CUYAHOGA COUNTY COMMON PLEAS COURT

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

Plaintiff,

vs.

No. 552424

METROHEALTH MEDICAL CENTER,

Defendant.

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
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For the Defendant:

REMINGER & REMINGER
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Also Present:

John Hank, Videographer

I N D E X

E X H I B I T S

None.

QUESTIONS INSTRUCTED NOT TO ANSWER

PAGE	LINE
85	3
85	20

INFORMATION REQUESTED

None.

PASADENA, CALIFORNIA; TUESDAY, JANUARY 23, 2007

3:17 P.M.

THE VIDEOGRAPHER: Good afternoon. My name is John Hank. I'm a certified legal video specialist here today for Jonnell Agnew & Associates, located at 170 South Euclid Avenue, Pasadena, California 91101. Today is January 23rd, 2007. The time is 3:17 p.m. We are located, today, at 170 South Euclid in Pasadena. 3:17:32PM

This deposition of Dr. R. Murphy Goldwin (sic) -- Goodwin is being take, today, on behalf of the plaintiffs, in the case caption Gloria Maslanka as parent and guardian of Shane Maslanka versus Metro Heart (sic) Medical Center, Case No. 552424 in the Court of Common Pleas, Cuyhoga County, Ohio. 3:17:58PM 3:18:18PM

Will counsel for the parties please identify themselves now.

MR. MALONE: Well, my name is Jim Malone. I represent MetroHealth Medical Center, not Metro Heart Medical Center. And the witness sitting to my right is Dr. T. Murphy Goodwin, not R. Murphy Goodwin. 3:18:25PM

MS. REID: Christine Reid, also here on behalf of MetroHealth Medical Center.

MR. BECKER: Michael Becker on behalf of Shane Maslanka and Gloria Maslanka. 3:18:42PM

MR. KULWICKI: David A. Kulwicki on behalf of Gloria and Shane Maslanka. 3:18:45PM

THE VIDEOGRAPHER: Thank you.

Will the court reporter please swear in the witness. 3:18:54PM

T. MURPHY GOODWIN, M.D.,

called as a witness by and on behalf of the Plaintiff, being first duly sworn, was examined and testified as follows:

3:18:54PM

EXAMINATION

THE VIDEOGRAPHER: We're on the record at 3:19. This is the start of Tape No. 1.

BY MR. BECKER:

Q. Hi, Doctor. State your full name for the record, please. 3:19:06PM

A. Thomas Murphy Goodwin.

Q. Doctor, you've been deposed before; correct?

A. Yes, I have.

Q. I just want to review the ground rules with you. This is a question-and-answer session under oath. If the question doesn't make sense or isn't artfully phrased, please tell me so, and I'd be happy to attempt to rephrase or restate the question. 3:19:20PM

Fair enough? 3:19:35PM

A. Yes. 3:19:36PM

Q. However, unless you indicate otherwise to me, I'm going to assume that you fully understood the question that I've posed and you were giving me your best and most complete answer today. 3:19:43PM

Fair enough?

A. Yes.

Q. And, Doctor, did you bring your complete file with you today?

A. Yes, I did. 3:19:51PM

Q. Okay. And you've just -- before we started, you handed it to me, and I passed it off to Mr. Kulwicki, and he's looking through it right now; correct?

A. Yes. 3:19:59PM

Q. Has anything been removed from your file?

A. No.

Q. I'm not sure that you've had an opportunity, but we did notice this deposition, duces tecum, and ask you to bring some things. 3:20:09PM

Have you had an opportunity to see a copy of the duces tecum that we send in this case?

A. I saw something that was -- I was alerted to by Mr. Malone, recently, and I think I have everything that I actually have access to that you've requested as far 3:20:27PM

as I know. 3:20:30PM

Q. Okay. One of the things that I specifically asked about, that you bring with you, is copy of handouts and/or hard copies of your PowerPoint presentation in two seminars you gave in 2006, one in 3:20:43PM Hawaii and the other in Switzerland.

MR. MALONE: I'm going to make an objection to any questioning about this. I'm going to let you ask the questions, but you're asking about presentations in 2006 when the question in the lawsuit is the standard of 3:20:58PM care in August of 2001. You also gave me less than fourteen hours notice for this request, and it's my understanding that the doctor doesn't actually have the material; that the materials that he presents are updated regularly, such that whatever fashion or 3:21:12PM whatever state they may have existed at the time of those presentations they no longer exist.

So we're not going to produce those -- those requested materials, but you can ask him questions about it if you want. 3:21:24PM

BY MR. BECKER:

Q. Doctor, I need to hear from you today, and it's true that I didn't give, certainly Mr. Malone much advance notice that seconded-amended request. But not withstanding I -- 3:21:37PM

MR. MALONE: The first amended wasn't much better, Michael. I think I got another two hours lead time on that one. 3:21:38PM

BY MR. BECKER:

Q. Do you have, sir, a copy of any handouts or PowerPoint material available for both of those seminars? 3:21:45PM

A. I did not have anything, but it's possible that the conference organizers have a booklet or something. I don't have anything that I've retained -- those talks come from a pool of material I have, and I pull out material for that presentation and from my general background of stuff. 3:22:00PM

Q. I didn't hear the end of that.

A. From any general background materials, I pull out that stuff. 3:22:16PM

Q. Okay.

A. But the conference organizers -- you know there was a booklet prepared for both of those. I don't retain a hard copy of those, but somebody probably has them. 3:22:27PM

Q. Who would I contact to obtain a copy of that booklet? Whoever put on the --

A. The Ferring Corporation put on the one conference in Switzerland and the post graduate division 3:22:39PM

of the Keck School of Medicine put on the course in Hawaii. 3:22:41PM

Q. Doctor, did you create any, or generate any notes as a result of your review of this case?

A. No. I folded some points in the record and some points in depositions, some parts of the chart, but I did not write anything in there or create any notes. 3:22:54PM

Q. Okay. So you kind of flagged some parts of the chart but no notes anywhere therein?

A. No. 3:23:09PM

Q. And that applies to depositions as well? No notes from depositions?

A. That's true.

Q. Now, last deposition I looked at that was by you, you did about 90 percent defense work and 10 percent plaintiff's work; is that true? 3:23:20PM

A. 85, 90 percent defense, 10 to 15 percent on behalf the patient.

Q. How long have you been doing medical legal work? 3:23:38PM

A. Since the mid 1990s.

Q. And approximately, how many do you -- cases do you review a year?

A. About 20.

Q. What percentage of your income does your 3:23:51PM

medical legal work account for? 3:23:54PM

A. Ten to fifteen percent.

Q. Do you review cases all over the country or do you do predominantly in California and, maybe, one or two other states? Can you give me a sense as to -- 3:24:10PM

A. Most in California. But I have reviewed cases in -- at one time or another, probably in eight or ten other states.

Q. Okay. How many cases have you done on behalf of -- at the request of MetroHealth Medical Center? 3:24:28PM

A. I believe three cases.

Q. And what are they, if you recall?

A. Jeez, I'm not sure I can remember the names of them. There -- one of them is -- Bahle, is the plaintiff. B-A-H-L-E. 3:24:51PM

Q. Okay.

A. And --

Q. It's another one named Colon (phonetic) that my office has with you?

A. Yes. 3:25:03PM

Q. Any others?

A. Yes. There are others. There's one or two others that I don't think I'm going to be able to remember the name of right now.

Q. Fair enough. You had actually come out to 3:25:14PM

MetroHealth and put on a presentation or assisted in a seminar at one time? 3:25:17PM

A. Yes.

Q. And how did that come about?

A. I'm invited to give lectures in different places around the country, and I'm -- Dr. Brian Mercer who is there is a colleague of mine. We served on the board of Maternal-Fetal Medicine Society and it was at one of those meetings; he said why don't you come to our annual conference at Metro. 3:25:26PM 3:25:38PM

Q. How many times have you done that?

A. Once.

Q. And are you -- consider yourself social friends with Brian Mercer?

A. Well, no. I mean, I -- I know him. He's a good guy. I knew him from meetings. That's the only place I've ever seen him. 3:25:49PM

Q. Have you ever gone to dinner with him?

A. No, but I -- you know, probably had a cocktail.

MR. MALONE: You would have if you were buying, I suppose. 3:26:02PM

THE WITNESS: He's a -- I know him from a scientific -- as a scientific colleague, probably 95 percent. And just a few other passing comments. How's your family doing, that kind of thing. 3:26:15PM

BY MR. BECKER: 3:26:18PM

Q. Fair enough. How many cases have you reviewed on behalf of the law firm Reminger & Reminger?

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

Q. Because of your relationship, or at least your professional relationship, with Brian Mercer, would you be uncomfortable looking at a case against MetroHealth Medical Center and acting as an expert? 3:26:33PM

A. It -- I'd have to assess it when it came up. I have looked at cases for plaintiffs, and I'm not asked very often. I -- unless I have a specific reason why I can't do it, if the description of the case seems like something I know about, it seems like it's worthy of investigation, I will do it. 3:27:02PM

The fact that one knows someone is involved with the services is an obvious thing that, you know -- personal relationships influence these decisions. So I can't say for sure whether I would say out right no. I -- it would probably weigh in the mix of all the factors against that. 3:27:19PM 3:27:32PM

Q. Fair enough. In the plaintiff's cases that you've done, can you think of the medical subject matters? Have -- have they been shoulder dystocia, Erb's palsy or Klumpke's palsy cases or have they been birth asphyxia? Can you give me a sense as to the 3:27:42PM

plaintiff's cases that you reviewed and actually agreed to act as an expert, given a deposition or made a trial appearance? 3:27:46PM

A. When -- one is -- one was a shoulder dystocia case that I can think of, brachial plexus injury. One was a -- asphyxia related to maternal seizure and preeclampsia the baby was -- sustained some brain damage. Another was a maternal death related to a pulmonary embolism. Another was a maternal injury related to a complicated surgery. 3:27:56PM 3:28:21PM

Q. Was the PE case, was it alleged that the deep vein thrombosis and pulmonary embolism occurred post deliver, if you remember?

