uncertainty of dates or a discrepancy of dates while

at a community prenatal clinic feels there are

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Q. Okay. Can we agree that an ob- -- obstetrician

I'm not familiar with the term "verbal policy."

A. I don't know -- I wouldn't call that a policy.

there is a practice?

policies, when policies are reduced to writing, that

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clinics have verbal policies and some have written

Q. Right. And you recognize that some prenatal

should follow it.

A. Well, in general, if you have a policy you

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care?

1 to know, it's sim- -- reasonable to put it on the chart.

2 Q. Can we agree that the obstetrician at the

3 prenatal clinic has an independent duty and

4 responsibility at each visit to confirm gestational age?

5 A. To the best of your ability, at that time,

6 given all the information you have, yes.

7 Q. Can we agree an obstetrician taking care of a

8 patient with suspected PROM -- PROM, has a duty -- that

9 it's critically important for them to confirm the PROM

10 itself; correct?

11 MR. MALONE: I'm going to object, because I

12 don't think it's a complete question.

13 MR. BECKER: I'm sorry.

14 MR. MALONE: If it is, I'm confused by it.

15 BY MR. BECKER:

16 Q. I'll start over, Doctor.

17 Can we agree, Doctor, that an obstetrician

18 taking care of a patient with suspected PROM, has an

19 independent duty to confirm the PROM? Do you agree?

20 A. Yes.

21 Q. And there are various ways to confirm PROM;

22 correct?

23 A. Yes.

24 Q. Would you tell me what they are?

25 A. One is by testing the pH of the fluid that's

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1 escaping from the cervix into the vagina. That's
2 so-called Nitrazine testing.
3 Q. Okay.
4 A. Another is by taking a specimen of the fluid
5 that appears to be escaping from the cervix and placing
6 it on a slide to look for a characteristic pattern of
7 drying called --
8 Q. That's the fern test?
9 A. -- called ferning.
10 Q. Okay.
11 A. Another, probably the most common, way is gross
12 rupture of membranes. In other words, the patient --
13 just fluid runs out all over the place. Those are
14 there -- there are other tests available; newer,
15 expensive tests and so forth. But those are still the
16 mainstay of confirming ruptured membranes.
17 Q. And if one still has unconfirmed, then one
18 should proceed to an ultrasound?
19 A. The ultrasound can't confirm ruptured
20 membranes. It can only give you a -- it's an indirect
21 support, one way or the other. For example, if the
22 ultrasound shows less fluid then you would expect, and
23 the patient says, I'm leaking, and you couldn't confirm
24 by the other tests, you'd say, well, it might be true
25 and I just -- my test just didn't pick it up. It's

1 falsely negative.

2 And on the other hand, if it looks normal you

3 could say, then, she probably isn't ruptured. But

4 neither case would be confident that that's absolutely

5 true. It's an indirect, and it's supportive.

6 Q. When do you, as a clinician, proceed to the

7 last step to confirm PPRM, and that is a dye testing?

8 When do you do that?

9 A. Very infrequently. I've done it once in 20

10 years.

11 Q. I have read that the reliability of the fern

12 and the Nitrazine are in the 80- or 90-percent range.

13 Do you agree?

14 A. You know, I -- it's interesting, because those

15 tests are used every day, but I'm not sure that they've

16 ever been subjected -- new tests that are introduced

17 have very detailed studies of sensitivity, specificity

18 predictive value. I'm not sure that ferning and

19 Nitrazine have ever been done in that way. The reason

20 you clinically can use ferning and Nitrazine is, because

21 they have -- you can do them repetitively if you you're

22 not sure. And you also have the ability just to watch

23 the amount of fluid that's coming out.

24 So by various means, you're able to determine,

25 with almost complete certainty, who really has ruptured

1 membranes or not. But sometimes it takes -- you know,
2 we'll say to the resident, go back and do that again if
3 the patient says, I'm leaking out, quickly do an exam.
4 So by repeated applications of the test, you can usually
5 almost figure out if a patient is ruptured or not.
6 Sometimes you do need to do the dye test. As I said, I
7 find that very unusual.
8 Q. You have written, Doctor, that the diagnosis of
9 PPROM is established by the presence of at least two of
10 the three standards of findings of pH greater or equal
11 to seven, a fern pattern of dry fluid, and vaginal
12 pooling of amniotic fluid; correct?
13 A. Yeah. That's what we just said.
14 Q. So unless you have two of the three, then PPROM
15 is never really established?
16 MR. BECKER: Objection.
17 MS. REID: Objection.
18 THE WITNESS: If you have -- if there's fluid
19 running out all of over the bed, that's going to do it.
20 You not going to subject --
21 BY MR. BECKER:
22 Q. Right.
23 A. -- the patient to the others.
24 Q. Right.
25 A. So you know if there's -- there's gross

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1 rupture. But if you're doubtful and you see a little

2 pool of fluid, you'd like to have something else to

3 confirm it. So you need one of those other tests.

4 Q. Okay. Can we agree that the obstetrician of

5 taking care of a patient with suspected PPRM, has an

6 independent duty to confirm gestational age?

7 A. Yes.

8 Q. And what are the means available to confirm

9 gestational age?

10 A. History, when the patient's last menstrual

11 period, the prenatal record showing the size and dates,

12 any prior ultrasounds that are available to you, you can

13 get some idea from -- by doing a scan at the time that

14 you're evaluating the patient, right when they have

15 ruptured membranes. Those are probably the main tools

16 that are available.

17 Q. Same question; the obstetrician taking care of

18 a patient with suspected PPRM has an independent duty

19 to confirm fetal presentation; do you agree?

20 A. Yes.

21 Q. Same question; the obstetrician taking care of

22 a patient with suspected PPRM has an independent duty

23 to confirm an estimated fetal weight?

24 A. I would say that you have to have an idea of

25 the gestational age of the patient. And if the

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1 estimated weight of the patient would make a difference
2 in the management, then a weight determination should be
3 made. On our own service, we like to have an estimated
4 weight on everybody who comes in with ruptured membranes
5 that's thought to be preterm premature ruptured
6 membranes.
7 Q. Why?
8 A. Because we might use it for -- it might change
9 management. In many services, or most services in the
10 country, you can't get an ultrasound for estimated fetal
11 weight when somebody comes in with ruptured membranes.
12 But you have -- you get an estimate of gestational age.
13 If the estimate of fetal weight would change your
14 management, then you should get it. If it doesn't, it's
15 an extra bit of information, so you can tell the baby
16 doctors ahead of time, you know, what you think is
17 coming out and so forth.
18 But the things that you have to know in order
19 to take good care of a patient are: The gestational
20 age, your best estimate of the gestational age, and the
21 position, and, of course, the general well-being based
22 on the monitor tracing and so forth.
23 Q. So when you feel the need to know estimated
24 fetal weight, you utilize ultrasound?
25 A. Yes. You can do it by other means, but if

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confirmation of PPRM, you shouldn't do an exam. You

A. No, I'd say, if you have con -- if you have

shouldn't engage in a digital exam?

Q. Unless you have confirmation of PPRM, you

shouldn't -- you shouldn't do an exam -- a digital exam.

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A. If you have confirmation of PPRM, you

PPRM; correct?

engage in a digital exam until you have confirmation of

Q. In fact, Doctor, you've written, you shouldn't

possible.

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another exam, you would limit the exams to the extent

evidence of distress in labor or some other reason to do

usually necessary at least once. But unless there's

digital examination is sometimes necessary. It's

patient is expected to labor and go on to deliver, then

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A. You try to limit digital examination. If the

digital exams?

taking care of a suspected PPRM, should avoid all

Q. Can we agree that the obstetrical team, when

gestational age of the patient.

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do -- by some means, you have to figure out the

care. It's not done in most hospitals. But you have to

that's how we do it -- it's -- it's not a standard of

examination. So if ultrasound is available -- and

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someone is preterm, ultrasound is better than clinical

1 shouldn't do one once you know that they have preterm

2 premature ruptured membranes. You shouldn't do an exam,

3 unless you're plan is to deliver. I sound like I'm not

4 making myself clear.

5 Q. Yeah. Either that or I -- I'm not hearing you

6 right. So tell me that one more time.

7 A. If you know that somebody has preterm premature

8 ruptured membranes and you're not planning to deliver

9 them, you should not do a digital exam. If you know

10 somebody has preterm premature ruptured membranes and

11 you think that the plan is for delivery, then you may do

12 an exam, and sometimes you need to do an exam, but we

13 generally try to limit the number of exams compared to

14 someone who has intact membranes.

15 Q. Well, have you written, Doctor, that -- that

16 unless PPRM is established, one should not engage in a

17 digital exam; it's only when PPRM has been established

18 that one then can do a digital exam. Have you written

19 that?

20 MR. MALONE: He just said -- I mean --

21 THE WITNESS: No, I wouldn't -- unless it's out

22 of context or something, I -- it would be contrary to my

23 teaching that you should -- unless you've established

24 PPRM, you shouldn't do an exam. Because I would say,

25 don't ever do an exam, even when you have established

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not increase the risk of ruptured membranes.
could. Under normal circumstances, a digital exam does
the membranes are already bulging out, for example, you
studied. It's, I think, unlikely, but it's possible if

4:11:57PM

A. It's -- I don't know that that's ever been
membranes by doing a digital exam?
Q. Can you also increase the risk of ruptured

4:11:47PM

chance of infection the -- rate of infection.
A. Because you increase -- you can increase the
Q. Okay. And why don't you do a digital exam?
digital exam.

4:11:35PM

do an exam, you look at the cervix, but you don't do a
examination to try and confirm it. In other words, you
ruptured, then you should do a sterile speculum
ruptured membranes, but you think they might be
than you asked me. If you're not sure if they have

4:11:24PM

A. Well, now, that's something different, I think,
digital exam?
unconfirmed PPRM, what are the dangers of doing a
Q. Well, what are the dangers -- if you have
BY MR. BECKER:

4:11:12PM

membranes, you should not do an exam.
don't -- and you -- and you think they have ruptured
You hope that the patient is going to stay pregnant,
PPRM, unless you're going to deliver the patient. If

1	Q. Can we agree that one should not -- in taking	4:12:25PM
2	care of a PPRM patient, one should not engage in	
3	amnioinfusion before gestational age is confirmed?	
4	A. You should only engage in amnioinfusion, in a	4:12:42PM
5	patient who has PPRM, if you're planning to deliver	
6	that patient, if -- if you're in the process of	
7	delivering that patient. You can't do amnioinfusion,	
8	otherwise.	
9	Q. Well, is -- is there a recommendation or a rule	4:12:54PM
10	that you don't do amnioinfusion at a certain gestational	
11	age, you only do it over -- past a certain gestational	
12	age?	
13	A. No. I don't know of any limitation like that.	
14	Q. In the prenatal care, can we agree that the	4:13:04PM
15	obstetrical caregiver has a responsibility to note	
16	fundal height?	
17	A. As a general rule.	
18	Q. Can we agree in PPRM, fetal presentation	4:13:49PM
19	should be confirmed prior to the administration of	
20	Pitocin?	
21	A. Yes.	
22	Q. Why?	
23	A. Because if you don't have -- if you don't have	
24	rupture of membranes -- well, because that can affect	4:14:05PM
25	your decision whether to give Pitocin. In other words,	

1 a person -- a patient at the same gestational age, if

2 you think somebody is 34 weeks and two days, or 36 weeks

3 and two days, and you think they have ruptured

4 membranes, you'll give Pitocin. That's a very common

5 practice. That's what we do. That's what many doctors

6 in the country do. If you think that they're not

7 ruptured in the same patient, you wouldn't give Pitocin.

8 Q. Well, what if you have a breech baby and you're

9 dealing with a 30-weeker or a 28-weeker, you don't want

10 to -- at least breech by history -- you don't want to

11 give Pitocin before they confirm fetal presentation, do

12 you?

13 A. I think that's a separate question. But, yes,

14 you don't want to give Pitocin until you know the

15 presentation. You have to know the presentation.

16 Q. All right.

17 Let's -- let's talk about Dr. Charada, in

18 standard of care violations by him -- and I'm just going

19 to talk about deviations here -- can we agree that Dr.

20 Charada failed to keep the prenatal and ACOG flow sheet

21 current and up-to-date, by failing to note the results

22 of Dr. Ashmed's ultrasound?