A. It was after termination of pregnancy in the middle of a pregnancy, and it was a women who had significant risk factors and no -- 3:28:43PM

Q. Prophylaxis.

A. No prophylaxis or appreciation that her medical condition was a significant risk factor that -- I review a number of others. Those are the ones that -- just the spectrum of things that come to mind right now. I do -- most of my practice is medical complications of pregnancy, besides intro part of management of preterm labor and stuff of what I see in consultations or women are sick with hypertension, thyroid disease, 3:28:57PM 3:29:12PM

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

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

A. That was in San Diego, California. 3:29:31PM

Q. And do you remember who the name of the plaintiff's lawyer was in that case?

A. Scott Benjamin.

Q. Now, let's talk about your current practice. Can you give me a sense of what your average week is like? 3:29:42PM

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 3:30:05PM 3:30:28PM obstetric side of obstetrics and gynecology that residents go through.

Q. And what percentage of your time is medical/legal work?

A. It's -- I mean, I'm basically counting there my 3:30:37PM

work week, you know, seven in the morning, seven at night, five days a week. 3:30:42PM

Q. Okay.

A. So I -- I never do any other work except on occasions like this during the waking hours -- daytime hours. 3:30:50PM

Q. The depositions that I looked at, Doctor -- maybe this is consistent with what you said is, you describe your practice as 15 to 20 percent clinical and about 25 percent of your time teaching; is that accurate? 3:31:02PM

A. Teaching is almost always supervising the residents and it's teaching at the bedside, yeah.

Q. That's accurate?

A. Yes. 3:31:11PM

Q. How many babies do you deliver a year?

A. I don't deliver any that are not just where I'm supervising the resident. I don't have my own OB patients. My private practice is only consultation.

Q. So if you were to actually deliver, it would be in the act of supervising a resident in the teaching role? 3:31:28PM

A. Yes.

Q. And do you have any experience working at a prenatal clinic where physician -- well, first of all, 3:31:41PM

do you have any experience working at a prenatal clinic that it is away from -- physically away from the hospital where delivery would take place? 3:31:46PM

A. You know, we had our own busy private practice for many years that was -- we did prenatal care of 100 patients a month, delivered 100 patients a month. It was freestanding and remote. I -- I'm involved in supervising a lot of clinics that send patients into us. But I don't -- I'm not the one actually out there seeing the patients every day. 3:32:04PM 3:32:17PM

Q. You're -- you supervise some clinics that send some patients in to you where the prenatal care is done off campus?

A. Yeah.

Q. And the delivery takes place at your hospital? 3:32:29PM

A. Yes.

Q. Just so we're in -- on the same page, what is the name of your hospital?

A. Los Angeles County University of Southern California Medical Center. 3:32:38PM

Q. Is it referred to as county hospital?

A. Yes. Well --

Q. What's the breakdown between private versus clinic patients at the county hospital?

A. It's one hundred percent clinical patients. 3:32:50PM

Q. When you say you supervise the prenatal clinics that ultimately, you know, funnel you patients for delivery, do you play any role in forms that are developed at the clinic -- at the prenatal clinic or the policy procedure of those clinics? 3:33:01PM 3:33:18PM

A. No. They'll often ask us, you know, what should we do in this setting. Sometimes they might -- sometimes they'll ask for specific information, like, what kind of a policy should we have in this area. But there's no formal way in which we do -- we generate a form that is used by all of the clinics in a certain area or even any one of them. 3:33:34PM

Q. All right. Let's review some definitions, Doctor. What is your understanding, at least in Ohio, of the phrase "standard of care"? 3:33:50PM

A. It's what a reasonable physician would do in same or similar circumstances to take care of a patient.

Q. Okay. I want you to assume the definition, now in Ohio, is what a reasonable, skillful and diligent physician would do in the same or similar circumstances. 3:34:10PM Would you assume that to be true?

A. Yes.

Q. Okay. And when I talk later in this deposition, I'm going to be talking about standard of care or standard of care violations. You've heard the 3:34:23PM

phrase deviations; correct? 3:34:27PM

A. Yes.

Q. Okay. And when I say the word deviations in the balance of this deposition, please, understand that I'm referring to a standard of care violation; is that fair? 3:34:34PM

A. Yes.

Q. Okay. Let's start with definitions of PROM P-R-O-M. What does that mean?

A. It means premature rupture of membranes. 3:34:45PM

Q. And what is PPROM?

A. Preterm premature rupture of membranes.

Q. What is -- what are tocolytics?

A. Those are drugs to stop uterine contractions.

Q. What is something called "rescue tocolytics"? 3:34:57PM

A. That's when tocolytics are used to arrest contractions for a short period of time because there's concern for fetal well-being. Actually, that term "rescue tocolytics" is a -- a popular term that I doubt has any formal definition, but that's what I mean by it and that's what most of my colleagues mean by that. 3:35:15PM

Q. Okay. I didn't get that. Tell me that again?

A. It's not -- rescue tocolytics is not something one could look up in a --

Q. No. But I -- I didn't get your definition. 3:35:25PM

A. Oh, it's a -- what it means to me, and this is based on my conversations with colleagues and understanding of the literature is, the use of tocolytics to arrest uterine contractions usually for a short period of time. Most often in response to the perception that the uterine activity is not being tolerated by the fetus. In other words, there's usually an -- an abnormality of the fetal heart tracing or you can anticipate that there will be an abnormality to fetal heart rate tracing and you try to stop the contractions for the next few minutes. Whereas tocolysis, in general, is something you might hope to continue for hours or days. It's not me. Is that yours? 3:35:28PM 3:35:41PM 3:36:06PM

MS. REID: It's not me. 3:36:17PM

BY MR. BECKER:

Q. Doctor, if you need to take a break during the deposition, take a call, feel free to do so.

A. It's not me, sorry.

MR. MALONE: I swear to God, it's coming from this library. Isn't it? 3:36:27PM

BY MR. BECKER:

Q. And the term "therapeutic tocolytics"?

A. I don't know what that term would mean. That's the -- not one that I commonly use. 3:36:37PM

Q. Prophylactic tocolytics? 3:36:41PM

A. That probably is meant to describe the use of drugs to prevent contractions before they've actually occurred.

Q. What is clinical chorioamnionitis? 3:36:54PM

A. That's -- clinical chorioamnionitis, an infection of the membranes inside the uterine cavity that can be detected by some clinical means. Usually, meaning, physical examination or observation of the patient. 3:37:13PM

Q. Preterm labor?

A. That's labor before 37 weeks gestation.

Q. And how do you define labor?

A. That's used -- the most common definition is, regular uterine contractions with progressive cervical change. 3:37:25PM

Q. Can you distinguish, for me, contractions from uterine irritability?

A. There's no specific way to tell those apart that I know of. The general way is, people would do it is, by how regularly they're occurring. If there is a distinct, discrete pattern to them and whether they can be distinguished discretely on a monitor. And often, you can only tell in retrospect, as they progress. You have to look at the whole clinical setting to tell if 3:37:49PM 3:38:06PM

it's, like, irritability or breech in contractions, if there is doubt. 3:38:10PM

Q. What is an induction of labor?

A. Induction of labor is beginning of labor when -- is giving medication to begin labor when a woman does not have any uterine activity, or has only background normal uterine activity, with the goal of getting her into labor. 3:38:21PM

Q. And how is that to be distinguished from an augmentation of labor? 3:38:41PM

A. If a person -- a women already has regular uterine contractions, and if you give medication to increase her intensity or frequency, that's augmentation of labor.

Q. And it doesn't matter whether one is in latent or active labor for there to be an augmentation -- latent phase or active phase? 3:38:56PM

A. It can be used equally in either phase.

Q. I want to talk about some medical principals, Doctor, see if we can agree on some things. 3:39:14PM

Can we agree that a patient -- obstetrical patient, has a clear interest in delivering and relaying the most accurate history and best information she can to the obstetrics team?

MR. MALONE: Objection. Read that again. 3:39:29PM

BY MR. BECKER: 3:39:30PM

Q. Can we agree that the obstetrical patient has a clear interest in delivering and relaying the most accurate information in history that she can to her obstetrical team? 3:39:42PM

MR. MALONE: Objection. I'm not sure what it has to do with anything. But if you understand it, can we agree that the patient wants to tell us the best she can tell us, I think is the about the size of it. I'm not sure what that has to do with anything. 3:39:55PM

THE WITNESS: If I understood you correctly, I -- I believe it's in the best interest of the patient to relay that information.