23 MR. MALONE: Objection.

24 THE WITNESS: I think he noted that the -- the

25 result that he saw on the 26th of July, but he didn't

4:14:08PM

4:14:25PM

4:14:37PM

4:14:51PM

4:15:04PM

4:15:16PM

1 draw any conclusions from it. He simply ordered another
2 ultrasound. I think that was sufficient. He could do
3 more. You could write more, but he didn't draw a
4 conclusion about the result. But he noted that
5 ultrasound result had come through; that he wanted it to
6 be repeated.
7 BY MR. BECKER:
8 Q. He didn't record the result, did he?
9 A. He just recorded a plan, I believe, to have a
10 repeat ultrasound.
11 Q. He didn't record the result, and he had a
12 responsibility to record the result and keep that chart
13 updated, didn't he?
14 A. I -- it depends on what's done with the record.
15 Sometimes the ultrasound results are forwarded to the
16 hospital along with the records. Sometimes the record,
17 just those few pages, are the only thing that are ever
18 forwarded. So I -- in most places, if there is a recent
19 ultrasound, it will be forwarded over with the other
20 records when those are updated, and they're usually
21 updated every few weeks in the third trimester.
22 Q. We've agreed, previously, Doctor, that the
23 prenatal clinic obstetrician has a responsibility, as
24 most -- as reasonably as possible, to keep those -- that
25 chart updated, particularly, because he's not going to

4:16:29PM

4:16:15PM

4:15:59PM

4:15:43PM

4:15:34PM

4:15:21PM

1 be the one to deliver. And we can agree, in this case,
2 Dr. Charada did not complete the form, where -- where
3 it's a place to show the results of the ultrasound, did
4 he?
5 A. Not to the best of my recollection.
6 Q. Okay. And he -- a diligent obstetrician should
7 have completed that; correct?
8 A. He should do that if it's not his presumption
9 that part of the record will also be forwarded for the
10 doctor's perusal on labor and deliver.
11 Q. Okay --
12 A. In other words, if you have new labs or new
13 records, and when the record is sent over, those are
14 going to be forwarded -- the question is, what is the
15 record?
16 Q. And if you doesn't note then --
17 MR. MALONE: Michael, please let him finish his
18 answer. Excuse me.
19 BY MR. BECKER:
20 Q. Go ahead, Doctor.
21 A. But if their practice is to forward only those
22 three pages, ever, and he has no reason to think that
23 that other one is going to be forwarded, then he should
24 note that down there so the doctors can have an updated
25 indication. If he has reason to believe, or he

1 personally, will send over the updated ultrasound

2 report, then he doesn't have the same obligation. He's

3 got to make the updated information available to whoever

4 is going to care for the patient.

5 Q. Fair enough. I want you to assume it's true,

6 that Dr. Charada has testified under oath that he had no

7 idea what was sent over and whatnot; under those

8 circumstances, he should have charted the finding in

9 that prenatal chart; correct?

10 MS. REID: Objection.

11 THE WITNESS: He -- if he -- he needs to

12 make -- he needs to have some understanding that --

13 another person that's going to take care of that patient

14 will have access to that information.

15 BY MR. BECKER:

16 Q. Right. And if he -- and that's the standard of

17 care?

18 A. I believe that's the standard of care, yes.

19 Q. Okay. And assuming that he did not do that,

20 that's a deviation?

21 A. Yeah -- I --

22 MR. MALONE: I'm just going to make an

23 objection.

24 But go ahead; you can answer.

25 THE WITNESS: If the -- when the updating takes

4:17:29PM

4:17:39PM

4:17:51PM

4:18:04PM

4:18:13PM

4:18:20PM

1 place, is -- that's part of a -- in all obstetric
2 practices, there's variation in that. Whether it
3 prints -- in our office, the clinics update the records.
4 After they've been sent over, initially, and somebody
5 has them in labor and delivery, they're updated about
6 every two weeks.
7 So, in this setting, I don't think there would
8 be -- have been any chance for someone to have any new
9 information from Dr. Charada's evaluation of the patient
10 at the time. But when he gets new information, that
11 could affect the patient's care either it -- it has to
12 be some way forwarded in whatever fashion it's
13 customarily done and whatever time frame it's
14 customarily done. And if it's not -- if nobody is going
15 to send that ultrasound report, then they should write
16 it in the prenatal record.
17 BY MR. BECKER:
18 Q. And if he didn't do that, then it's a
19 deviation?
20 A. If he -- if it was not -- I mean, he obviously
21 didn't do it before 7/31, because that's only four days
22 from the day he saw the report. So there's very few
23 practices that would have done that. And that would be
24 in -- just chance if that was whatever their time frame
25 is from the last time he updated it. But -- let's say

4:18:23PM

4:18:34PM

4:18:53PM

4:19:08PM

4:19:15PM

4:19:30PM

1 that was the day he was supposed to send over the
 2 updated records, if he did not note that on the prenatal
 3 record and he did not send the ultrasound, I think that
 4 would be below the standard of care.

Q. Okay. Thank you.

Did Dr. Charada make an independent

determination of gestational age last time he saw the

patient?

A. He noted the gestational age on the chart, what

was his best estimate of the patient's gestational age.

MR. BECKER: You have his chart? You've been

through this so we can hand it back to the doctor?

MR. KULWICKI: Yeah, why?

MR. BECKER: Well, I want to give the doctor

the -- his records back. One second, Doctor?

MR. KULWICKI: You know. Let's go off the

record for one second.

THE VIDEOGRAPHER: We're off the record at

4:20.

(Recess.)

THE VIDEOGRAPHER: We're back on the record at

4:26.

BY MR. BECKER:

Q. Doctor, you understand that the last prenatal

visit that Dr. Charada had this patient, he had already

1 received the ultrasound for the 7/12; correct?

2 A. Yes.

3 Q. And I think we've established that he had a

4 responsibility, either, to note that ultrasound

5 resort -- result in the chart -- chart or to ensure that

6 the ultrasound was going to be sent over to the

7 hospital; correct?

8 A. Yes.

9 Q. Now, did he make a determination of gestational

10 age on the last office prenatal visit? If he did, I --

11 I'm overlooking it.

12 A. No, he didn't -- he didn't note that down.

13 Q. Okay. That's a deviation?

14 A. It could be. It -- I mean, that's not -- I'd

15 have to look at the whole rest of the record and see

16 what else he's noted on here. It can be at -- at any

17 given time in a patient's care that you're not sure how

18 far along they are. So he has a new bit of information

19 on this date, and he's not sure what gestational age she

20 is, and he feels like he needs a confirmatory ultrasound

21 to say.

22 So if you're going to take care of the patient,

23 you have to arrive at a conclusion if she needs an

24 intervention. If she doesn't need an intervention that

25 day, he may not be able to tell. So he doesn't

4:26:39PM

4:26:48PM

4:27:11PM

4:27:26PM

4:27:44PM

4:27:55PM

1 necessarily have to write it down. But a doctor who is
2 going to actually care for the patient, he doesn't
3 foresee that she's going to be in the hospital four days
4 later, has to come to a conclusion, because your
5 decisions depend on the gestational age.
6 So at this point, it appears that he felt he
7 could not confirm the gestational age. He had an
8 ultrasound that conflicted with the last menstrual
9 period, and he wanted to get another ultrasound to
10 decide what gestational age she is. Sometimes people
11 would write here that she's this gestational age or that
12 one, and I'm not sure what she is.
13 Q. But we previously agreed that if he had, in his
14 mind, there was discrepancy between dates, he had to
15 make it clear on that prenatal chart that there is a
16 discrepancy in dates for the subsequent caregivers;
17 correct?
18 A. He should make clear any meaningful information
19 that somebody else would need to take care of the
20 patient. And so he notes that there was -- he doesn't
21 note, specifically, the dates. I believe he noted there
22 that was an ultrasound done and that he requested
23 another ultrasound.
24 Q. Here's my question, doctor: Is it a deviation
25 from him by failing to note the discrepancy in dates --

4:29:03PM

4:28:48PM

4:28:37PM

4:28:24PM

4:28:10PM

4:27:58PM

1 by letting the subsequent caregivers know there's a
2 discrepancy in dates in his mind, is it a deviation of a
3 diligent obstetrician?
4 A. I think it would be best practice to write down
5 all the information that you have from the ultrasound.
6 what he's done here -- let me just make sure that I've
7 seen everything --
8 Q. Take your time.

9 A. -- that what was obtained on that date. There
10 was a progress not page; isn't there?
11 MR. MALONE: Yeah, go to 22. Right there.

12 THE WITNESS: So he's written in his progress
13 notes -- and that's where I was recalling that --
14 ultrasound to be rescheduled 8/20/01. What he's
15 communicating is that, he needs more information to
16 establish the patient's gestational age; that a
17 reasonable person can't be sure what her gestational age
18 is at this time.

19 BY MR. BECKER:

20 Q. Well, that's your interpretation. He's not
21 making it clear to subsequent caregivers of the
22 discrepancy in dates, is he?
23 A. I think a reasonable person who looks at this
24 record has enough information to say, that there's
25 some -- if they get this prenatal -- the progress notes

1 also, that there's some information that needs to be
2 obtained further to establish the patient's date, or
3 there is some uncertainty of the patient's dates. I
4 think it would be best for him to write down, we're not
5 sure about the dates, the ultrasound is different than
6 our preceding dates, and she may be -- she needs a
7 further follow up.
8 Instead what he writes down is -- he doesn't
9 put down the dates, puts down the fundal height, and
10 writes, we need another ultrasound.
11 Q. I want you to tell me what it is about that
12 chart and progress note that tells you that he has a --
13 a concern about a discrepancy of dates?
14 A. He doesn't write down the dates, and he --
15 although, he has previously noted them. And he
16 previously ordered an ultrasound, and he wants a
17 follow-up ultrasound. It is -- it is an inference from
18 that information that he is uncertain about the
19 patient's dates.
20 Q. But he didn't communicate that to a subsequent
21 caregiver, and he had a responsibility to do that.
22 We've agreed on that earlier, correct?
23 A. I think there's enough information here that a
24 responsible caregiver picking up this record could
25 determine that the patient -- that there was some

4:31:43PM

4:31:19PM

4:31:01PM

4:30:46PM

4:30:33PM

4:30:22PM

1 uncertainty about the patient's dates. I think that it

2 could have been made clearer by the doctor.

3 Q. Now, Doctor, do you think that Dr. Lewis knew,

4 by looking at that chart, that Dr. Charada had a

5 discrepancy -- felt, in his mind, there was a

6 discrepancy in dates?

7 A. She couldn't be certain. She'd have to infer

8 that from looking at the record and looking at his note,

9 that he was going to get a follow-up ultrasound.

10 Q. Okay. But the follow-up ultrasound was simply

11 done at the -- at the recommendation of Dr. Ashmed;

12 isn't that true?

13 A. Yes. But also --

14 Q. He's --

15 A. Yeah.

16 Q. Excuse me.

17 A. But that's part -- the reason for the follow-up

18 ultrasound is to confirm the dates; that's one of the

19 reasons.

20 Q. The follow-up ultrasound was relative to the

21 kidney anomaly?

22 A. That's one of the reasons.

23 Q. Okay. No reasonable person can conclude, based

24 on that chart by Dr. Charada, that he had a concern

25 about discrepancy of dates?

1 MS. REID: Objection. He's answered it, like,

2 three times.

3 MR. MALONE: Yeah.

4 THE WITNESS: No, I think a reasonable person

5 could conclude that, it's -- the record is not as clear

6 as it could. And -- but I think a reasonable person

7 could conclude there was some concern about the

8 patient's dates.

9 BY MR. BECKER:

10 Q. Can we agree that a diligent obstetrician

11 should have made it clear, more clear than what you see

12 there and what you're inferring in there, should have

13 made it more clear to a subsequent caregiver that

14 there's a real concern, in his mind, about discrepancy

15 in dates?

16 Hold on a minute, Doctor, because I'm getting

17 tired. I don't remember what my question was.

18 She's going to read it back, okay?

19 (The previous question was read.)

20 BY MR. BECKER:

21 Q. Are you assuming that the progress flow sheet

22 was sent with the ACOG sheet?

23 A. Yes.

24 Q. Okay. If Dr. Charada had no knowledge what

25 documents were sent, can we agree that -- that a

4:35:46PM

4:35:35PM

4:35:25PM

4:35:00PM

4:34:45PM

4:34:34PM

1 diligent obstetrician should have made it more clear
2 than what he did, that there is a discrepancy of dates
3 there? Yes or no?
4 A. If he knows that this is the -- or if he has
5 reason to believe that this is the only information
6 that's going to be conveyed, I think that there is
7 meaningful information that could influence another
8 doctor's care, that's not conveyed on this.
9 Q. That's a yes to my answer (sic)?
10 A. So, yes, I think that other information should
11 have been conveyed. And if he knew that this was all
12 that was going, that would not be adequate.
13 Q. Let's talk about the -- the steps that
14 Dr. Lewis or Razi (phonetic) did to confirm PROM --
15 PPROM. What steps did they utilize?
16 A. Ferning and Nitrazine tests were initially
17 done.
18 Q. They were all negative?
19 A. They were negative.
20 Q. Okay.
21 A. And then, subsequently, the patient ruptured.
22 Q. When did the patient rupture?
23 A. When she -- it says ruptured in triage.
24 Q. What time, if you know?
25 A. I'd have to -- I don't know that you can

1 actually tell that from that --
2 Q. To be fair with you, I don't think it's clear
3 in the record what time -- the exact time the membranes
4 ruptured. Can we agree, at least when the results of
5 the fern in the pooling came back -- the fern, the
6 Nitrazine, the pooling came back, that Dr. Lewis and
7 Dr. Razi, the supervising attending obstetrician, should
8 have had real questions whether or not there was PPRM,
9 at that point, and they came back negative?
10 A. You can't tell when they come back negative.
11 The person could be ruptured and it's negative, or it
12 could and is probably more likely that they're not
13 ruptured if they're both negative. And if -- if the
14 patient has some leaking of fluid, or any history of
15 leaking of fluid, you'll have to confirm that. That's
16 my understanding, that the -- Dr. Lewis's statement is
17 the patient ruptured grossly in the triage area, and
18 there was no question of ruptured membranes. That's the
19 way most ruptured membranes are confirmed.
20 Q. I'm going to take it one step at a time.
21 A. Okay.
22 Q. Because the minutes here, I think, are critical
23 as to what happened in triage and the record is unclear,
24 I think. She's got negative -- she's got a negative
25 fern; she's got a negative Nitrazine. At the moment

4:36:59PM

4:36:48PM

4:36:31PM

4:36:18PM

4:35:58PM

4:35:48PM

4:38:22 PM

25 unit like this, you could have three or four patients a
24 If you have some suspicion -- after all, in a
23 judgment not to do and exam.

4:38:08 PM

22 you're suspicion is very high, then it's probably most
21 membranes and the ferning and pooling are negative, but
20 you -- if you have a very high suspicion of ruptured
19 ruptured, then it's reasonable to do a digital exam. If
18 you made a determination that they're probably not
17 then it's acceptable to do a digital examination. If

4:37:54 PM

16 and Nitrazine and you think that they're not ruptured,
15 THE WITNESS: If you do -- if you do ferning
14 But go ahead on this question.
13 "PPROM" in this hypothetical.

4:37:37 PM

12 MS. REID: I'm going to object to the use of
11 have engaged in a digital exam?
10 PPROM, Dr. Lewis, the obstetrical nurses, should not
9 fluid, until there was reasonable confirmation of the
8 Q. Can we agree, that until there was a gush of

4:37:18 PM

7 they're negative, but that would be unusual.
6 see obvious pooling, and you think I'm not sure why
5 A. You have to have some uncertainty, unless you
4 whether the membranes have ruptured?

4:37:03 PM

3 caregivers had had real doubt or at least uncertainty
2 ruptured yet, can we agree that the obstetrical
1 those are known, assuming that the membranes haven't

4:39:53PM

25 mom carrying 1,000-gram baby versus a mom carrying a
24 difference between a -- in a physical exam, between a
23 obstetrical caregiver should be able to discern the
22 Can we agree that -- we previously agreed that
21 resident -- maybe we didn't say it this way.

4:39:31PM

20 Q. But -- we previously agreed that a -- even a
19 she thought was reasonable.
18 she believed that she arrived at a gestational age that
17 based on that determination, she believed the patient --
16 there was a physical assessment of the patient. And

4:39:08PM

15 had consulted the prenatal record. And she made a --
14 A. Well, she got the patient's history, and she
13 Q. What did she do?

4:38:48PM

12 A. No. She --
11 the administer -- the administration of Pitocin?
10 steps to confirm gestational age and presentation before
9 Can we agree that Dr. Lewis failed to take
8 Q. Okay. Thank you.

4:38:37PM

7 BY MR. BECKER:
6 exam.
5 and pooling a negative, you can do an exam -- a digital
4 don't need to worry about it. So once you have ferning
3 your cervix is closed, and you don't need to -- you
2 Ferning, pooling is negative; you check them, you say
1 night come in, they think they ruptured membranes.

4:38:26PM

4:39:57PM	1	3,000-gram baby?
	2	A. Generally.
	3	Q. Okay. And --
	4	A. But there's a fair -- I -- I agree, generally.
4:40:01PM	5	There's a lot of variation in that. I do ultrasounds
	6	for estimated weight all the time. Many of patients
	7	come in and somebody -- I do a scan on them, I call the
	8	doctor and I say, you thought this baby was 2500 grams,
	9	and it's not. It's 1500 grams or it's 1000 grams, and
4:40:18PM	10	you -- this is significant growth restriction. And
	11	nobody knew it, or they had a -- a suspicion but they
	12	doubted it.
	13	So there's a lot of variation which a
	14	conscientious doctor can determine, just as is evidenced
4:40:24PM	15	by the prenatal record. Dr. Lewis had the prenatal
	16	record, which shows the size of the baby, pretty much
	17	fitting with the gestational age. It's not right on,
	18	but it's not very far off. And this is from
	19	Dr. Charada's assessment.
4:40:39PM	20	So we have more than one doctor, looked at this
	21	patient and thought, this baby looks like it's about
	22	this size. And she goes to the patient and says, what's
	23	last menstrual period? What's your due date? You have
	24	a recent ultrasound examination. This is all part of
4:40:55PM	25	the doctor trying to determine how far along the patient

1 is. And all of these factors combined can give her a
2 reasonable assessment of the patient's age. And I think
3 that Dr. Lewis used all those criteria.
4 Now, if I -- if Dr. Lewis is on my service, I
5 say to her the next day, if you got a patient that's
6 3,000 grams and didn't notice it, what were the factors
7 that went into that? What's the patient's body habitus?
8 Who else has seen the patient? Is there any other
9 explanation for this? Sometimes it happens that we --
10 that's why we don't -- we can't rely, always, on the
11 physical assessment.
12 Q. Right. Sometimes you're dealing with an obese
13 patient, it's difficult to -- to figure out how big a
14 baby you have, but --
15 A. Right. That doesn't apply in this case.
16 Q. Right.
17 A. But sometimes you can't -- you just can't tell,
18 accurately, a person's gestational age by the physical
19 assessment. And that's what we're dealing with here.
20 But that's -- that's something that happens to every
21 obstetrician who takes care of patients.
22 Q. But let's apply it to this case, Doctor. We've
23 got -- we've got a doctor that thought she was taking
24 care of a 36- or 37-weeker with an estimate -- with a
25 suspected estimated weight of -- of 3,000 grams, when

4:43:15PM

physical assessment is not on the money. And you have

encounter in practice. That's -- sometimes, your

thing that reasonable, good obstetricians still

that kind of assessment. But that is a reason -- a

usual? No. More often than not, you're able to make

4:43:03PM

that on a physical assessment. It can happen. Is it

job, tomorrow on my service or I, myself, could miss

But a conscientious physician is doing a good

difference.

could be a little bit more. Still, it's a significant

4:42:50PM

usually, be 2500 grams. Could be a little bit less,

34-and-a-half, 35; the weight between 34 and 36 could,

the average ges -- this baby's actual dates were around

difference is between 3,000 and 1,000. I think the --

THE WITNESS: Yeah. I don't think the

4:42:30PM

But, please, we've got to move along.

Isn't universally so. I'll let him do it one more time.

that -- and then he's given you explanation of why that

you read the transcript. He has said generally, and

answered that particular question about five times, if

4:42:21PM

MR. MALONE: Objection, Mike. I think he's

the difference just on physical exam?

obstetrical caregiver, should have been able to discern

Would you expect that a diligent caregiver --

4:42:03PM

she had a 27-weeker with 1,000 grams.

1 to put it together with the rest of the information you
2 have.

3 One of the most important things that the
4 obstetrician relies on is communicating with the

5 patient. And that's -- you've got to go by their
6 history. And we don't instant access to all

7 information, so the patient's history of her dates and
8 recent ultrasound is important, and that also shapes
9 your assessment of all the other information.

10 BY MR. BECKER:

11 Q. Doctor, with a clinical history of complaining
12 of leaking clear fluid one hour before triage and noted
13 wetness in the undergarments, and negative fern, and
14 negative nitra -- Nitrazine, and negative pooling,
15 would you think more likely than not, that patient is --
16 has not ruptured the membranes yet?

17 A. You just can't tell for sure. They might not
18 have. That could be somebody who is just laboring, and
19 they're having a heavy discharge with their have labor,
20 so you -- you've got to do some kind of assessment of
21 the cervix if the fern and Nitrazine are negative.

22 Q. Can we agree that Dr. Lewis failed to take
23 steps to confirm presentation before the administration
24 of Pitocin?

25 A. I -- my impression was that the presentation

4:43:19PM

4:43:29PM

4:43:43PM

4:43:55PM

4:44:15PM

4:44:28PM

1	was confirmed before that, before the impre-- before	4:44:30PM
2	the administration of Pitocin.	
3	Q. Can I represent to you, that Pitocin was	
4	started at 8:00 o'clock, and they didn't do an	
5	ultrasound for fetal presentation until 10:00 p.m. that	4:44:41PM
6	night. Assuming that to be true; is that a deviation?	
7	MR. MALONE: Well, I'm -- I'm going to object	
8	because that isn't the way presentation was confirmed.	
9	THE WITNESS: Yeah. Physical assessment can be	4:45:00PM
10	used to confirm presentation as well.	
11	BY MR. BECKER:	
12	Q. Do you see anything in the chart, Doctor, in	
13	your review of this case, where presentation was	
14	confirmed prior to the administration of Pitocin?	4:45:23PM
15	MR. MALONE: What time did you say that the	
16	Pitocin was started, Mike, in your question?	
17	MR. BECKER: I think that was 8:00 p.m.	
18	MS. REID: I don't know how accurate that is.	
19	THE WITNESS: 8:30 or so, I believe the --	4:45:41PM
20	MS. REID: I think it's 8:30.	
21	MR. BECKER: Yeah.	
22	THE WITNESS: The physical exam noted times	
23	20:38, and the Pitocin started around the same time.	
24	And my presumption was that, the position of the baby	4:45:49PM
25	was determined prior to the initiation of Pitocin.	

4:46:54PM

4:46:37PM

4:46:27PM

4:46:14PM

4:46:02PM

4:45:50PM

1 BY MR. BECKER:

2 Q. Is the testimony by one doctor in this case,

3 that the reason they did the ultrasound is to confirm

4 the presentation, and that was done at 10:00 o'clock;

5 can we agree, assuming, hypothetically, that the

6 administration of Pitocin prior to the confirmation of

7 presentation is a deviation?

8 A. No. If you believe the patient is vertex, to

9 the best of your ability when you start the Pitocin, and

10 then later on someone says, you know, I'm not sure of

11 the position, let's check it, that -- that happens every

12 day in units. You go back with the ultrasound and they

13 say, yeah, she is vertex, or, no, she's flipped and

14 she's breech, or -- this can happen. So the fact that

15 the ultrasound was done later to confirm it, just means

16 that.

17 Q. Is there somewhere from Dr. Lewis's deposition

18 or somewhere in the chart that you're concluding that

19 she -- she thought this patient was a vertex

20 presentation?

21 A. I don't remember if the question was ever asked

22 of her. It's one of the cardinal points for

23 administering Pitocin; you have to know the person is

24 vertex before giving Pitocin, unless, you're doing a

25 planned breech delivery, which is uncommon. I don't

1 know how often that would have been done here.

2 Q. Doctor, I want you to assume that MetroHealth

3 had a system in play called an "Epic System," at this

4 time, where the results of Dr. Ashmed's ultrasound were

5 entered into this base -- computer base system, and

6 these people in the triage division had access to that

7 diagnostic ultrasound. Can you assume that to be true?

8 MS. REID: Objection.

9 MR. MALONE: Michael, that's absolutely false.

10 Why would you ask him to assume that? Every bit of

11 evidence you gathered to date has been contrary to that,

12 including the deposition of the computer engineer that

13 the designed the system.

14 MR. KULWICKI: That's wrong.

15 MR. MALONE: Well, it's -- it's absolutely not

16 wrong.

17 MR. KULWICKI: It's wrong. He couldn't say one

18 way or the another.

19 MR. MALONE: Yes, he did.

20 MR. KULWICKI: We're still trying to chase that

21 down, so it's not --

22 MR. MALONE: You don't ask -- you ask the

23 questions you want answered. But if you want the truth,

24 you got to answer broader questions. Now, I'm going to

25 let him assume whatever you asked him to assume.

1	MR. BECKER: Okay.	4:47:54PM
2	MR. MALONE: But, Michael, I'm telling you,	
3	that's flat out dead wrong.	
4	MR. BECKER: Well, we need to nail that down.	
5	MR. MALONE: And you heard it from Graham	4:47:58PM
6	Ashmed, you've heard it from everybody who was involved,	
7	including, Judette Lewis. I don't recall if you asked	
8	all those people. But if you didn't, shame on you. But	
9	I believe you did.	
10	MR. BECKER: Okay.	4:48:09PM
11	BY MR. BECKER:	
12	Q. You know the hypothetical. You know what a	
13	hypothetical is.	
14	A. Yeah.	
15	Q. Just -- just assume it's true that they had a	4:48:11PM
16	computerized system at Metro, and the diagnostic testing	
17	was accessible to certain people within the obstetrical	
18	division at the main hospital; assuming that to be true,	
19	okay?	
20	MR. MALONE: Which diagnostic testing, now?	4:48:30PM
21	Just to be specific --	
22	MR. BECKER: Ultra- -- ultrasound.	
23	MR. MALONE: The ultrasound report of	
24	Dr. Ashmed?	
25	MR. BECKER: Right.	4:48:36PM

1 MR. MALONE: And that was accessible to certain

2 people; and who were those certain people?