BY MR. BECKER:

Q. And have you found that patients generally try to give the best history and information they can to the obstetrical team? 3:40:01PM

MR. MALONE: Well, objection to "try." What does that have to do with anything, "try." Doctor's try to do the best they can all the time too. Is that -- want to make an agreement on that? 3:40:17PM

BY MR. BECKER:

Q. Can you answer, Doctor?

A. Generally, I believe they do.

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

exam or even by ultrasound, it should be readily apparent to an obstetrical caregiver whether or not he's taking of care of 1,000-gram baby versus a 3,000-gram baby? 3:40:29PM

A. Generally, it -- in the aggregate, if someone has a setting where there is a baby normal, near term size, versus one that is 1,000 grams. It would normally be apparent on the clinical exam. 3:40:41PM

Q. Can we agree that one of the factors influencing the success of tocolytics is the gestational age of the fetus? 3:40:58PM

A. No. I don't think that that is known. It's debated, and there may be certain tocolytics that are more effective at some gestational ages.

Q. Would the factor of whether or not the mom is truly in labor impact the success of tocolytics? 3:41:19PM

A. If the membranes are intact, then the use of tocolytics in patients who are not truly in labor -- it's much more likely to suppress contractions then in those who have established labor whether the membranes are ruptured. There is no data one way or the other. 3:41:40PM

Q. What are the factors or tests available for the obstetrician that he can utilize in a PPROM patient to predict that labor will likely ensue?

A. The main tools that you have is your experience 3:42:13PM

in clinical observation. There are not really very many other tools that I know of for the patient who has ruptured membranes to predict which are going to progress in labor, at least that are not commonly applied. 3:42:16PM 3:42:48PM

Q. There's something about a fibro- -- fetal fibronectin test?

A. Yes. But that's only if the membranes are intact. Because if -- if membranes are ruptured, it's always positive, because there is a lot of fibronectin in the amniotic fluid. 3:42:48PM

Q. So that wouldn't apply to PPROM?

A. Right.

Q. And you did some research on another drug or something. Is that also only when the membranes are intact? I forgot what the question was. 3:42:55PM

A. Yes. A drug that we would use to arrest labor, and if a patient -- if it didn't work, you could say, well, this probably is more substantial labor. That would be a very indirect way of figuring it out. That would only be in -- usually, in intact membranes. 3:43:08PM

Q. Salivary estriol?

A. Salivary estriol has never been studied in ruptured membranes. It would be used in cases of intact membranes. It's not currently available clinically. 3:43:26PM

But if it were available -- it's never been studied in ruptured membranes. 3:43:31PM

Q. So in your clinical experience, when you have a patient, hypothetically, comes in PPROM, what do you look for to give you a sense as to whether or not this patient will -- labor will ensue, and how quickly the labor will progress? What are the factors that you look for? 3:43:42PM

A. If -- if they're rupt- -- many patients who have ruptured membranes have no uterine activity at all or minimal, and those patients have the highest likelihood of remaining without progressing in labor, even though the majority of them do develop contractions within 24 to 48 hours. Some of them will stay pregnant for a long period of time, depending on how far along they're in gestation. And if a patient is having regular uterine activity when they rupture membranes, in my experience, they rarely stay pregnant for a long period of time. Most of them progress to -- to deliver. 3:43:54PM 3:44:15PM

Q. Within a matter of seven days? 3:44:33PM

A. It depends on other circumstances. But if the patient has regular uterine activity, and has gross ruptured membranes, it depends mostly on the gestational age of the patient as to -- I would say that, if that happens anywhere near term, virtually, all of the 3:44:54PM

patients will progress to deliver within, you know, a day. 3:44:57PM

Q. 36 weeks, same answer?

A. Yes.

Q. 34 weeks? 3:45:04PM

A. Same answer. I would take that answer probably back down to 32 weeks or so. If a patient comes on with contractions and ruptured membranes -- regular contractions and ruptured membranes -- before 32 weeks, sometimes -- although, it's relatively infrequent, the 3:45:20PM contractions will abate with or without tocolysis. No, there's never been a study done where half the patients were given tocolysis and half of them were given a placebo after ruptured membranes with regular contractions to see if tocolysis makes a difference. 3:45:36PM And the only studies were -- made -- patients with ruptured membranes were included and tocolysis was given, you can't really draw the conclusion that it does anything.

So most of us are skeptical that tocolysis does 3:45:49PM anything in ruptured membranes. Although, sometimes if we think we can limit the harm, we do use it. So -- now I'm going off and forgot what your question was, but --

MR. BECKER: Can you help me? I forgot my question as well. 3:46:05PM

THE WITNESS: I must have been rambling for awhile. 3:46:05PM

(The previous question was read back.)

BY MR. BECKER:

Q. Oh, I remember, Doctor. I asked you about 36 weeks with PROM, when do you expect delivery and you said within a day or -- or so. And then you said same answer to 34 weeks. And you said same answer to 32 weeks; right? 3:46:06PM

A. Yes. 3:46:51PM

Q. When we go under 32 weeks, the chances are increased that you have a greater latency period?

A. That's correct. Most of what's known about latency period is known from patients who ruptured membranes before 32 weeks and have -- don't have contractions when they rupture, or have very infrequent contractions. And from that, we know that the earlier in gestation you are, the longer the latent period. 3:47:05PM

Q. Okay.

A. For those patients who rupture membranes and have regular contractions, it's far fewer the patients that stay pregnant. And I don't know exactly what the number is. I would say that it's a lot less than 50 percent stay pregnant for more than two days, if they have regular contractions when they come in ruptured. 3:47:19PM 3:47:35PM

Q. Well, what does regular contractions mean, and how is that different than infrequent contractions? What's a regular contraction? 3:47:39PM

A. Regular contractions meaning -- means contractions that looks like they could be labor contractions, if they're occurring every three to four minutes. There isn't really a definition -- a specific definition of regular contractions. It's the pattern that looks consistent with labor. 3:47:48PM

Now, as we already discussed, labor has other components to the definition. But everybody who is going to change their cervix and progress in labor, so that you can give them that name, has to start contracting at some point when they haven't yet changed. 3:48:04PM

So many times you're in the situation of saying, does this look like labor, and you have to make the initial assessment just on the basis of the uterine contraction pattern. So in the case we're discussing, the patient had regular uterine activity. That's my opinion. 3:48:21PM 3:48:37PM

Q. This case has regular uterine --

A. Yes.

Q. -- activity?

A. Yes.

Q. What about the intensity of the contractions in 3:48:42PM

this case? 3:48:44PM

A. I think the intensity was listed as one plus or not very strong --

Q. Okay.

A. -- by the nurses. 3:48:58PM

Q. Is that a marker, whether or not you're having regular contractions, the intensity? Is that a factor to consider?

A. It is a factor. If a patient is, you know, very uncomfortable or groaning in pain, then the 3:49:01PM patient, under those circumstances, is virtually one-hundred percent to likely deliver in a short period of time. If the patient is not very uncomfortable and they're low intensity, sometimes those contractions will abate, and, you know, she could stay pregnant longer, 3:49:19PM which is relatively infrequent.

Q. You write that the only unequivocal effect from tocolytics, from randomized control trials, is a delay in delivery of 48 hours; right?

A. Yes. 3:49:41PM

Q. That just means, no question, you're going to get 48 hours with tocolytics?

A. No, what that means is -- first of all, that applies only to patients with intact membranes, not with ruptured membranes. But if you -- what it means is, if 3:49:56PM

there is any unequivocal -- if there is any effect, the only one we know of is that in more patients who receive a drug than placebo are still pregnant 48 hours later, if they come in with preterm labor and contractions within intact membranes. 3:50:00PM 3:50:18PM

Q. Are you aware of any literature that stands to the proposition that: In a PPROM, use of tocolytics under 32, generally, will buy you at least three or four days? Are you aware of any literature that stands for that proposition? 3:50:33PM

A. I can't say that there is no literature. I can say that the vast majority of the literature is supportive that there is no known benefit of tocolysis with ruptured membranes. Con- -- many conscientious doc- -- some conscientious doctors never use it. There are many medical centers in the country that just don't use tocolysis in ruptured membranes. Some do thinking that if it has a benefit in intact membranes, it might have a benefit even in ruptured membranes. If it's not too risky, let's give it a try. That's the extent of the logic. But we -- I'm always careful to point out to the residents, don't tell anybody that you can look it up; that's it actually going to be beneficial. That's why you should never administer it if you think it has any downside. 3:50:50PM 3:51:07PM 3:51:24PM

Q. I think we earlier established that there are a number of factors that you look at to determine whether or not this mom is going to go on to actual labor. One is, how frequently there is contractions; two is, the strength of the contractions; correct? 3:51:25PM 3:51:39PM

A. That would be one factor.

Q. Okay. What other factors are there, if any?

A. Other factors that -- in general, or in this case?

Q. In general. 3:51:54PM

A. In general --

Q. We'll talk about this case, in a moment. In general.

A. In general, other evidence of whether it would progress in labor is if there's associated vaginal bleeding. That is not uncommon. And if you have that, then the patient is much more likely to progress. 3:51:59PM

Q. Any other factors?

A. Uterine tenderness or fever.

Q. Signs of clinical chorio? 3:52:13PM

A. Yes.

Q. Any other --

A. That would strongly suggest that you're going to progress in labor.

Q. Any other factors? Just -- let's talk about 3:52:20PM

all of them that you can think of? 3:52:23PM

A. Others are laboratory tests and so forth, which one would not get back for hours. You know, such as high white blood cell count, evidence of infection and so forth. I think the clinical factors that tell the 3:52:35PM obstetrician whether somebody is likely to progress in labor are really mostly at your finger tips when the patient first presents, and those are the ones that we've already described.