3 MR. BECKER: Jim, would you let me --

4 MR. MALONE: Well, I mean, you're asking

5 questions that can't be answered because of ambiguities,

6 Michael. And you start of with a premise that isn't

7 true.

8 MR. BECKER: I'm only going to get one

9 opportunity to depose this doctor. I'm going ask him a

10 hypothetical, we'll see what other discovery --

11 MR. MALONE: Well, go ahead. I just -- I can't

12 sit here and let the hypothetical go unchallenged when

13 it's this far wrong.

14 MR. BECKER: Then just enter your objection.

15 MR. MALONE: I did.

16 MR. BECKER: Okay. Can I go?

17 MR. MALONE: Yeah.

18 BY MR. BECKER:

19 Q. Okay. Do you remember my question?

20 MS. REID: No.

21 THE WITNESS: I'm not exactly --

22 MR. BECKER: Want to try it?

23 (The previous question was read.)

24 THE WITNESS: Okay. I'll assume that to be

25 true.

4:51:14PM	1	BY MR. BECKER:
	2	Q. Okay. Now, can we agree that Dr. Lewis should
	3	have utilized, if she was aware of -- and had the means
	4	to make access to this information, should have utilized
4:51:26PM	5	that to look at the results of the ultrasound?
	6	MR. MALONE: Objection.
	7	THE WITNESS: If such a result was available to
	8	her, and she was aware of that, she should have utilized
	9	that, I do believe.
4:51:35PM	10	BY MR. BECKER:
	11	Q. And if she didn't, it would be a deviation?
	12	MR. MALONE: Objection.
	13	THE WITNESS: If she was aware of -- that it
	14	was there and she actually had access to it and she
4:51:43PM	15	didn't use it, that would be deviation from the standard
	16	of care.
	17	BY MR. BECKER:
	18	Q. And even if she didn't have access to it, and
	19	someone else, like a supervisor or the senior attending
4:51:58PM	20	had access to it, she should have been made aware of the
	21	system and the individuals that had access to them;
	22	correct?
	23	MR. MALONE: Objection.
	24	THE WITNESS: If -- if she didn't have access
4:52:08PM	25	to it, but she knew that that result was available -- it

4:53:19 PM

4:53:08 PM

4:53:01 PM

4:52:46 PM

4:52:29 PM

4:52:16 PM

1 depends on -- to some extent on -- on a variable of,
2 such as, how much access? Do you have to call a
3 supervisor in from home with that information? You'd
4 have to have some sense that it was important
5 information. And to -- to that degree, you rely to some
6 extent on -- on the patient. If it's very easily
7 available, and I think that she should get it, if it's
8 readily available.
9 BY MR. BECKER:
10 Q. Either through her or her supervisor in-house,
11 that would be readily available?
12 MR. MALONE: Well, objection. Are you asking
13 if it would be readily available, or if he was obligated
14 if, hypothetically, it had been readily available. It's
15 two different questions.
16 BY MR. BECKER:
17 Q. You understand my question?
18 MR. MALONE: I'm going to ask you to clarify
19 because I don't understand it.
20 Wait for him to ask you another question.
21 BY MR. BECKER:
22 Q. If -- if the -- if she had access herself or if
23 her supervisor in-house had access, then it should have
24 been utilized; correct?
25 MR. MALONE: Objection.

1 Go ahead.

2 THE WITNESS: I think I would just use the term

3 "readily available." Because we couldn't, sitting here,

4 go through all the circumstances that would make it

5 readily available. My main thought is, if there was a

6 system set up to retrieve it after hours, that would

7 mean readily available. So -- but if the supervisor has

8 never heard of it, and you call him and say, I happen to

9 know it's on that computer; can you let me in? Well,

10 what are you doing that -- this could be a significant

11 burden.

12 But if the supervisor knew and there was a -- a

13 more -- a process set up to get those results after

14 hours, then I think one should go and get them.

15 BY MR. BECKER:

16 Q. Okay. Let's go back to Dr. Lewis. What did

17 she do to confirm gestational age besides physical exam?

18 We talked about that.

19 What else did she do to confirm gestational

20 age?

21 A. She took a history from the patient.

22 Q. Okay. What did the history say?

23 A. Well, she determined that the patient had had

24 an ultrasound, and that, to the best of her

25 understanding from talking to the patient, did not

1	change her due date.	4:54:20PM
2	Q. Okay. What -- is that in the chart?	
3	A. That, I believe, mostly I learned from her	
4	deposition.	
5	Q. Okay. Well, you -- did you read her	4:54:27PM
6	deposition?	
7	A. Yes.	
8	Q. Okay. And is there a -- is there a discrepancy	
9	between the two depositions?	
10	MS. REID: Between whose two depositions?	4:54:47PM
11	MR. MALONE: What two depositions?	
12	MR. BECKER: The mom and Dr. Lewis.	
13	MR. MALONE: There's -- they have different	
14	stories between -- you mean, Gloria Maslanka.	
15	MR. BECKER: Yes.	4:54:55PM
16	MR. MALONE: -- and Judette Lewis? I -- I	
17	think we can agree that they have different stories.	
18	THE WITNESS: Yes, I do know --	
19	BY MR. BECKER:	
20	Q. Is there a discrepancy, Doctor?	4:55:01PM
21	A. I did notice a discrepancy.	
22	Q. Okay. And does the chart support the mom's	
23	version?	
24	A. Well, to -- yeah, to some extent it does.	
25	But --	4:55:18PM

4:56:40 PM

4:56:20 PM

4:56:01 PM

4:55:45 PM

4:55:33 PM

4:55:20 PM

25 believe that Gloria Maslanka's recollection of the
24 reflective of the ultrasound. So she had reason to
23 information from Gloria Maslanka that was accurately
22 internally consistent, and she obtained a lot of
21 independent corroboration of that. But her story is,
20 why the doctor speaking with a patient would have
19 A. Well, it wouldn't -- I mean, there's no reason
18 either before or after Shane's birth?
17 version of events, is not corroborated by anyone else,
16 Q. Can we agree that what Lewis -- Dr. Lewis's
15 A. That's correct.
14 of the exchange between Gloria and her is not charted?
13 Q. Can we agree that Dr. Lewis's version of the --
12 her.
11 the dates and Mom said that that's what Dr. Ashmed told
10 A. That; that the baby, in fact, was smaller than
9 mom's version?
8 Q. What is it about the chart that supports the
7 out. So to that extent, it did support it.
6 the baby was smaller, and that's how -- how it did come
5 expected at the time of the ultrasound. And, in fact,
4 Dr. Ashmed had told her that the baby was smaller than
3 recollection of -- of -- I think the mom recalled that
2 A. Well, I don't remember exactly the mom's
1 Q. To what extent does it?

4:57:54PM

reason for a conscientious doctor to ignore any bit of

A. Well, I can't believe -- there would be no

truthful?

opinion as to which version is more accurate or -- or

Q. Okay. I -- I -- are you -- do you have an

4:57:44PM

off on the wrong track.

you the most important bit of information, it sets you

just can't ignore it. And if the patient doesn't tell

of the patient's recollection. You have got to -- you

that -- it places the obstetrician sort of at the mercy

4:57:27PM

some other information, that's an -- an important thing

this and this about it, but, in a way, doesn't remember

misconception. If the patient says, I remember this,

about that ultrasound, then the doctor doesn't have any

So a patient says, I don't remember anything

4:57:12PM

history, what the patient conveys to you.

in the 21st century, relies a lot on the patient's

the change in dates. So this -- the obstetrician, still

convey the most important bit of information, which was

position at the time of the ultrasound, and, yet, didn't

4:56:50PM

baby's kidneys, and she -- a specific detail, the baby's

remembered Dr. Ashmed mentioning a problem with the

A. Because Dr. -- Ms. Maslanka told her that she

Q. Why did she have reason to believe that?

4:56:42PM

ultrasound was accurate.

1	information that the patient tells her about the	4:57:58 PM
2	ultrasound information. So if she said, Dr. Ashmed told	
3	me my baby is very small and my due date is different,	
4	no doctor would want to ignore that information.	
5	Q. So is that a yes to my question, as to which	4:58:10 PM
6	side do you believe?	
7	A. Well, yeah, I guess it is. I think --	
8	Q. Okay.	
9	A. -- that that's the most plausible -- based on	
10	my experience, no obstetrician that I've ever run across	4:58:19 PM
11	would want to just ignore meaningful information that	
12	the patient is conveying to them. On the other hand, it	
13	does happen sometimes that patient remembers some bits	
14	of information and not others, and that's just the best	
15	that people can do sometimes.	4:58:34 PM
16	Q. Do you appreciate, Doctor, at least in Ohio,	
17	that whether whose version is correct or truthful,	
18	that's up to the trier of fact, the jury, and not you;	
19	do you understand that?	
20	MR. MALONE: Well -- well, objection --	4:58:45 PM
21	MS. REID: You just asked him a question.	
22	MR. MALONE: -- you're the one that asked him	
23	the question. I'm not going to ask him that question at	
24	trial. You chose to ask him that question. Now he	
25	gives you an answer; he doesn't need a lecture in the	4:58:49 PM

1	law. Just ask another question, please.	4:58:52PM
2	BY MR. BECKER:	
3	Q. Do -- do -- do you understand the question?	
4	A. Yes, I understand.	
5	Q. Okay. Can we agree, Doctor, at the time of	4:58:57PM
6	admission to L & D, Dr. Lewis dictated a handwritten	
7	admit note to Dr. Evanhouse; she handwrote another note	
8	to Dr. Evanhouse, another resident; correct?	
9	A. I don't recall exactly how Dr. Evanhouse came	
10	to the information that he wrote down in the admit note.	4:59:14PM
11	I know that it reflected part of her assessment and part	
12	of his assessment.	
13	Q. Did you read Dr. Evanhouse's deposition?	
14	A. I don't think I did.	
15	MR. MALONE: Huh-uh.	4:59:28PM
16	BY MR. BECKER:	
17	Q. Do you appreciate that Dr. Evanhouse --	
18	there's -- there's an entry in the chart by Dr. -- a	
19	Dr. Evanhouse; do you appreciate that?	
20	A. Yes.	4:59:43PM
21	Q. Do you acknowledge that Dr. Evanhouse contained	
22	no reference to comments by Gloria about the 7/12/01	
23	ultrasound; you appreciate that?	
24	A. There is nothing in the record about what	
25	Gloria Maslanka said about that 7/12 ultrasound, only	4:59:57PM

1 that it was done, and that the patient had been -- you
2 know, a history had been obtained from her.
3 Q. Did -- in fact, Doctor, the chart says,
4 "7/12/01 ultrasound equals," and there's a blank there;
5 remember that?
6 A. Yes.
7 Q. Now, the fact that it's a blank, what does that
8 connote to you?
9 A. That they expected to get the actual ultrasound
10 result by looking at the prenatal records, or by some
11 other means, or perhaps fill it in in the morning when
12 it was possible to go over and obtain it. They were
13 going to put it in -- put the information in later. In
14 other words, it could be important.
15 Q. Okay. Could be important, and it's unknown --
16 unknown at the time that ultrasound or that history is
17 taken?
18 A. Yes, it is unknown. The only thing they know
19 about it is what the patient herself is able to
20 communicated to them about it.
21 Q. Doctor, have you ever had a patient, and a
22 resident of yours end up -- first of all, was this an
23 induction or augmentation, in this case? In this case?
24 A. In my opinion, it was augmentation.
25 Q. Okay. Have you ever had an augmentation of

5:00:02 PM
5:00:17 PM
5:00:30 PM
5:00:41 PM
5:00:58 PM
5:01:22 PM

1 labor in a presumed, 36-weeker by one of your residents,
2 and it turned out to be a 27-weeker? Has that ever
3 happened to you?
4 MR. MALONE: Objection.
5 THE WITNESS: I can't recall if that has
6 happened. It's -- it has happened before that someone
7 who was presumed to be further along, 35, 36, 37 weeks,
8 was much less far along, and it's determined only after
9 the baby comes out. That happens from time to time --
10 BY MR. BECKER:
11 Q. Okay.
12 A. -- through a series of events.
13 BY MR. MALONE:
14 Q. Okay. Doctor, there was a -- a Dr. Goodwin
15 that called Dr. Lewis after the delivery. Are you aware
16 of that?
17 A. I heard -- I saw Dr. Lewis's deposition that
18 that was how she learned that the baby, actually, was of
19 lower gestational age.
20 Q. Okay. And would you expect Dr. Lewis, in that
21 phone conversation, when she receives a call from the
22 delivering physician and say this baby is not as big as
23 you think it is, we've got a very premature baby, would
24 you expect that -- Dr. Lewis to say to Dr. Goodwin, boy,
25 she told me the ultrasound is consistent with the age?