Q. Bleeding, strength of the contractions, 3:52:51PM frequency of contractions. Have I missed anything? Clinical chorio.

A. Signs of clinical chorio.

Q. Right.

A. Uterine tenderness. 3:53:03PM

Q. Uterine tenderness.

A. Yes.

Q. We covered it?

A. I think that -- I mean, if something else occurs to me I'll let you know. But I think those are 3:53:09PM most of the things you use clinically to make an assessment. You can do laboratory assessments, you can do amniocentesis and other things to draw amniotic fluid out and do tests on it, but these are infrequently used. So for the vast majority of patients with preterm 3:53:20PM

premature ruptured membranes, I think those are the tools that you would use. 3:53:20PM

Q. I think we've already agreed to this, but the lower the gestational age the likely greater the latency period? 3:53:40PM

A. In general.

Q. In general.

A. As I said, most of the information is obtained from people when they contract -- when they rupture membranes, are not in labor, they don't have regular contractions. 3:53:48PM

Q. Can we agree that with PPROM, an accurate diagnosis of PPROM is critical on the management of this patient?

A. Yes. 3:54:01PM

Q. Why?

A. Well, if a patient does not have ruptured membranes, the natural history of the whole condition is different than if they have ruptured membranes. Just as we are pointing out, tocolytics -- there's reasonable evidence that with intact membranes and the same uterine ac- -- contractions you -- more patients who receive a tocolytic -- some tocolytics -- will still be pregnant in 48 hours than those who receive placebo; we know that. But if you have -- missed the diagnosis and they 3:54:13PM 3:54:30PM

really have ruptured membranes, then you don't have a good reason to expect that benefit because you -- it's never been shown. 3:54:32PM

Q. I didn't hear the end.

A. It's never -- you don't have a good reason to expect the same benefit if they have ruptured membranes, because it's never been known. So that's just one example of the kind of thinking that is influenced by whether the patient has -- has ruptured membranes or not. You have to -- you have to be able to confirm that. 3:54:48PM 3:54:50PM

Q. Would you agree with this statement, that an accurate assessment of gestational age and knowledge of maternal, fetal and neonatal risks are essential to appropriate evaluation, counseling and management of a patient with PPROM? 3:55:04PM

A. Yes.

Q. Are you familiar with something called an epic system?

A. Not by that name. 3:55:20PM

Q. Do you have a computerized record keeping system at county hospital?

A. No.

Q. Do you have a computerized -- is that the only hospital you have privileges at, county hospital? 3:55:33PM

A. No. I have privileges at a number of hospitals where we consult. 3:55:36PM

Q. Do any of them have computerized charting?

A. None of them have computerized charting. Some of them have computerized doctors' orders and so forth. Actually, none of them have computerized charting, at the present time. 3:55:47PM

Q. Do you have an understanding of what the Epic -- Epic System is?

A. No. 3:55:54PM

Q. Can Depo-Provera -- if a women is taking that as a birth control, can that lead to an inaccurate last menstrual period?

A. Well, if you're taking Depo-Provera, you may not have any menstrual periods at all. And the -- the time you get pregnant is your first ovulation and you were destined to have a period but you got pregnant on that first ovulation, then there will be no last menstrual period. 3:56:32PM

Q. I was under the impression that Depo-Provera causes women for, at least a short term, the next three or four or six months, to have an irregular period? 3:56:47PM

A. It can. So even though most women have no bleeding, if you have some bleeding and then you get pregnant on one of those early ovulations, as you're 3:57:03PM

escaping from the Depo-Provera, it could certainly be confusing to figure out the due date from the last menstrual period. 3:57:07PM

Q. Could the amniotic fluid index, as observed through ultrasound, influence how long a PPROM patient will stay pregnant? 3:57:23PM

A. It can give some general -- actually, I don't know that there is any data on that. Most people have the impression that if there is no fluid seen on the ultrasound, you're more likely to deliver sooner than if there is some fluid. That depends somewhat on how far you are from the time of rupture, because the process of the fluid actually leaking out takes, you know, some hours. But there can be some association in chronic ruptured membranes. 3:57:40PM 3:57:56PM

Q. Now, I want to talk about the duty and responsibilities of the obstetrical caregivers in 2001, or the standard of care by some of the agents of MetroHealth.

In 2001 can we -- and in all these questions, so you understand, on standard of care, are directed to what the standard of care was in 2001, understood? 3:58:16PM

A. Yes.

Q. Okay. Can we agree that care -- the obstetrical care providers at outlying community 3:58:33PM

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? 3:58:35PM

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. 3:58:57PM

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. 3:59:17PM 3:59:31PM

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? 3:59:54PM

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 4:00:10PM

care? 4:00:13PM

A. Well, in general, if you have a policy you should follow it.

Q. Right. And you recognize that some prenatal clinics have verbal policies and some have written 4:00:24PM policies, when policies are reduced to writing, that there is a practice?

A. I don't know -- I wouldn't call that a policy. I'm not familiar with the term "verbal policy."

Q. Okay. Can we agree that an ob- -- obstetrician 4:00:36PM at a community prenatal clinic feels there are uncertainty of dates or a discrepancy of dates while he's taking care of a patient, he has a responsibility to indicate his perceived discrepancy in dates on the chart in a timely fashion? 4:01:01PM

A. When the information that makes one suspect that the dates might not be correct is made available to you, it should be noted in the chart. You can't, sometimes, draw a conclusion about that until you get -- you get other bits of information. So when the 4:01:28PM conclusion is drawn as to what any bit of laboratory information signifies is, something that's within the judgment of the doctor to do it. But if you have something that is material to the patient's care that comes to your notice that other practitioners might want 4:01:35PM

to know, it's sim- -- reasonable to put it on the chart. 4:01:39PM

Q. Can we agree that the obstetrician at the prenatal clinic has an independent duty and responsibility at each visit to confirm gestational age?

A. To the best of your ability, at that time, given all the information you have, yes. 4:01:57PM

Q. Can we agree an obstetrician taking care of a patient with suspected PROM -- PPROM, has a duty -- that it's critically important for them to confirm the PPROM itself; correct? 4:02:28PM

MR. MALONE: I'm going to object, because I don't think it's a complete question.

MR. BECKER: I'm sorry.

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

BY MR. BECKER: 4:02:34PM

Q. I'll start over, Doctor.

Can we agree, Doctor, that an obstetrician taking care of a patient with suspected PPROM, has an independent duty to confirm the PPROM? Do you agree?

A. Yes. 4:02:52PM

Q. And there are various ways to confirm PPROM; correct?

A. Yes.

Q. Would you tell me what they are?

A. One is by testing the pH of the fluid that's 4:03:04PM

escaping from the cervix into the vagina. That's so-called Nitrazine testing. 4:03:11PM

Q. Okay.

A. Another is by taking a specimen of the fluid that appears to be escaping from the cervix and placing it on a slide to look for a characteristic pattern of drying called -- 4:03:19PM

Q. That's the fern test?

A. -- called ferning.

Q. Okay. 4:03:28PM

A. Another, probably the most common, way is gross rupture of membranes. In other words, the patient -- just fluid runs out all over the place. Those are there -- there are other tests available; newer, expensive tests and so forth. But those are still the mainstay of confirming ruptured membranes. 4:03:40PM

Q. And if one still has unconfirmed, then one should proceed to an ultrasound?

A. The ultrasound can't confirm ruptured membranes. It can only give you a -- it's an indirect support, one way or the other. For example, if the ultrasound shows less fluid then you would expect, and the patient says, I'm leaking, and you couldn't confirm by the other tests, you'd say, well, it might be true and I just -- my test just didn't pick it up. It's 4:03:57PM 4:04:11PM

falsely negative. 4:04:13PM

And on the other hand, if it looks normal you could say, then, she probably isn't ruptured. But neither case would be confident that that's absolutely true. It's an indirect, and it's supportive. 4:04:22PM

Q. When do you, as a clinician, proceed to the last step to confirm PPROM, and that is a dye testing? When do you do that?

A. Very infrequently. I've done it once in 20 years. 4:04:40PM

Q. I have read that the reliability of the fern and the Nitrazine are in the 80- or 90-percent range.

Do you agree?

A. You know, I -- it's interesting, because those tests are used every day, but I'm not sure that they've ever been subjected -- new tests that are introduced have very detailed studies of sensitivity, specificity predictive value. I'm not sure that ferning and Nitrazine have ever been done in that way. The reason you clinically can use ferning and Nitrazine is, because they have -- you can do them repetitively if you you're not sure. And you also have the ability just to watch the amount of fluid that's coming out. 4:04:54PM 4:05:05PM

So by various means, you're able to determine, with almost complete certainty, who really has ruptured 4:05:27PM

membranes or not. But sometimes it takes -- you know, we'll say to the resident, go back and do that again if the patient says, I'm leaking out, quickly do an exam. So by repeated applications of the test, you can usually almost figure out if a patient is ruptured or not. Sometimes you do need to do the dye test. As I said, I find that very unusual. 4:05:30PM 4:05:41PM

Q. You have written, Doctor, that the diagnosis of PPROM is established by the presence of at least two of the three standards of findings of pH greater or equal to seven, a fern pattern of dry fluid, and vaginal pooling of amniotic fluid; correct? 4:05:56PM

A. Yeah. That's what we just said.

Q. So unless you have two of the three, then PPROM is never really established? 4:06:11PM

MR. BECKER: Objection.

MS. REID: Objection.

THE WITNESS: If you have -- if there's fluid running out all of over the bed, that's going to do it. You not going to subject -- 4:06:21PM

BY MR. BECKER:

Q. Right.

A. -- the patient to the others.

Q. Right.

A. So you know if there's -- there's gross 4:06:23PM

rupture. But if you're doubtful and you see a little pool of fluid, you'd like to have something else to confirm it. So you need one of those other tests. 4:06:25PM

Q. Okay. Can we agree that the obstetrician of taking care of a patient with suspected PPROM, has an independent duty to confirm gestational age? 4:06:37PM

A. Yes.

Q. And what are the means available to confirm gestational age?

A. History, when the patient's last menstrual period, the prenatal record showing the size and dates, any prior ultrasounds that are available to you, you can get some idea from -- by doing a scan at the time that you're evaluating the patient, right when they have ruptured membranes. Those are probably the main tools that are available. 4:06:51PM 4:07:15PM

Q. Same question; the obstetrician taking care of a patient with suspected PPROM has an independent duty to confirm fetal presentation; do you agree?

A. Yes. 4:07:30PM

Q. Same question; the obstetrician taking care of a patient with suspected PPROM has an independent duty to confirm an estimated fetal weight?

A. I would say that you have to have an idea of the gestational age of the patient. And if the 4:07:47PM

estimated weight of the patient would make a difference in the management, then a weight determination should be made. On our own service, we like to have an estimated weight on everybody who comes in with ruptured membranes that's thought to be preterm premature ruptured membranes. 4:07:48PM 4:07:58PM

Q. Why?

A. Because we might use it for -- it might change management. In many services, or most services in the country, you can't get an ultrasound for estimated fetal weight when somebody comes in with ruptured membranes. But you have -- you get an estimate of gestational age. If the estimate of fetal weight would change your management, then you should get it. If it doesn't, it's an extra bit of information, so you can tell the baby doctors ahead of time, you know, what you think is coming out and so forth. 4:08:10PM 4:08:22PM

But the things that you have to know in order to take good care of a patient are: The gestational age, your best estimate of the gestational age, and the position, and, of course, the general well-being based on the monitor tracing and so forth. 4:08:34PM

Q. So when you feel the need to know estimated fetal weight, you utilize ultrasound?

A. Yes. You can do it by other means, but if 4:08:47PM

someone is preterm, ultrasound is better than clinical examination. So if ultrasound is available -- and that's how we do it -- it's -- it's not a standard of care. It's not done in most hospitals. But you have to do -- by some means, you have to figure out the gestational age of the patient. 4:08:51PM 4:09:05PM

Q. Can we agree that the obstetrical team, when taking care of a suspected PPROM, should avoid all digital exams?

A. You try to limit digital examination. If the patient is expected to labor and go on to deliver, then digital examination is sometimes necessary. It's usually necessary at least once. But unless there's evidence of distress in labor or some other reason to do another exam, you would limit the exams to the extent possible. 4:09:18PM 4:09:37PM

Q. In fact, Doctor, you've written, you shouldn't engage in a digital exam until you have confirmation of PPROM; correct?

A. If you have confirmation of PPROM, you shouldn't -- you shouldn't do an exam -- a digital exam. 4:09:50PM

Q. Unless you have confirmation of PPROM, you shouldn't engage in a digital exam?

A. No, I'd say, if you have con- -- if you have confirmation of PPROM, you shouldn't do an exam. You 4:10:02PM

shouldn't do one once you know that they have preterm premature ruptured membranes. You shouldn't do an exam, unless you're plan is to deliver. I sound like I'm not making myself clear. 4:10:05PM

Q. Yeah. Either that or I -- I'm not hearing you right. So tell me that one more time. 4:10:18PM

A. If you know that somebody has preterm premature ruptured membranes and you're not planning to deliver them, you should not do a digital exam. If you know somebody has preterm premature ruptured membranes and you think that the plan is for delivery, then you may do an exam, and sometimes you need to do an exam, but we generally try to limit the number of exams compared to someone who has intact membranes. 4:10:30PM

Q. Well, have you written, Doctor, that -- that unless PPROM is established, one should not engage in a digital exam; it's only when PPROM has been established that one then can do a digital exam. Have you written that? 4:10:47PM

MR. MALONE: He just said -- I mean -- 4:10:59PM

THE WITNESS: No, I wouldn't -- unless it's out of context or something, I -- it would be contrary to my teaching that you should -- unless you've established PPROM, you shouldn't do an exam. Because I would say, don't ever do an exam, even when you have established 4:11:11PM

PPROM, unless you're going to deliver the patient. If you hope that the patient is going to stay pregnant, don't -- and you -- and you think they have ruptured membranes, you should not do an exam. 4:11:12PM

BY MR. BECKER: 4:11:24PM

Q. Well, what are the dangers -- if you have unconfirmed PPROM, what are the dangers of doing a digital exam?

A. Well, now, that's something different, I think, than you asked me. If you're not sure if they have ruptured membranes, but you think they might be ruptured, then you should do a sterile speculum examination to try and confirm it. In other words, you do an exam, you look at the cervix, but you don't do a digital exam. 4:11:35PM 4:11:47PM

Q. Okay. And why don't you do a digital exam?

A. Because you increase -- you can increase the chance of infection the -- rate of infection.

Q. Can you also increase the risk of ruptured membranes by doing a digital exam? 4:11:57PM

A. It's -- I don't know that that's ever been studied. It's, I think, unlikely, but it's possible if the membranes are already bulging out, for example, you could. Under normal circumstances, a digital exam does not increase the risk of ruptured membranes. 4:12:16PM

Q. Can we agree that one should not -- in taking care of a PPROM patient, one should not engage in amnioinfusion before gestational age is confirmed? 4:12:25PM

A. You should only engage in amnioinfusion, in a patient who has PPROM, if you're planning to deliver that patient, if -- if you're in the process of delivering that patient. You can't do amnioinfusion, otherwise. 4:12:42PM

Q. Well, is -- is there a recommendation or a rule that you don't do amnioinfusion at a certain gestational age, you only do it over -- past a certain gestational age? 4:12:54PM

A. No. I don't know of any limitation like that.

Q. In the prenatal care, can we agree that the obstetrical caregiver has a responsibility to note fundal height? 4:13:04PM

A. As a general rule.

Q. Can we agree in PPROM, fetal presentation should be confirmed prior to the administration of Pitocin? 4:13:49PM

A. Yes.

Q. Why?

A. Because if you don't have -- if you don't have rupture of membranes -- well, because that can affect your decision whether to give Pitocin. In other words, 4:14:05PM

a person -- a patient at the same gestational age, if you think somebody is 34 weeks and two days, or 36 weeks and two days, and you think they have ruptured membranes, you'll give Pitocin. That's a very common practice. That's what we do. That's what many doctors in the country do. If you think that they're not ruptured in the same patient, you wouldn't give Pitocin. 4:14:08PM 4:14:25PM

Q. Well, what if you have a breech baby and you're dealing with a 30-weeker or a 28-weeker, you don't want to -- at least breech by history -- you don't want to give Pitocin before they confirm fetal presentation, do you? 4:14:37PM

A. I think that's a separate question. But, yes, you don't want to give Pitocin until you know the presentation. You have to know the presentation. 4:14:51PM

Q. All right.

Let's -- let's talk about Dr. Charada, in standard of care violations by him -- and I'm just going to talk about deviations here -- can we agree that Dr. Charada failed to keep the prenatal and ACOG flow sheet current and up-to-date, by failing to note the results of Dr. Ashmed's ultrasound? 4:15:04PM

MR. MALONE: Objection.

THE WITNESS: I think he noted that the -- the result that he saw on the 26th of July, but he didn't 4:15:16PM

draw any conclusions from it. He simply ordered another ultrasound. I think that was sufficient. He could do more. You could write more, but he didn't draw a conclusion about the result. But he noted that ultrasound result had come through; that he wanted it to be repeated. 4:15:21PM 4:15:34PM

BY MR. BECKER:

Q. He didn't record the result, did he?

A. He just recorded a plan, I believe, to have a repeat ultrasound. 4:15:43PM

Q. He didn't record the result, and he had a responsibility to record the result and keep that chart updated, didn't he?

A. I -- it depends on what's done with the record. Sometimes the ultrasound results are forwarded to the hospital along with the records. Sometimes the record, just those few pages, are the only thing that are ever forwarded. So I -- in most places, if there is a recent ultrasound, it will be forwarded over with the other records when those are updated, and they're usually updated every few weeks in the third trimester. 4:15:59PM 4:16:15PM

Q. We've agreed, previously, Doctor, that the prenatal clinic obstetrician has a responsibility, as most -- as reasonably as possible, to keep those -- that chart updated, particularly, because he's not going to 4:16:29PM

be the one to deliver. And we can agree, in this case, Dr. Charada did not complete the form, where -- where it's a place to show the results of the ultrasound, did he? 4:16:32PM

A. Not to the best of my recollection. 4:16:44PM

Q. Okay. And he -- a diligent obstetrician should have completed that; correct?

A. He should do that if it's not his presumption that part of the record will also be forwarded for the doctor's perusal on labor and deliver. 4:16:58PM

Q. Okay --

A. In other words, if you have new labs or new records, and when the record is sent over, those are going to be forwarded -- the question is, what is the record? 4:17:06PM

Q. And if you doesn't note then --

MR. MALONE: Michael, please let him finish his answer. Excuse me.