5:02:00PM

5:02:16PM

5:02:29PM

5:01:53PM

5:01:37PM

5:01:25PM

5:02:35PM
5:02:39PM
5:02:52PM
5:02:57PM
5:03:01PM
5:03:15PM

1 MR. MALONE: Objection. We're getting into --
2 BY MR. BECKER:
3 Q. Wouldn't you expect her to do it?
4 MR. MALONE: No. We're not going -- I mean,
5 that's pretty speculative, isn't it? She might have
6 first said, gee wiz, I'm really sorry that happened, or
7 gee wiz, what a tragedy; or gee wiz, she missed -- I
8 mean, there is a million things she could have -- who
9 the hell knows what she was going to say, Michael? Come
10 on.
11 BY MR. BECKER:
12 Q. Would -- wouldn't you have expected that?
13 MR. MALONE: Don't answer that. It's silly.
14 BY MR. BECKER:
15 Q. Do you think --
16 A. I -- I don't know what she would have said.
17 Q. Okay.
18 A. She could have said any number of things. It's
19 inappropriate --
20 Q. Okay. Let me ask you this one, Doctor: Would
21 you have expected a case where you end up augmenting
22 labor on a 27-weeker thinking it's a 36-weeker, would
23 you expect that case to be discussed in peer review, or
24 M and M?
25 MS. REID: Objection.

5:03:15PM	1	MR. MALONE: Objection. That one shall not be
	2	answered. What they do or don't do is absolutely
	3	privileged by statutes in Ohio. Sorry.
	4	MR. BECKER: No. I'm sorry, sir, because I
5:03:22PM	5	think that's a very relevant --
	6	MR. MALONE: Then we disagree.
	7	MR. BECKER: Okay.
	8	MR. MALONE: What do you want to do?
	9	MR. BECKER: You going to direct him not to
5:03:27PM	10	answer?
	11	MR. MALONE: I just did.
	12	BY MR. BECKER:
	13	Q. Is he your counsel, Doctor?
	14	MR. MALONE: No. But I retained him for
5:03:33PM	15	purposes of this case.
	16	BY MR. BECKER:
	17	Q. Doctor, can we agree that sometimes on
	18	documentation in -- in a chart can be so egregious, that
	19	it reflects substandard medical practice?
5:04:03PM	20	A. Yeah. I think there are settings like that,
	21	Yes.
	22	Q. Dr. Razi had a responsibility to oversee this
	23	patient; correct?
	24	A. He was the supervising physician.
5:04:15PM	25	Q. He had a responsibility to make sure that --

5:05:51PM

5:05:31PM

5:05:12PM

5:04:47PM

5:04:28PM

5:04:18PM

1 that this junior resident did a good job assessing
2 gestational age?
3 A. He's responsible for all of the care provided
4 by the residents while he's the supervisor.
5 Q. Do you think Dr. Razi did a good job overseeing
6 and ensuring that Dr. Lewis did a good job assessing
7 gestational age in this case?
8 A. I think within the confines of how
9 supervisor -- how a supervisor works, I think that
10 Dr. Razi acted within the reasonable standard of care.
11 Q. Can we agree, that Dr. Lewis failed to
12 appreciate 1,000-gram estimated fetal weight, either by
13 physical exam or ultrasound?
14 A. She failed to appreciate the fact that the baby
15 was much smaller than was suspected -- thought to be by
16 gestational age; I agree with that.
17 Q. If -- if -- if the system that Metro was set up
18 that the ultrasound of Dr. Ashmed was supposed to be
19 sent over to L & D, and for some reason someone dropped
20 the ball and it didn't happen, can we agree that it's a
21 system's ailure (sic) -- system's failure by -- by that
22 ultrasound of Dr. Ashmed not getting to L & D?
23 A. If there was a system set up that said, you
24 know, when ultrasound is completed it's supposed to go
25 to labor and delivery and to the clinic, and that was

1 the preestablished system, and it wasn't done, then
2 that -- that was a failure to comply with one's own
3 system.
4 Q. Okay. And that would be a deviation, if that's
5 the way the system was set up?
6 A. No. I -- I -- I think that that -- because you
7 could have a system set up that's way above any standard
8 of care. Most ultrasounds performed in prenatal care in
9 2001, and probably still today, go only to the doctor
10 who is providing the care for the patient at that time.
11 They do not go straight to labor and delivery. So the
12 fact that someone might have a system that's set up that
13 was -- was allowed -- able to do that, doesn't mean, by
14 itself, that they've established a new standard of care
15 for themselves. I think -- conveying the results to the
16 person that's providing the care at that time is the
17 standard of care. And, then, from that record, all the
18 information is collected, and it's conveyed to labor and
19 delivery, as we previously have gone over.
20 Q. Doctor, you have written -- in fact, you've
21 quoted Fanaroff in an article, by talking about the
22 morbidity of 1,000-gram infants in your new book. And
23 you state that, roughly, 10 percent -- 11 percent of
24 those between 1,000 and 1500 grams end up with
25 neurologic compromise; correct?

5:07:09 PM

5:06:49 PM

5:06:32 PM

5:06:18 PM

5:06:08 PM

5:05:51 PM

5:08:38PM

5:08:29PM

5:08:16PM

5:08:04PM

5:07:25PM

5:07:11PM

1 A. Approximately.

2 Q. And that means, assuming good obstetrical and

3 neonatal care 1,000 grams to 1500-gram babies, nine

4 times out of ten, they avoid neurologic injury; correct?

5 A. Yes.

6 Q. Now, I want you to assume this true, Doctor,

7 that Dr. Lewis has testified, that had she known that

8 the gestational age was reassigned, that the ultrasound

9 reflected a much smaller baby, she would not have

10 administered Pitocin. Can you assume that to be true?

11 A. Yes.

12 Q. In fact, that would be the standard of care?

13 A. Yes.

14 Q. You certainly don't engage in augmentation or

15 induction of labor at a -- when you have PPRM at a

16 27- or 28-weeker; correct?

17 A. Correct.

18 Q. You engage in what's called "expectant

19 management;" correct?

20 A. Unless there's evidence of infection or fetal

21 compromise or some other reason to think that you need

22 to deliver the baby.

23 Q. Right. In this case, we can agree, Doctor,

24 there was no evidence of clinical chorio when the mom

25 presented?

5:09:45PM

25 phrasing it because you're saying no evidence. But I
24 A. Well, I'm just taking issue with the way you're

5:09:29PM

23 mom came in?
22 clinical chorioamnionitis, by that definition, when the
21 foul-smelling amniotic fluid; there was no evidence of
20 Maternal fever, fetal tachycardia, a tender uterus,
19 clinical chorioamnionitis, which by definition is:
18 Q. Okay. But you're -- I'm asking you about

5:09:15PM

17 said, this is very concerning for infection.
16 infection, or I think it's very likely. I would have
15 would not feel confident in saying, I'm sure you have an
14 didn't have fever, she didn't have tenderness, so I

5:09:04PM

13 regular contractions have infection going on. She
12 come in with preterm premature ruptured membranes and
11 As a matter of fact, probably most people who
10 certainly evidence.

5:08:49PM

9 you asked me if there was no evidence. There was
8 clinical chorioamnionitis. So that's a -- you said --
7 contractions; that's very commonly associated with
6 came in, and ruptured membranes, and had regular
5 diagnosis of clinical chorioamnionitis. But the mother

5:08:39PM

4 A. I don't think you could have made a definite
3 subclinical chorio. I'm talking about clinical chorio.
2 Q. Clinical chorio. I'm not talking about
1 A. Well, no, I wouldn't agree with that.

1 would not -- one could not make a definitive diagnosis
 2 of clinical chorioamnionitis, but I wouldn't say that
 3 there is no evidence. Ruptured membranes and -- if you
 4 take the universe of pregnant women who are at this
 5 gestational age, let's say 27 weeks, and you take people
 6 who rupture their membranes and have regular
 7 contractions, they're about a thousand more times likely
 8 to have chorioamnionitis than the lady who's in the
 9 clinic at 27 weeks. That's the reason that most people
 10 rupture membranes and have contractions.
 11 Now, is that going to be enough for me to say,
 12 I'm so sure you're infected, that I need to induce your
 13 labor? No. I think you -- you wait -- you would want
 14 to also have fever or tenderness or a foul-smelling
 15 amniotic fluid to go ahead and do the next step. But
 16 you're strongly suspicious of the infection. In other
 17 words, there is some evidence. But can you make a
 18 definitive diagnosis of clinical chorioamnionitis based
 19 on the way she presented it? No, I agree you cannot.
 20 Q. So when you have a -- a 28-weeker and you
 21 manage -- you're -- with PPRM, and you were managing
 22 with -- expectantly, you manage with tocolytics,
 23 broad-spectrum antibiotics and corticosteroids; correct?
 24 A. We measure -- corticosteroids, broad-spectrum
 25 antibiotics and sometimes with tocolytics. It depends

1 on the circumstances. We may or may not use them.

2 Q. Okay. If you know that the gestational age is

3 under 30 week -- 30 weeks, you generally manage with

4 tocolytics; correct?

5 A. We do. A lot of the conscientious doctors

6 don't. It's -- there is no standard of care in that

7 regard, but we do.

8 Q. Well -- well, the -- okay. So if you were

9 managing this mom and you appreciated the true

10 gestational age, you, Dr. Goodwin, would have --

11 broad-spectrum antibiotics, tocolytics and

12 corticosteroids; correct?

13 A. I probably would have used those three.

14 Q. Okay. And tell me why you would use those

15 three? Take each one of those, and tell me why you

16 would -- why would you use that drug? Why would you do

17 that? Why would you do that?

18 A. The tocolysis is in hopes of delaying delivery.

19 Q. Okay.

20 A. Fully aware that there is no scientific

21 evidence that it -- that it works, but -- but it might

22 work and it should, probably, not be harmful, unless you

23 wait too long after infection is established. The

24 antibiotics is in hopes of prolonging the latent phase,

25 the time to delivery.

Q. And -- and that's been established by studies?
A. But not in a patient like this, because a patient who came in contracting after ruptured membranes didn't get into those studies. They had to be labor. with preterm premature ruptured membranes not in labor. That's how you get into that -- those studies.
Q. Okay. You're not aware of any studies that deal with -- with that, with a PPRM that's contracting and that is not in labor?
A. I don't say that there's no studies. But I'm saying that the large studies that have been done, the -- the NIH, Maternal Fetal Network -- Medicine Network study, the Oracle study, in British commonwealth country, patients who were almost, exclusively, not in labor; preterm premature ruptured membranes. But we say it may be, if the antibiotics are safe, it could be that it will also help in these patients. We don't know.
As a matter of fact, we -- we're -- people are almost certain that it would be less beneficial, but it might be beneficial. And even if the baby delivers, it could help with decreasing the chance of infection in the baby, so there is no reason not to give them. So we -- I would give them in this case.
And the steroids, I would give in the hopes that it's going to reduce respiratory distress. It

5:13:32PM

5:13:19PM

5:13:03PM

5:12:50PM

5:12:34PM

5:12:24PM

5:14:33PM

And the other problem is, that you can only

they're contracting before the cervix is changing.

actually is in labor has to have a period of time where
said, when I told you that definition, every patient who
changes is -- is the definition of labor. But as I

5:14:21PM

THE WITNESS: Yeah. Progressive cervical

MR. MALONE: Let him finish his answer, please.

Q. You said progressive --

change.

I said, the definition of labor involves cervical

5:14:09PM

A. Well, she had regular uterine contractions. As

Q. By your definition?

A. No.

she came in, she wasn't in labor; correct?

Q. We can establish in this case, this mom, when

5:14:01PM

does.

not been -- it's not been demonstrated, but we hope it
benefit in ruptured membranes, so we hope it does. It's

long enough, that it shouldn't be able to have some

why if the pregnancy -- if the patient stays pregnant

5:13:47PM

benefits in intact membranes, and there's no real reason

those benefits. But it has the membranes -- has the

know. It's not proven in ruptured membranes that it has

is -- is conflicting on that. That's as much as we

5:13:35PM

might reduce intraventricular hemorrhage. The data

1 know the definition after it's happening, because you

2 have to do a couple of exams some hours apart to know

3 for sure. So in the -- in many practical settings, you

4 have to look at the entire clinical setting and make a

5 decision, do you think this is labor or not.

6 BY MR. BECKER:

7 Q. Okay.

8 A. My assessment looking at this patient --

9 looking at the fetal heart rate tracing and the

10 contraction tracing, is that the way she presented with

11 a gush of fluid and the contractions like she had, that

12 she was actually in labor. Reasonable people could

13 disagree on that. That's my assessment, if I'm at the

14 bedside caring her in this setting.

15 THE VIDEOGRAPHER: Two minutes of tape left.

16 MR. MALONE: We'll change the tape deck. We'll

17 go into more questions as soon as the tape is changed.

18 THE VIDEOGRAPHER: We're off the record at

19 5:15. This is the end of Tape No. 1, of Dr. Goodwin's

20 deposition.

21 (Recess.)

22 THE VIDEOGRAPHER: We're back on the record at

23 5:24. This is the start of Tape No. 2 of Dr. Goodwin's

24 deposition.

25 ///

5:25:53PM

5:25:39PM

5:25:23PM

5:25:12PM

5:24:59PM

5:24:48PM

1 BY MR. BECKER:

2 Q. Doctor, have you ever heard the phrase, when

3 you see on a standing order for admitted L & D patient,

4 "labor precautions"?

5 A. Yes.

6 Q. What does that mean?

7 A. Well, that's usually used on -- when you're

8 discharging someone from L & D. You're telling them

9 what to watch out for so they know when to return when

10 they're in labor.

11 Q. If you were actually planning on inducing or

12 augmenting the patient, you wouldn't use that phrase

13 "labor precautions," would you? it wouldn't make sense?

14 A. I'm -- I'm just not familiar with using it on

15 admission to the hospital. We don't usually include

16 that as one of our standard things to do.

17 Q. You're assuming that there is a gush of fluid,

18 in this case?

19 A. Yes.

20 Q. What's the basis for that?

21 A. It's --

22 Q. Is it charted?

23 A. No, it's not charted. It was either in

24 deposition or interrogatory or some -- some response

25 that -- I saw somewhere, Dr. Lewis, relate that. I

5:27:04PM

whether -- how far the cervix is dilated, that would be

5:26:52PM

the main factors that we look at these days are,

A. A lady without PPRM, I would look at the --

deliver or not?

look at as to whether the lady without PPRM is going to

Q. What are the -- again, what are the factors you

in six hours and some are going to deliver in six weeks.

depends on -- you know, some people are going to deliver

is and so forth. It can be successful, but it all

underlying the labor and, you know, how far dilated she

5:26:30PM

A. -- the outcome depends entirely what's

Q. Yeah.

A. -- and she's in labor --

Q. Right.

doesn't have ruptured membranes and she's 28 weeks --

5:26:25PM

A. If the patient has ruptured membranes --

Q. Is it successful?

BY MR. BECKER:

MR. KULWICKI: And what's the likely outcome?

Q. Okay.

5:26:16PM

A. Steroids and tocolytics.

at 28 weeks, what's the standard of care? Tocolytics?

membranes had not ruptured and the patient had labored

Q. Okay. If -- if the patient -- if their mem--

5:26:00PM

believe that there was a gush of fluid that came out.

1 one factor. Another would be the length of the cervix,
2 usually by ultrasound or fetal fibronectin testing.
3 Those would be the main tools that one would have to
4 tell you if the patient is likely to stay pregnant for a
5 long period of time or a short period of time.
6 Q. Okay. Now, with the PPRM, same tools? Same
7 factors?
8 A. We discussed this a little bit right at the
9 very beginning. You can't use the fibronectin, and you
10 can't use the transvaginal ultrasound. You can't really
11 use, even, cervical dilatation, because sometimes the
12 person who is dilated by the bag, when they rupture
13 membranes, the cervix then collapses. You don't really
14 even want to do an exam. You just look at the cervix.
15 And if you look at it and it appears closed, it doesn't
16 have the same predictive value in somebody who has
17 rupture of membranes.
18 So we are not nearly as good at trying to
19 predict who -- who has ruptured membranes, is going to
20 be pregnant the next day or the next two days. That's
21 something that we are -- don't have nearly the tools
22 that we have for people who have intact membranes.
23 Q. And -- and the standard of care, where the
24 PPRM, but no prenatal -- no labor is, we agreed
25 tocolytics, broad-spectrum antibiotics and corti- --

5:28:26PM

5:28:07PM

5:27:53PM

5:27:39PM

5:27:26PM

5:27:09PM

1 corti- -- corticosteroids in a 28-weeker; correct?

2 A. If it's a 28-weeker -- I wouldn't say

3 tocolytics are a standard of care, but they're commonly
4 used. We use them, but they're not standard of care.

5 Good doctors around the country don't use them. But

6 tocolytic -- or antibiotics is a standard of care. I

7 think that steroids, it's very commonly used, and I

8 think it should be considered a standard of care, yeah.

9 Q. So with -- hypothetically, if this patient was

10 not in labor and she's got PPRM at 28 weeks, is it

11 likely that you're going to be able to buy at least

12 seven days to ten days of additional latency period?

13 MR. MALONE: Hypothetically.

14 THE WITNESS: I'd have to look up the exact

15 data on that. Of all patients who come in with preterm

16 premature ruptured membranes at 28 weeks, who are not in

17 labor, I -- I just don't remember offhand if they're

18 more likely than not to be pregnant a week later. I

19 really don't honestly remember that.

20 My sense is that it's -- it -- it might be near

21 that number, nearly 50 percent. I really -- I'd have to

22 look up the data on that. The further along that you're

23 in gestation, the less likely you are to be pregnant a

24 week later when your membranes rupture. I -- I just

25 don't remember what the data is at 24, 25, 26, 27, --8,

5:30:18 PM

5:30:05 PM

5:29:44 PM

5:29:20 PM

5:28:41 PM

5:28:30 PM

5:31:44PM

5:31:29PM

5:31:00PM

5:30:41PM

5:30:30PM

5:30:20PM

1 weeks, exactly.
2 BY MR. BECKER:
3 Q. You don't know, in this case, had they not
4 given -- you can't rule out that, had they not "pitted"
5 this lady and simply given her an IV bolus, you would
6 have reduced the uterine irritability, and she could
7 have gone on for weeks? You can't rule that out, can
8 you?
9 A. No. I can't rule that out. It could be
10 possible. I don't think it's likely, but it's possible.
11 Q. Now, you keep saying this lady was in labor.
12 You define labor as progressive cervical change. I want
13 you to look at the strips up -- and if I'm wrong, I
14 stand corrected. But it's my belief that "pit" was
15 started around 8:00 p.m. I want you to look at the
16 strips until mom comes, until the Pitocin is started,
17 and I want to you comment on frequency, the strength of
18 those contractions.
19 A. Well, the monitor tracing that I have begins
20 at --
21 Q. Tell me what panel number you have. That might
22 be easier, if you do have a panel number there, Doctor.
23 MR. MALONE: Page number one, right here.
24 THE WITNESS: Okay. Yeah, it's -- actually
25 just says page number one. Funny it doesn't actually

5:32:33PM

5:32:25PM

5:32:12PM

5:32:03PM

5:31:53PM

5:31:49PM

1 have a.

2 MR. MALONE: There's the time on it.

3 THE WITNESS: -- panel number. 18:12.

4 BY MR. BECKER:

5 Q. Okay.

6 MR. KULWICKI: 18:12?

7 BY MR. BECKER:

8 Q. That's -- 18:12, is like --

9 A. 6:00 --

10 Q. -- 6:12 p.m.?

11 A. Yes.

12 Q. Okay. So tell me when you see her first

13 contraction?

14 A. Well, there is no contraction tracing at all

15 through -- up to -- through 19:10, there's -- the

16 contraction monitor just isn't picking up any -- it's

17 not monitoring. I'm not even sure if it would have been

18 attached at that time.

19 Q. Okay. Well, wait a minute. I want to make

20 sure that we establish it, from 16:12 one 17:10 --

21 MR. KULWICKI: 18:12.

22 THE WITNESS: 18:12 -- 6:12 p.m.

23 MR. MALONE: 18:12 is 6:12 p.m.

24 THE WITNESS: Yeah.

25 ///

1	BY MR. BECKER:	5:32:34PM
2	Q. I'm sorry. From 6:12 p.m. until -- did you say	
3	7:10 p.m., there's no contractions?	
4	A. It's not -- the monitor isn't on.	
5	Q. Well, there's no contractions recorded on the	5:32:45PM
6	monitor; correct?	
7	A. I -- let's -- this is -- it's not even -- it's	
8	probably sitting on the bed. It's not attached to the	
9	patient or something or she's moving around.	
10	Q. So we've got no documented contractions by	5:32:56PM
11	fetal monitoring, correct, between 6:12 and 7:10 p.m.?	
12	correct?	
13	A. I would say you have no attempt to monitor.	
14	Q. No evidence of contractions, right, on the --	
15	A. No. I mean, it's different. It sounds like --	5:33:09PM
16	no evidence sounds like someone was trying to monitor,	
17	and wasn't getting it. I'm saying that the monitor	
18	wasn't on.	
19	Q. Okay. What is the -- what is the -- the	
20	notes --	5:33:19PM
21	MR. BECKER: You want to take that, Doctor?	
22	THE WITNESS: I apologize, one second.	
23	MR. BECKER: That's okay. We'll go off the	
24	record.	
25	THE VIDEOGRAPHER: We're off the record at	5:33:31PM

1	5:33 p.m.	
2	(Recess.)	
3	THE VIDEOGRAPHER: We're back on the record at	5:35.
4		BY MR. BECKER:
5		Q. Okay. Doctor, you have the chart in front of
6		you. Feel free to utilize, not only the strips, but the
7		clinical chart, the nurses notes as well, in answering
8		some of these questions. It's not a memory contest.
9		Between 6:12 and 7:10, how were the
10		contractions described in the chart by the caregivers,
11		whether nurses or obstetricians?
12		A. I'd have to look at the nurses notes to see
13		that.
14		MR. MALONE: Back here. You got to sort of
15		pull that out, but that black line -- that's a flow
16		sheet.
17		THE WITNESS: I don't know that I have notes in
18		that time frame. I'm just trying to find them. The
19		nurses notes that I'm seeing relate to a time around
20		8:00 o'clock.
21		BY MR. BECKER:
22		Q. Okay. Let's -- let's go to the -- let's go to
23		the strips from 7:10 until 8:25 or 8:30. Tell me how
24		you interpret the strips; tell me how often there are
25		

5:38:25PM

5:38:16PM

5:37:58PM

5:37:31PM

5:37:01PM

5:36:50PM

1 contractions; the frequency of the contractions; the
2 intensity of the contractions.
3 A. From -- the contraction tracing that I can
4 interpret, looks to me where it began, is at 19:15.
5 That's 7:15 p.m. And in the first ten minutes, you
6 can't tell exactly how often she's contracting. The
7 contractions, you can see on there, might be two or
8 three in ten minutes, and the next ten minutes it
9 appears that she has three or four contractions in a
10 ten-minute period. That's -- I'm looking at ending at
11 19:31 beginning at 19:20.
12 And the next period from 19:31 to 19:41, it's
13 hard to discern contractions. There might be one or
14 two. This is -- the tracing below the base line, so
15 this happens when the patient moves or something. It's
16 hard to interpret that. 19:41 to 19:51, there's three
17 contractions.
18 MR. KULWICKI: Three?
19 THE WITNESS: Yeah. That's what I see, three
20 contractions. 19:41 to 19:51, there's three
21 contractions.
22 BY MR. BECKER:
23 Q. What -- what is the increase in the -- in
24 the -- the pressure?
25 A. Well, this is an indirect measure of pressure,

1 so it's, strictly speaking, not a direct pressure
2 measurement, but it's a ten millimeter of mercury rise
3 or so from baseline. That's 10 to 20, and the two
4 contractions at 19:45 and at 19:46, and at 19:49, and
5 there's contractions -- the -- the amount of rise is
6 very loosely related to the intensity of contractions,
7 because this is not a direct pressure catheter
8 measurement, so --
9 Q. It's not an IUPC?
10 A. Right. So depending on the contour of the
11 patient's abdomen, the placement of the transducer and
12 so forth, you may get a nice big rise or you might get a
13 lessor of a rise. There is a general association with
14 the intensity of the contractions, but it's -- it's by
15 no means one to one.
16 After 19:51, the contractions occur about every
17 two to three minutes. And allowing for -- for variation
18 in the monitor, there are periods where you -- you can't
19 really discern them. And there's periods where they're
20 quite clearly discern -- discerned. And this is
21 characteristic of patients who have -- who are being
22 monitored in early labor.
23 We've monitored hundreds of
24 patients in trials of preterm labor drugs, and this is
25 what one sees. If you look at 21:25, for example, this