BY MR. BECKER:

Q. Go ahead, Doctor. 4:17:12PM

A. But if their practice is to forward only those three pages, ever, and he has no reason to think that that other one is going to be forwarded, then he should note that down there so the doctors can have an updated indication. If he has reason to believe, or he 4:17:27PM

personally, will send over the updated ultrasound report, then he doesn't have the same obligation. He's got to make the updated information available to whoever is going to care for the patient. 4:17:29PM

Q. Fair enough. I want you to assume it's true, that Dr. Charada has testified under oath that he had no idea what was sent over and whatnot; under those circumstances, he should have charted the finding in that prenatal chart; correct? 4:17:39PM

MS. REID: Objection. 4:17:51PM

THE WITNESS: He -- if he -- he needs to make -- he needs to have some understanding that -- another person that's going to take care of that patient will have access to that information.

BY MR. BECKER: 4:18:04PM

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

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

Q. Okay. And assuming that he did not do that, that's a deviation? 4:18:13PM

A. Yeah -- I --

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

But go ahead; you can answer.

THE WITNESS: If the -- when the updating takes 4:18:20PM

place, is -- that's part of a -- in all obstetric practices, there's variation in that. Whether it prints -- in our office, the clinics update the records. After they've been sent over, initially, and somebody has them in labor and delivery, they're updated about every two weeks. 4:18:23PM 4:18:34PM

So, in this setting, I don't think there would be -- have been any chance for someone to have any new information from Dr. Charada's evaluation of the patient at the time. But when he gets new information, that could affect the patient's care either it -- it has to be some way forwarded in whatever fashion it's customarily done and whatever time frame it's customarily done. And if it's not -- if nobody is going to send that ultrasound report, then they should write it in the prenatal record. 4:18:53PM 4:19:08PM

BY MR. BECKER:

Q. And if he didn't do that, then it's a deviation?

A. If he -- if it was not -- I mean, he obviously didn't do it before 7/31, because that's only four days from the day he saw the report. So there's very few practices that would have done that. And that would be in -- just chance if that was whatever their time frame is from the last time he updated it. But -- let's say 4:19:15PM 4:19:30PM

that was the day he was supposed to send over the updated records, if he did not note that on the prenatal record and he did not send the ultrasound, I think that would be below the standard of care. 4:19:33PM

Q. Okay. Thank you. 4:19:52PM

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. 4:20:04PM

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? 4:20:19PM

MR. KULWICKI: You know. Let's go off the record for one second.

THE VIDEOGRAPHER: We're off the record at 4:20.

(Recess.) 4:20:31PM

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 4:26:34PM

received the ultrasound for the 7/12; correct? 4:26:39PM

A. Yes.

Q. And I think we've established that he had a responsibility, either, to note that ultrasound resort -- result in the char- -- chart or to ensure that 4:26:48PM the ultrasound was going to be sent over to the hospital; correct?

A. Yes.

Q. Now, did he make a determination of gestational age on the last office prenatal visit? If he did, I -- 4:27:11PM I'm overlooking it.

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

Q. Okay. That's a deviation?

A. It could be. It -- I mean, that's not -- I'd have to look at the whole rest of the record and see 4:27:26PM what else he's noted on here. It can be at -- at any given time in a patient's care that you're not sure how far along they are. So he has a new bit of information on this date, and he's not sure what gestational age she is, and he feels like he needs a confirmatory ultrasound 4:27:44PM to say.

So if you're going to take care of the patient, you have to arrive at a conclusion if she needs an intervention. If she doesn't need an intervention that day, he may not be able to tell. So he doesn't 4:27:55PM

necessarily have to write it down. But a doctor who is going to actually care for the patient, he doesn't foresee that she's going to be in the hospital four days later, has to come to a conclusion, because your decisions depend on the gestational age. 4:27:58PM 4:28:10PM

So at this point, it appears that he felt he could not confirm the gestational age. He had an ultrasound that conflicted with the last menstrual period, and he wanted to get another ultrasound to decide what gestational age she is. Sometimes people would write here that she's this gestational age or that one, and I'm not sure what she is. 4:28:24PM

Q. But we previously agreed that if he had, in his mind, there was discrepancy between dates, he had to make it clear on that prenatal chart that there is a discrepancy in dates for the subsequent caregivers; correct? 4:28:37PM

A. He should make clear any meaningful information that somebody else would need to take care of the patient. And so he notes that there was -- he doesn't note, specifically, the dates. I believe he noted there that was an ultrasound done and that he requested another ultrasound. 4:28:48PM

Q. Here's my question, doctor: Is it a deviation from him by failing to note the discrepancy in dates -- 4:29:03PM

by letting the subsequent caregivers know there's a discrepancy in dates in his mind, is it a deviation of a diligent obstetrician? 4:29:10PM

A. I think it would be best practice to write down all the information that you have from the ultrasound. What he's done here -- let me just make sure that I've seen everything -- 4:29:22PM

Q. Take your time.

A. -- that what was obtained on that date. There was a progress not page; isn't there? 4:29:30PM

MR. MALONE: Yeah, go to 22. Right there.

THE WITNESS: So he's written in his progress notes -- and that's where I was recalling that -- ultrasound to be rescheduled 8/20/01. What he's communicating is that, he needs more information to establish the patient's gestational age; that a reasonable person can't be sure what her gestational age is at this time. 4:29:59PM

BY MR. BECKER:

Q. Well, that's your interpretation. He's not making it clear to subsequent caregivers of the discrepancy in dates, is he? 4:30:06PM

A. I think a reasonable person who looks at this record has enough information to say, that there's some -- if they get this prenatal -- the progress notes 4:30:19PM

also, that there's some information that needs to be obtained further to establish the patient's date, or there is some uncertainty of the patient's dates. I think it would be best for him to write down, we're not sure about the dates, the ultrasound is different than our preceding dates, and she may be -- she needs a further follow up. 4:30:22PM 4:30:33PM

Instead what he writes down is -- he doesn't put down the dates, puts down the fundal height, and writes, we need another ultrasound. 4:30:46PM

Q. I want you to tell me what it is about that chart and progress note that tells you that he has a -- a concern about a discrepancy of dates?

A. He doesn't write down the dates, and he -- although, he has previously noted them. And he previously ordered an ultrasound, and he wants a follow-up ultrasound. It is -- it is an inference from that information that he is uncertain about the patient's dates. 4:31:01PM

Q. But he didn't communicate that to a subsequent caregiver, and he had a responsibility to do that. We've agreed on that earlier; correct? 4:31:19PM

A. I think there's enough information here that a responsible caregiver picking up this record could determine that the patient -- that there was some 4:31:43PM

uncertainty about the patient's dates. I think that it could have been made clearer by the doctor. 4:31:44PM

Q. Now, Doctor, do you think that Dr. Lewis knew, by looking at that chart, that Dr. Charada had a discrepancy -- felt, in his mind, there was a discrepancy in dates? 4:31:55PM

A. She couldn't be certain. She'd have to infer that from looking at the record and looking at his note, that he was going to get a follow-up ultrasound.

Q. Okay. But the follow-up ultrasound was simply done at the -- at the recommendation of Dr. Ashmed; isn't that true? 4:32:19PM

A. Yes. But also --

Q. He's --

A. Yeah. 4:32:19PM

Q. Excuse me.

A. But that's part -- the reason for the follow-up ultrasound is to confirm the dates; that's one of the reasons.

Q. The follow-up ultrasound was relative to the kidney anomaly? 4:32:23PM

A. That's one of the reasons.

Q. Okay. No reasonable person can conclude, based on that chart by Dr. Charada, that he had a concern about discrepancy of dates? 4:32:42PM

MS. REID: Objection. He's answered it, like, three times. 4:32:44PM

MR. MALONE: Yeah.

THE WITNESS: No, I think a reasonable person could conclude that, it's -- the record is not as clear as it could. And -- but I think a reasonable person could conclude there was some concern about the patient's dates. 4:32:49PM

BY MR. BECKER:

Q. Can we agree that a diligent obstetrician should have made it clear, more clear than what you see there and what you're inferring in there, should have made it more clear to a subsequent caregiver that there's a real concern, in his mind, about discrepancy in dates? 4:32:57PM 4:33:13PM

Hold on a minute, Doctor, because I'm getting tired. I don't remember what my question was.

She's going to read it back, okay?

(The previous question was read.)

BY MR. BECKER: 4:33:18PM

Q. Are you assuming that the progress flow sheet was sent with the ACOG sheet?

A. Yes.

Q. Okay. If Dr. Charada had no knowledge what documents were sent, can we agree that -- that a 4:34:31PM

diligent obstetrician should have made it more clear than what he did, that there is a discrepancy of dates there? Yes or no? 4:34:34PM

A. If he knows that this is the -- or if he has reason to believe that this is the only information that's going to be conveyed, I think that there is meaningful information that could influence another doctor's care, that's not conveyed on this. 4:34:45PM

Q. That's a yes to my answer (sic)?

A. So, yes, I think that other information should have been conveyed. And if he knew that this was all that was going, that would not be adequate. 4:35:00PM

Q. Let's talk about the -- the steps that Dr. Lewis or Razi (phonetic) did to confirm PROM -- PPROM. What steps did they utilize? 4:35:25PM

A. Ferning and Nitrazine tests were initially done.

Q. They were all negative?

A. They were negative.

Q. Okay. 4:35:35PM

A. And then, subsequently, the patient ruptured.

Q. When did the patient rupture?

A. When she -- it says ruptured in triage.

Q. What time, if you know?

A. I'd have to -- I don't know that you can 4:35:46PM

actually tell that from that -- 4:35:48PM

Q. To be fair with you, I don't think it's clear in the record what time -- the exact time the membranes ruptured. Can we agree, at least when the results of the fern in the pooling came back -- the fern, the 4:35:58PM Nitrazine, the pooling came back, that Dr. Lewis and Dr. Razi, the supervising attending obstetrician, should have had real questions whether or not there was PPROM, at that point, and they came back negative?

A. You can't tell when they come back negative. 4:36:18PM The person could be ruptured and it's negative, or it could and is probably more likely that they're not ruptured if they're both negative. And if -- if the patient has some leaking of fluid, or any history of leaking of fluid, you'll have to confirm that. That's 4:36:31PM my understanding, that the -- Dr. Lewis's statement is the patient ruptured grossly in the triage area, and there was no question of ruptured membranes. That's the way most ruptured membranes are confirmed.

Q. I'm going to take it one step at a time. 4:36:48PM

A. Okay.

Q. Because the minutes here, I think, are critical as to what happened in triage and the record is unclear, I think. She's got negative -- she's got a negative fern; she's got a negative Nitrazine. At the moment 4:36:59PM

those are known, assuming that the membranes haven't ruptured yet, can we agree that the obstetrical caregivers had had real doubt or at least uncertainty whether the membranes have ruptured? 4:37:03PM

A. You have to have some uncertainty, unless you see obvious pooling, and you think I'm not sure why they're negative, but that would be unusual. 4:37:18PM

Q. Can we agree, that until there was a gush of fluid, until there was reasonable confirmation of the PPROM, Dr. Lewis, the obstetrical nurses, should not have engaged in a digital exam? 4:37:37PM

MS. REID: I'm going to object to the use of "PPROM" in this hypothetical.

But go ahead on this question.

THE WITNESS: If you do -- if you do ferning and Nitrazine and you think that they're not ruptured, then it's acceptable to do a digital examination. If you made a determination that they're probably not ruptured, then it's reasonable to do a digital exam. If you -- if you have a very high suspicion of ruptured membranes and the ferning and pooling are negative, but you're suspicion is very high, then it's probably most judicious not to do and exam. 4:37:54PM 4:38:08PM

If you have some suspicion -- after all, in a unit like this, you could have three or four patients a 4:38:22PM

night come in, they think they ruptured membranes. Ferning, pooling is negative; you check them, you say your cervix is closed, and you don't need to -- you don't need to worry about it. So once you have ferning and pooling a negative, you can do an exam -- a digital exam. 4:38:26PM 4:38:37PM

BY MR. BECKER:

Q. Okay. Thank you.

Can we agree that Dr. Lewis failed to take steps to confirm gestational age and presentation before the administer -- the administration of Pitocin? 4:38:48PM

A. No. She --

Q. What did she do?

A. Well, she got the patient's history, and she had consulted the prenatal record. And she made a -- there was a physical assessment of the patient. And based on that determination, she believed the patient -- she believed that she arrived at a gestational age that she thought was reasonable. 4:39:08PM

Q. But -- we previously agreed that a -- even a resident -- maybe we didn't say it this way. 4:39:31PM

Can we agree that -- we previously agreed that obstetrical caregiver should be able to discern the difference between a -- in a physical exam, between a mom carrying 1,000-gram baby versus a mom carrying a 4:39:53PM

3,000-gram baby? 4:39:57PM

A. Generally.

Q. Okay. And --

A. But there's a fair -- I -- I agree, generally. There's a lot of variation in that. I do ultrasounds 4:40:01PM for estimated weight all the time. Many of patients come in and somebody -- I do a scan on them, I call the doctor and I say, you thought this baby was 2500 grams, and it's not. It's 1500 grams or it's 1000 grams, and you -- this is significant growth restriction. And 4:40:18PM nobody knew it, or they had a -- a suspicion but they doubted it.

So there's a lot of variation which a conscientious doctor can determine, just as is evidenced by the prenatal record. Dr. Lewis had the prenatal 4:40:24PM record, which shows the size of the baby, pretty much fitting with the gestational age. It's not right on, but it's not very far off. And this is from Dr. Charada's assessment.

So we have more than one doctor, looked at this 4:40:39PM patient and thought, this baby looks like it's about this size. And she goes to the patient and says, what's last menstrual period? What's your due date? You have a recent ultrasound examination. This is all part of the doctor trying to determine how far along the patient 4:40:55PM

is. And all of these factors combined can give her a reasonable assessment of the patient's age. And I think that Dr. Lewis used all those criteria. 4:40:58PM

Now, if I -- if Dr. Lewis is on my service, I say to her the next day, if you got a patient that's 3,000 grams and didn't notice it, what were the factors that went into that? What's the patient's body habitus? Who else has seen the patient? Is there any other explanation for this? Sometimes it happens that we -- 4:41:09PM

that's why we don't -- we can't rely, always, on the physical assessment. 4:41:22PM

Q. Right. Sometimes you're dealing with an obese patient, it's difficult to -- to figure out how big a baby you have, but --

A. Right. That doesn't apply in this case. 4:41:32PM

Q. Right.

A. But sometimes you can't -- you just can't tell, accurately, a person's gestational age by the physical assessment. And that's what we're dealing with here. But that's -- that's something that happens to every obstetrician who takes care of patients. 4:41:43PM

Q. But let's apply it to this case, Doctor. We've got -- we've got a doctor that thought she was taking care of a 36- or 37-weeker with an estimate -- with a suspected estimated weight of -- of 3,000 grams, when 4:41:59PM

she had a 27-weeker with 1,000 grams. 4:42:03PM

Would you expect that a diligent caregiver -- obstetrical caregiver, should have been able to discern the difference just on physical exam?

MR. MALONE: Objection, Mike. I think he's answered that particular question about five times, if you read the transcript. He has said generally, and that -- and then he's given you explanation of why that isn't universally so. I'll let him do it one more time. But, please, we've got to move along. 4:42:21PM 4:42:30PM

THE WITNESS: Yeah. I don't think the difference is between 3,000 and 1,000. I think the -- the average ges- -- this baby's actual dates were around 34-and-a-half, 35; the weight between 34 and 36 could, usually, be 2500 grams. Could be a little bit less, could be a little bit more. Still, it's a significant difference. 4:42:50PM

But a conscientious physician is doing a good job, tomorrow on my service or I, myself, could miss that on a physical assessment. It can happen. Is it usual? No. More often than not, you're able to make that kind of assessment. But that is a reason- -- a thing that reasonable, good obstetricians still encounter in practice. That's -- sometimes, your physical assessment is not on the money. And you have 4:43:03PM 4:43:15PM

to put it together with the rest of the information you have. 4:43:19PM

One of the most important things that the obstetrician relies on is communicating with the patient. And that's -- you've got to go by their history. And we don't instant access to all information, so the patient's history of her dates and recent ultrasound is important, and that also shapes your assessment of all the other information. 4:43:29PM

BY MR. BECKER: 4:43:43PM

Q. Doctor, with a clinical history of complaining of leaking clear fluid one hour before triage and noted wetness in the undergarments, and negative fern, and negative nitra- -- Nitrazine, and negative pooling, would you think more likely than not, that patient is -- has not ruptured the membranes yet? 4:43:55PM

A. You just can't tell for sure. They might not have. That could be somebody who is just laboring, and they're having a heavy discharge with their have labor, so you -- you've got to do some kind of assessment of the cervix if the fern and Nitrazine are negative. 4:44:15PM

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

A. I -- my impression was that the presentation 4:44:28PM

was confirmed before that, before the impre- -- before the administration of Pitocin. 4:44:30PM

Q. Can I represent to you, that Pitocin was started at 8:00 o'clock, and they didn't do an ultrasound for fetal presentation until 10:00 p.m. that night. Assuming that to be true; is that a deviation? 4:44:41PM

MR. MALONE: Well, I'm -- I'm going to object because that isn't the way presentation was confirmed.

THE WITNESS: Yeah. Physical assessment can be used to confirm presentation as well. 4:45:00PM

BY MR. BECKER:

Q. Do you see anything in the chart, Doctor, in your review of this case, where presentation was confirmed prior to the administration of Pitocin?

MR. MALONE: What time did you say that the Pitocin was started, Mike, in your question? 4:45:23PM

MR. BECKER: I think that was 8:00 p.m.

MS. REID: I don't know how accurate that is.

THE WITNESS: 8:30 or so, I believe the --

MS. REID: I think it's 8:30. 4:45:41PM

MR. BECKER: Yeah.

THE WITNESS: The physical exam noted times 20:38, and the Pitocin started around the same time. And my presumption was that, the position of the baby was determined prior to the initiation of Pitocin. 4:45:49PM

BY MR. BECKER: 4:45:50PM

Q. Is the testimony by one doctor in this case, that the reason they did the ultrasound is to confirm the presentation, and that was done at 10:00 o'clock; can we agree, assuming, hypothetically, that the 4:46:02PM administration of Pitocin prior to the confirmation of presentation is a deviation?

A. No. If you believe the patient is vertex, to the best of your ability when you start the Pitocin, and then later on someone says, you know, I'm not sure of 4:46:14PM the position, let's check it, that -- that happens every day in units. You go back with the ultrasound and they say, yeah, she is vertex, or, no, she's flipped and she's breech, or -- this can happen. So the fact that the ultrasound was done later to confirm it, just means 4:46:27PM that.