5:40:00PM

5:39:45PM

5:39:17PM

5:39:02PM

5:38:47PM

5:38:27PM

1 is what happens when someone just readjusts the monitor,
2 and suddenly what were not that clear of contractions
3 are more clear. And it's not that something magical
4 happened between 21:24 and 21:25. It's just the
5 placement of the -- the uterine contraction monitor or
6 the --
7 Q. But I don't want to get into when Pitocin is on
8 board.
9 A. Yeah, I understand. But I'm just pointing out
10 that you can't -- there's a long time period here when
11 Pitocin is on, you -- you don't see anything. Pitocin
12 is not diminishing the contractions. The contractions
13 were actually going on just the hour before. It's just
14 that you can't monitor them.
15 Q. So how would you characterize the -- the
16 contractions between 7:10 and 8 -- 8:30? Would you say
17 that they are regular, irregular, mild?
18 A. They're regular contractions. They're -- I
19 think the nurses indicate that they're one plus. This
20 is the way many patients present in preterm labor.
21 Q. In one plus, and --
22 A. Out of three.
23 Q. -- out of three. And -- and certainly, you've
24 had many patients, Doctor, that have been presented with
25 strips like this, where you've given them, either, IV

5:41:28 PM

5:41:17 PM

5:40:59 PM

5:40:41 PM

5:40:29 PM

5:40:07 PM

1	fluids or tocolytics, and -- and they have	5:41:32PM
2	not delivered within 24, 48 hours; true?	
3	A. Yes, I have.	
4	Q. Okay. So I -- so I want to understand -- I'm	
5	not trying to be cute, Doctor, I just want to understand	5:42:06PM
6	what it is about these strips that you just described to	
7	me. Can we agree, there's -- there's no cervical change	
8	from the time monitoring has begun and before Pitocin?	
9	A. Yes.	
10	Q. Okay.	5:42:23PM
11	A. In practical terms, when you have preterm	
12	ruptured membranes and you're trying to assess whether	
13	someone is in labor, you never have cervical change --	
14	Q. Okay.	
15	A. -- until they're absolutely -- you -- you just	5:42:29PM
16	don't do exams. That's -- that's below the standard of	
17	care. So you have to -- clinically, you make a	
18	diagnosis based on, if they're regular uterine	
19	contractions in this setting, is this, probably, real	
20	labor or not. And in this setting to me, I -- it looks	5:42:44PM
21	to me like this is somebody who is really getting into	
22	labor. Even with cervical change, it's not 100-percent	
23	diagnosis.	
24	Q. Have you written, Doctor, that 60 percent of	
25	the time, if you give Pitocin -- or give tocolytics,	5:43:03PM

5:43:03PM	1	based simply on the -- the contractions, that the
	2	patient likely is not going to be in labor, 60 percent
	3	of the time?
	4	A. The patients with intact membranes using
5:43:10PM	5	conventional diagnosis of preterm labor, it's a lot
	6	of the patients really are not in labor; that's true.
	7	Q. Okay. So whatever I read that you wrote, that
	8	was referring to intact membranes?
	9	A. Yes. That's why the studies of tocolytics and
5:43:24PM	10	intact membranes are very confusing. A lot of patients
	11	we think are in labor, turn out not to be, unless you
	12	use very strict criteria.
	13	Q. Okay. And -- so it's just that you saw some --
	14	some contractions in those two hours, and you feel more
5:43:43PM	15	likely than not, you wouldn't have been able to stay the
	16	onset of active labor for at least 48 hours; that's what
	17	you feel?
	18	A. Yes. It's not just some contractions. It's,
	19	you know, regular contractions are occurring every
5:44:00PM	20	three -- two to three minutes --
	21	Q. Okay.
	22	A. -- three to four minutes in different parts of
	23	that tracing.
	24	Q. And you feel that way, simply, because of your
5:44:10PM	25	experience, education, but also, the strips as they

5:45:41PM

25 innumerable patients like this, so my opin-- opinion
24 That's the base -- you know, I've taken care of
23 well, and she falls into that group.

5:45:16PM

22 That's -- that's intuitive, and it's medically true as
21 much more likely to deliver than those who don't.
20 Patients who are having regular uterine activity are
19 we can't use all that information to guide us in that.
18 can't tell 100 percent, so some probably did. So we --
17 don't -- didn't get in the studies. Some, you -- you
16 rupture studies who are having regular contractions,

5:44:59PM

15 A. Well, most patients who are in the preterm
14 you're referring to?

5:44:39PM

13 still would have delivered in 48 hours? Is that a study
12 how do you arrive that this baby -- this -- this mom
11 to understand why you say more likely than not. How --
10 Q. Well, we know you would, Doctor. I just want

5:44:24PM

9 weeks, I would still try and stop it.
8 patient who presents like this. If I knew she was 28
7 short time frame; that's what I would expect from a
6 me, comports with a patient who usually delivers in a
5 ruptured membranes, the overall clinical setting is, to

5:44:14PM

4 A. The strips, the fact that the patient has
3 Q. Okay. Anything else besides the strips?

2 A. Yeah.

1 appear?

1 in a patient like this -- if somebody comes up to me and

2 says to me, Doctor, I have two patients next to one

3 other; and one is have no contractions, and one is

4 having contractions like this; and you said, Doctor,

5 what is the chances that either one of these two people

6 is going to be pregnant in 48 hours? The chance that

7 the one who is contracting is going to be pregnant is

8 much less than the person who has no uterine activity.

9 Q. But -- but -- but the fact that this is a

10 28-weeker, that increases their chance of extending

11 beyond 28 weeks -- or beyond 48 hours compared to a

12 30-weeker; correct?

13 A. That would -- difference would be hard to tell.

14 But between 28 weeks and 34 weeks, yeah.

15 Q. Okay.

16 A. There -- it's -- they have a higher chance of

17 staying pregnant in any given setting. But their chance

18 of staying pregnant is still -- you know, if you have

19 ruptured membranes and regular contractions, you're very

20 likely to deliver in the next 48 hours.

21 Q. Okay. And can you point to me any study that

22 stands for that proposition? Any study, any writing,

23 anything that comes to mind that stands for that

24 proposition, that opinion you're giving in this case?

25 A. I -- I'd have -- I can't remember exactly a

chapter and verse. I think it's -- there's not that

many studies that would have taken this group of

patients and give you gestational age specific

information about when they deliver, with or without

treatment. There's no study that shows the treatment

benefits, you know, so you -- you'd have to dissect a

published study.

And as I said, the studies that have the most

information, didn't include a lot of patients like this.

Q. Right. But -- but to be fair with us, Doctor,

what you're doing is, you're presuming this lady would

have gone into labor even though she hadn't shown signs

of labor, by definition, for the first two hours; you're

presuming she would have. And with that presumption,

then, you're applying your experience that she's not

going to go 48 hours; correct?

MR. MALONE: Well, I'm going to show an

objection. That's not what he's testified to. He's

testified that she did go into labor during those first

two hours, and he's taking you through those strips to

demonstrate it. And, now, I think you're misquoting

him, and I think you're being unfair. It's late, and

we're all getting tired, but I think that's unfair.

Please ask another question.

MR. BECKER: Read the question, back, please.

5:46:52 PM

5:47:09 PM

5:47:22 PM

5:47:38 PM

5:47:44 PM

5:48:31 PM

5:49:35PM

///

MR. MALONE: I think --

deprived --

You've given us tonight, the -- the employees at Metro

Q. And by the -- by the admitted deviations that

5:49:21PM

A. So --

Q. Right.

some patients stay pregnant for weeks.

could stay pregnant that long, and some patients do, and

However, a lot -- we still hold out hope that somebody

5:49:10PM

that she wouldn't have stayed pregnant for 48 hours.

In labor, I think that more -- it's more likely than

inferring from what's published on patients who are not

So I'm -- my -- based on my experience and

advanced, you know, after the fact.

5:48:50PM

sterile examination, you -- until they're very far

have somebody with PPROM, you can't confirm that by

the early stages of labor. And by definition, when you

A. Yes. Well, I'm -- I'm saying that she was in

this lady would have gone into labor?

5:48:38PM

don't go 48 hours; correct? You're making a presumption

you're applying your rule that PPROM's that are in labor

Q. So you're taking that presumption, and then

5:48:31PM

BY MR. BECKER:

(The previous question was read.)

5:50:42PM

Q. Well, not only was she deprived of a chance in going 48 hours, she was deprived of a chance to go seven days or two weeks, correct, by not getting tocolytics,

5:50:30PM

BY MR. BECKER:
said that if she knew she was 28, she would have attempted to delay her delivery.

5:50:09PM

she should be induced. And I think the -- Dr. Lewis has plan, presuming that she was 34 or 36 weeks, was that 28 weeks, there was no chance of her -- the reasonable staying pregnant for 48 hours. Not knowing that she was to that extent, there would have been some chance of her they would have attempted to tocolyze her. And that --

5:49:48PM

known -- if the caregivers had known she was 28 weeks, interpretation of the record, if the patient had THE WITNESS: From our dialogue and from my Answer the question, if you can, Doctor.

5:49:42PM

deviations. things, you've misquoted things; there are no admitted deviations. You've argued with him, you've presumed MR. MALONE: I don't know of any admitted

5:49:35PM

MS. REID: Objection.
MR. MALONE: Objection.
Q. -- this mom of an opportunity or a chance to go beyond 48 hours; correct?

BY MR. BECKER:

1	IV antibiotics and corticosteroids?	5:50:45PM
2	MR. MALONE: Deprived of a chance?	
3	MR. BECKER: Yeah.	
4	MR. MALONE: That is the question?	
5	MR. BECKER: Yeah.	5:50:53PM
6	MR. MALONE: Deprived?	
7	MR. BECKER: Yup.	
8	MR. MALONE: Her role in this, of course, is	
9	being it negated by you. She had no role in this.	
10	THE WITNESS: If you presume that she's 34 to	5:51:00PM
11	36 weeks, then there is no point in trying to prolong	
12	the pregnancy. So the doctor's made their best	
13	assessment, and the conclusion they came to --	
14	Dr. Lewis's assessments made it unreasonable to try to	
15	delay delivery.	5:51:18PM
16	BY MR. BECKER:	
17	Q. Right. Doctor, we can agree that -- that had	
18	the chart been kept current and updated, as we talked	
19	about earlier, more likely than not, assuming Dr.	
20	Lewis's testimony is to be believed, she would not have	5:51:32PM
21	engaged in augmentation of labor; she would have engaged	
22	in expected management; correct?	
23	MR. MALONE: Objection.	
24	MS. REID: Objection.	
25	THE WITNESS: If Dr. Lewis had -- Dr. Lewis's	5:51:46PM

1 testimony, as I understand it, that she would have
 2 engaged in expected management if she had understood the
 3 patient's gestational age more likely to be 28 weeks.

4 BY MR. BECKER:

5 Q. Right. And we've previously agreed that it's a
 6 deviation from Dr. Charada not to have brought that
 7 chart up to date, if he was unsure or didn't even have a
 8 clue as to what records are sent over to Metro. We
 9 previously agreed on that, true?

10 MR. MALONE: Objection. It's not true.

11 THE WITNESS: Well, I -- we -- I'd have to
 12 revisit -- we agreed on something.

13 BY MR. BECKER:

14 Q. Okay. We'll have to look at --
 15 A. I'd have to look at exactly what we agreed on,
 16 because I -- I wouldn't put it in exactly the terms that
 17 you've put it.
 18 Q. Okay.

19 A. It depends what he had reason to believe what
 20 would be communicated from the information that was --
 21 that he had on that day.

22 BY MR. BECKER:

23 Q. Well --

24 MR. KULWICKI: Don't rehash this.

25 MR. BECKER: Okay.

5:54:04 PM

question. "As we agreed, should have, could have, would

It's inappropriate. Please ask a straight forward

throwing that stuff in there. That's just not fair.

MR. MALONE: Objection, Mike. You got to stop

gestational age --

5:53:51 PM

likely should have been done, had they known the

Q. If this was expected management, as we agreed

you can have cervical change.

on the gestational age and so forth, sometimes, before

have to make the diagnosis for various reasons depending

5:53:21 PM

you can't clinically wait for that, because you -- you

have definitive cervical change. But in many settings,

A. They go on to have a baby, or they go on to

Q. They go on to have cervical change?

A. Well --

5:53:12 PM

Q. Okay. Well, how do you know in retrospect?

A. Well, you know only know it in retrospect.

from actual labor?

Q. And -- and how do you distinguish early labor

have real labor. It's the first phase of labor.

5:52:53 PM

It's what every human being goes through before they

A. I don't think early labor has a definition.

labor? Your textbook?

Q. Where can I go to find a definition of early

5:52:37 PM

BY MR. BECKER:

1 have," I mean, come on. You want to make a final
 2 argument, you're going to be given an opportunity to do
 3 that in the courtroom. You're not going to do it with
 4 this witness in cross-examination.

5 Wait for a question, please.

6 BY MR. BECKER:

7 Q. In retrospect, Doctor, for this patient, she
 8 received the wrong medication. She received Pitocin,
 9 and she should have received betamethasone, among other
 10 things; correct?

11 MR. MALONE: Objection.

12 THE WITNESS: If the physicians had known her
 13 true gestational age, they agreed, and Dr. Lewis agrees,
 14 that she would have given betamethasone and would not
 15 have given Pitocin. And to that extent, I agree with
 16 your statement.

17 BY MR. BECKER:

18 Q. You have written, Doctor, that in --
 19 inaccurate diagnosis of early preterm labor has serious
 20 consequences; true?

21 A. Yes.

22 Q. Serious consequences?

23 A. Yes. I'm -- I'm referring to preterm labor

24 with intact membranes, but it's a general -- I believe

25 that statement, yeah.

1 Q. You agree that the diagnosis of early preterm

2 labor is difficult and is accompanied by a high-false

3 positive rate?

4 A. Yes. That's, again, with regard to intact

5 membranes. But it is true.

6 Q. Doctor, 22 percent of women, you did -- you had

7 a study where 22 percent of women presented with

8 symptoms of preterm labor, and most of those women

9 delivered in five weeks after presentation?

10 A. I could -- I could believe that. I don't

11 remember that, exactly. Again, that would be intact

12 membranes.

13 MR. MALONE: You want to take a break to go

14 through your notes?

15 MR. BECKER: Yeah, that's fine.

16 THE VIDEOGRAPHER: We're off the record at

17 5:58.

18 (Recess.)

19 THE VIDEOGRAPHER: We're back on the record at

20 6:07.

21 BY MR. BECKER:

22 Q. Doctor, you have written a few times that, if

23 there is any question whether a patient is in labor or

24 not, the best thing to do is to give them a few more

25 hours, sit back, look, reassess; correct, in a PPRM

6:09:07PM

6:08:45PM

6:08:27PM

6:08:13PM

6:07:58PM

6:07:48PM

1 patient?
2 A. I don't know if I've written exactly that, but
3 it's -- it's not a bad plan to follow, in general.
4 Q. Okay. To your knowledge, has any doctor from
5 Metro ever come to Los Angeles and given -- or either
6 come here or provided expert testimony in a malpractice
7 claim against your hospital or USC?
8 A. I wouldn't have any idea.
9 Q. You have no idea.
10 Can you have a urinary tract infection and an
11 upper respiratory infection without intrauterine
12 infection?
13 A. Yes.
14 Q. Okay. And what's keeping urinary tract
15 infection local versus ascending up into the vaginal
16 canal?
17 A. Well, there is a lot of different things. I
18 mean, it's -- it's in the -- it's separated by a number
19 of layers of tissues. So unless a urinary tract
20 infection gets into the blood stream, or unless the
21 bacteria that caused the urinary infection are also in
22 the vagina, then the two should stay separate.
23 Q. Okay. You're making a couple of assumptions
24 for your ultimate opinion in causation in this case.
25 One is, you're assuming there was a gush of fluid; and

6:10:26PM

well as the severity of RDS; do you appreciate that?
steroids on board to reduce the risk of inter- -- IVH as
you need, comfortably, 48 hours to have a full affect of
Q. And -- and the key is -- you understand that

6:10:10PM

hours later.
probably have -- be more likely able to be pregnant 48
membranes at 28 weeks and not in labor, that she would
A. I think if she was spontaneous preterm ruptured

6:09:48PM

period beyond 48 hours?
not, she would have likely proceeded with a latency
is in error, then would you agree that, more likely than
Q. Okay. Now, if either one of those assumptions

6:09:39PM

A. Yes.
first two hours.
Q. That she was in preterm early labor in the
second part was?

6:09:26PM

membranes, and I'm also assuming -- I'm sorry, the
interrogatories. But I believe there was clear ruptured
believe from either Dr. Lewis's deposition or one of the
A. I recall the phrase "a gush of fluid," I

6:09:11PM

Q. Okay.
assuming that she had obvious rupture of membranes.
A. In answer to your first question, I -- I'm
7:00 o'clock and 8:30, was in early labor; correct?
two is, you're assuming that the mom, between

1	A.	Yes.	6:10:31PM
2	Q.	Okay.	
3	MR. KULWICKI:	I got some here.	
4	BY MR. BECKER:		
5	Q.	Doctor, are you familiar with Allen's article	6:11:05PM
6		on tocolytic therapy in preterm PROM? Preterm PROM?	
7	MR. MALONE:	Preterm PROM, what is --	
8	MR. BECKER:	No, PROM.	
9	BY MR. BECKER:		
10	Q.	Toco -- are you familiar with his article?	6:11:14PM
11	A.	I don't remember that by -- by that name. I'd	
12		have to look -- look at it.	
13	Q.	Can we agree that a physical exam when a	
14		patient is admitted to L & D, should that include fundal	
15		height?	6:11:37PM
16	A.	I think that's common practice. It's not a	
17		standard of care. Some doctors don't do it, but I don't	
18		know what percentage do do it, but it's commonly done.	
19	Q.	Can we agree, if there is any doubt about --	
20		any doubt about the gestational age of this fetus,	6:11:52PM
21		ultrasound should have been performed?	
22	A.	If ultrasound for gestational age is readily	
23		available, and the clinician forms the impression that	
24		they're not sure of the date, then it's better to	
25		perform an ultrasound. I agree with that; an ultrasound	6:12:05PM

6:13:51PM

Q. Should this mom have also received antibiotics
period and the prenatal record that they had.

6:13:12PM

the doctor's had from relying on the last menstrual
age, it would have given a more accurate impression than
performed to measure the fetus and, again, gestational

6:12:50PM

A. I believe that if an ultrasound had been
the -- of the fetus's age?
that would have given a truer, more accurate picture of
performed in this case in L & D, more likely than not,
Q. We can agree that had an ultrasound been

6:12:39PM

A. No.
interpretation?
Q. Do you have any disagreement with Dr. Ashmed's
I can't recall if I've seen the films.
A. I -- don't -- I've seen the report. I don't --

6:12:23PM

7/12, in this case?
Q. Have you looked at the ultrasound films from
would be within two or three weeks.
closer to two weeks. But the range -- published range
within -- that's between two and three weeks, probably

6:12:09PM

patient's gestational age was, it would be accurate
A. At 28 weeks, which we ultimately know this
gestational age at -- in mid -- second trimester?
Q. How accurate is ultrasound in estimating
to confirm the gestational age.

1 For Group B Strep at -- during the -- in L & D?
 2 A. For Group 2, this mom, I believe, should have
 3 received antibiotics to prevent Group B Strep
 4 transmission in labor and delivery.
 5 Q. Was it deviation to withhold antibiotics in
 6 this case?
 7 A. Yes. I mean, even if you think somebody is 36
 8 weeks, you should still give the antibiotics. I believe
 9 that is a deviation from the standard of care. I saw
 10 where they were ordered, but, apparently, not given.
 11 Q. The fact that this mom was charted as being
 12 one-centimeter by an exam, is that influencing in your
 13 opinion, in any way, as to whether or not she likely was
 14 in early preterm labor?
 15 A. A -- if she was charted as being four
 16 centimeters, I'd say for sure she is. And -- but if --
 17 if she's charted at one centimeter, she still could be
 18 in early preterm labor.
 19 Q. Okay.
 20 A. And I'm basing that -- so -- it -- it -- it
 21 doesn't put me off the track. It -- it would be more --
 22 I'd be more certain if she was further dilated. But
 23 even the fact that she's one centimeter, could be
 24 consistent with someone who is in labor, especially with
 25 ruptured membranes.

6:15:12PM

6:14:54PM

6:14:46PM

6:14:21PM

6:14:06PM

6:13:54PM

6:15:13PM	1	Q. Now, with multiples, is it not unusual to see
	2	them in one centimeter when they come in?
	3	A. Could be.
	4	Q. Yeah. And that doesn't mean just because you
6:15:25PM	5	see a multiple at one centimeter, means they're in preterm
	6	labor, does it?
	7	A. Not necessarily, no.
	8	Q. We're almost done.
6:16:47PM	9	Now, Doctor, when this mom was admitted, did
	10	the plan -- feel free to look at the plan on 7/31/01,
	11	20:38.
	12	A. Yes.
	13	MR. MALONE: These are the plans down here.
6:17:30PM	14	THE WITNESS: I'm looking at 7/31/01, 20:38.
	15	BY MR. BECKER:
	16	Q. Yeah. Under impression, you see at the bottom
	17	it says "impression," it also says "plan."
	18	A. Yes.
6:17:41PM	19	Q. Okay. And do you see any indication on that
	20	plan to either induce or augment labor?
	21	A. No.
	22	Q. In fact, contrarily, it says, "Labor
	23	precautions." Does that suggest to you to look for
	24	signs of labor?
6:18:01PM	25	A. It's -- it means to me, at this time, they're

1 trying to assess, is this labor? What's going on?

2 MR. BECKER: Anything else?

3 BY MR. BECKER:

4 Q. Do you find anywhere in that chart, where

5 there -- there's a change of plan to start augmenting

6 labor?

7 A. No. I -- I don't see it clearly stated that --

8 where the change of plan is indicated.

9 Q. Do you offer the responsibility that Pitocin

10 was inadvertently placed on the patient?

11 A. No. If you think somebody is 36 weeks, you

12 should give Pitocin. You have to give Pitocin, if they

13 have ruptured membranes and you think they're 36 weeks.

14 It's just a question of whether you do it immediately or

15 whether you -- you can wait and see if they have

16 spontaneous labor on their own, or you can give it

17 promptly.

18 Q. What was the rush in "pitting" this patient --

19 A. This is just --

20 Q. -- before she left triage?

21 A. This is a -- a change in practice that's gone

22 on over years. It used to be that you would give a

23 patient like this six hours to see if they labored on

24 their own. Gradually, there's been less and less

25 tolerance for waiting, because the -- if you think a

6:18:04PM

6:18:36PM

6:19:12PM

6:19:27PM

6:19:43PM

6:19:58PM

6:21:14PM

THE WITNESS: This is what would have happened

MR. MALONE: Objection.

information could be at hand; correct?

failure by Dr. Charada of not updating the chart so that

MetroHealth of not having that system in place, or a

Q. This is either a system's failure by

BY MR. BECKER:

delivery.

all the information to the doctor's on labor and

the country, doesn't allow for immediate conveyance of

in place, similar to most systems in most hospitals in

responsible in the sense that she -- the system that was

THE WITNESS: I would say "something" is

MR. MALONE: Objection.

correct?

ultrasound at the time she rendered care to this mom;

Dr. Lewis not having the results of Dr. Ashmed's

something or someone at Metro would be responsible for

Q. Doctor, we can agree, just to wrap up, that

and start Pitocin.

as soon as we confirm ruptured membranes, to go ahead

and so there's been more and more of a tendency to say,

The downside of giving it early is, virtually, nothing,

they can sometimes develop an overwhelming infection.

patient is 36 weeks, the downside of waiting is that

6:20:56PM

6:20:45PM

6:20:31PM

6:20:15PM

6:20:02PM

1 in most hospitals in the country, as far as the chart
2 being available and the ultrasound being available, in
3 2001, to my knowledge. Most hospitals would not have a
4 recent ultrasound result or lab results sent over to
5 labor and delivery at this time in gestation. And
6 that -- that's -- that's the state of -- the way
7 information is communicated. It's not ideal.
8 BY MR. BECKER:
9 Q. Well, if the hospital is not going to send it
10 over, then, we've previously agreed, Dr. Charada has a
11 responsibility to -- to so indicate in the chart the
12 discrepancy of dates, so a subsequent caregiver can
13 provide better care?
14 A. Yes.
15 Q. All right.
16 A. And then when -- when that is sent over, that
17 person will have that information.
18 MR. BECKER: I'm -- I'm done.
19 THE VIDEOGRAPHER: This concludes the
20 January 23rd, 2007, deposition of Dr. Goodwin.
21 We're off the record at 6:22, and this is the
22 end of Tape No. 2.
23 (The deposition was concluded
24 at 6:22 p.m.)
25

6:22:09 PM

6:22:00 PM

6:21:44 PM

6:21:31 PM

6:21:16 PM

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Please be advised the foregoing deposition was read, and I

state there are:

(Check one)

_____ NO CORRECTIONS

_____ CORRECTIONS ATTACHED

_____ T. MURPHY GOODWIN, M.D.

_____ Date Signed

---oo---

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
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I, T. MURPHY GOODWIN, M.D., having appeared for
my deposition on January 23, 2007, do this date declare
under penalty of perjury that I have read the foregoing
deposition, I have made any corrections, additions or
deletions that I have deemed necessary to make in order to
render the within transcript true and correct.
IN WITNESS WHEREOF, I hereunto subscribe my name
this _____ day of _____, 2007.

W I T N E S S

REPORTER'S CERTIFICATION OF CERTIFIED COPY

I, KARINA GARCIA, CSR No. 12818, a

Certified Shorthand Reporter for the County of

San Bernardino, State of California, do hereby

certify that the foregoing pages constitute a true

and correct copy of the deposition of

T. Murphy Goodwin, M.D., taken on January 23, 2007.

I further certify that I am neither counsel

for, nor related to any party to said action, nor in

any way interested in the outcome thereof.

IN WITNESS WHEREOF, I hereunto subscribe

my name this 5th day of February, 2007.

Karina Garcia
Certified Shorthand Reporter in
and for the County of San Bernardino,
State of California

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