Q. Is there somewhere from Dr. Lewis's deposition or somewhere in the chart that you're concluding that she -- she thought this patient was a vertex presentation? 4:46:37PM

A. I don't remember if the question was ever asked of her. It's one of the cardinal points for administering Pitocin; you have to know the person is vertex before giving Pitocin, unless, you're doing a planned breech delivery, which is uncommon. I don't 4:46:54PM

know how often that would have been done here. 4:46:54PM

Q. Doctor, I want you to assume that MetroHealth had a system in play called an "Epic System," at this time, where the results of Dr. Ashmed's ultrasound were entered into this base -- computer base system, and 4:47:16PM these people in the triage division had access to that diagnostic ultrasound. Can you assume that to be true?

MS. REID: Objection.

MR. MALONE: Michael, that's absolutely false. Why would you ask him to assume that? Every bit of 4:47:31PM evidence you gathered to date has been contrary to that, including the deposition of the computer engineer that the designed the system.

MR. KULWICKI: That's wrong.

MR. MALONE: Well, it's -- it's absolutely not 4:47:40PM wrong.

MR. KULWICKI: It's wrong. He couldn't say one way or the another.

MR. MALONE: Yes, he did.

MR. KULWICKI: We're still trying to chase that 4:47:43PM down, so it's not --

MR. MALONE: You don't ask -- you ask the questions you want answered. But if you want the truth, you got to answer broader questions. Now, I'm going to let him assume whatever you asked him to assume. 4:47:51PM

MR. BECKER: Okay. 4:47:54PM

MR. MALONE: But, Michael, I'm telling you, that's flat out dead wrong.

MR. BECKER: Well, we need to nail that down.

MR. MALONE: And you heard it from Graham Ashmed, you've heard it from everybody who was involved, including, Judette Lewis. I don't recall if you asked all those people. But if you didn't, shame on you. But I believe you did. 4:47:58PM

MR. BECKER: Okay. 4:48:09PM

BY MR. BECKER:

Q. You know the hypothetical. You know what a hypothetical is.

A. Yeah.

Q. Just -- just assume it's true that they had a computerized system at Metro, and the diagnostic testing was accessible to certain people within the obstetrical division at the main hospital; assuming that to be true, okay? 4:48:11PM

MR. MALONE: Which diagnostic testing, now? Just to be specific -- 4:48:30PM

MR. BECKER: Ultra- -- ultrasound.

MR. MALONE: The ultrasound report of Dr. Ashmed?

MR. BECKER: Right. 4:48:36PM

MR. MALONE: And that was accessible to certain people; and who were those certain people? 4:48:34PM

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

MR. MALONE: Well, I mean, you're asking questions that can't be answered because of ambiguities, Michael. And you start of with a premise that isn't true. 4:48:43PM

MR. BECKER: I'm only going to get one opportunity to depose this doctor. I'm going ask him a hypothetical, we'll see what other discovery -- 4:48:51PM

MR. MALONE: Well, go ahead. I just -- I can't sit here and let the hypothetical go unchallenged when it's this far wrong.

MR. BECKER: Then just enter your objection.

MR. MALONE: I did. 4:48:58PM

MR. BECKER: Okay. Can I go?

MR. MALONE: Yeah.

BY MR. BECKER:

Q. Okay. Do you remember my question?

MS. REID: No. 4:49:05PM

THE WITNESS: I'm not exactly --

MR. BECKER: Want to try it?

(The previous question was read.)

THE WITNESS: Okay. I'll assume that to be true. 4:51:14PM

BY MR. BECKER: 4:51:14PM

Q. Okay. Now, can we agree that Dr. Lewis should have utilized, if she was aware of -- and had the means to make access to this information, should have utilized that to look at the results of the ultrasound? 4:51:26PM

MR. MALONE: Objection.

THE WITNESS: If such a result was available to her, and she was aware of that, she should have utilized that, I do believe.

BY MR. BECKER: 4:51:35PM

Q. And if she didn't, it would be a deviation?

MR. MALONE: Objection.

THE WITNESS: If she was aware of -- that it was there and she actually had access to it and she didn't use it, that would be deviation from the standard 4:51:43PM of care.

BY MR. BECKER:

Q. And even if she didn't have access to it, and someone else, like a supervisor or the senior attending had access to it, she should have been made aware of the 4:51:58PM system and the individuals that had access to them; correct?

MR. MALONE: Objection.

THE WITNESS: If -- if she didn't have access to it, but she knew that that result was available -- it 4:52:08PM

depends on -- to some extent on -- on a variable of, such as, how much access? Do you have to call a supervisor in from home with that information? You'd have to have some sense that it was important information. And to -- to that degree, you rely to some extent on -- on the patient. If it's very easily available, and I think that she should get it, if it's readily available. 4:52:16PM 4:52:29PM

BY MR. BECKER:

Q. Either through her or her supervisor in-house, that would be readily available? 4:52:46PM

MR. MALONE: Well, objection. Are you asking if it would be readily available, or if he was obligated if, hypothetically, it had been readily available. It's two different questions. 4:53:01PM

BY MR. BECKER:

Q. You understand my question?

MR. MALONE: I'm going to ask you to clarify because I don't understand it.

Wait for him to ask you another question. 4:53:08PM

BY MR. BECKER:

Q. If -- if the -- if she had access herself or if her supervisor in-house had access, then it should have been utilized; correct?

MR. MALONE: Objection. 4:53:19PM

Go ahead. 4:53:20PM

THE WITNESS: I think I would just use the term "readily available." Because we couldn't, sitting here, go through all the circumstances that would make it readily available. My main thought is, if there was a 4:53:23PM system set up to retrieve it after hours, that would mean readily available. So -- but if the supervisor has never heard of it, and you call him and say, I happen to know it's on that computer; can you let me in? Well, what are you doing that -- this could be a significant 4:53:53PM burden.

But if the supervisor knew and there was a -- a more -- a process set up to get those results after hours, then I think one should go and get them.

BY MR. BECKER: 4:53:58PM

Q. Okay. Let's go back to Dr. Lewis. What did she do to confirm gestational age besides physical exam? We talked about that.

What else did she do to confirm gestational age? 4:54:06PM

A. She took a history from the patient.

Q. Okay. What did the history say?

A. Well, she determined that the patient had had an ultrasound, and that, to the best of her understanding from talking to the patient, did not 4:54:18PM

change her due date. 4:54:20PM

Q. Okay. What -- is that in the chart?

A. That, I believe, mostly I learned from her deposition.

Q. Okay. Well, you -- did you read her deposition? 4:54:27PM

A. Yes.

Q. Okay. And is there a -- is there a discrepancy between the two depositions?

MS. REID: Between whose two depositions? 4:54:47PM

MR. MALONE: What two depositions?

MR. BECKER: The mom and Dr. Lewis.

MR. MALONE: There's -- they have different stories between -- you mean, Gloria Maslanka.

MR. BECKER: Yes. 4:54:55PM

MR. MALONE: -- and Judette Lewis? I -- I think we can agree that they have different stories.

THE WITNESS: Yes, I do know --

BY MR. BECKER:

Q. Is there a discrepancy, Doctor? 4:55:01PM

A. I did notice a discrepancy.

Q. Okay. And does the chart support the mom's version?

A. Well, to -- yeah, to some extent it does. But -- 4:55:18PM

Q. To what extent does it? 4:55:20PM

A. Well, I don't remember exactly the mom's recollection of -- of -- I think the mom recalled that Dr. Ashmed had told her that the baby was smaller than expected at the time of the ultrasound. And, in fact, 4:55:33PM the baby was smaller, and that's how -- how it did come out. So to that extent, it did support it.

Q. What is it about the chart that supports the mom's version?

A. That; that the baby, in fact, was smaller than 4:55:45PM the dates and Mom said that that's what Dr. Ashmed told her.

Q. Can we agree that Dr. Lewis's version of the -- of the exchange between Gloria and her is not charted?

A. That's correct. 4:56:01PM

Q. Can we agree that what Lewis -- Dr. Lewis's version of events, is not corroborated by anyone else, either before or after Shane's birth?

A. Well, it wouldn't -- I mean, there's no reason why the doctor speaking with a patient would have 4:56:20PM independent corroboration of that. But her story is, internally consistent, and she obtained a lot of information from Gloria Maslanka that was accurately reflective of the ultrasound. So she had reason to believe that Gloria Maslanka's recollection of the 4:56:40PM

ultrasound was accurate. 4:56:42PM

Q. Why did she have reason to believe that?

A. Because Dr. -- Ms. Maslanka told her that she remembered Dr. Ashmed mentioning a problem with the baby's kidneys, and she -- a specific detail, the baby's 4:56:50PM position at the time of the ultrasound, and, yet, didn't convey the most important bit of information, which was the change in dates. So this -- the obstetrician, still in the 21st century, relies a lot on the patient's history, what the patient conveys to you. 4:57:12PM

So a patient says, I don't remember anything about that ultrasound, then the doctor doesn't have any misconception. If the patient says, I remember this, this and this about it, but, in a way, doesn't remember some other information, that's an -- an important thing 4:57:27PM that -- it places the obstetrician sort of at the mercy of the patient's recollection. You have got to -- you just can't ignore it. And if the patient doesn't tell you the most important bit of information, it sets you off on the wrong track. 4:57:44PM

Q. Okay. I -- I -- are you -- do you have an opinion as to which version is more accurate or -- or truthful?

A. Well, I can't believe -- there would be no reason for a conscientious doctor to ignore any bit of 4:57:54PM

information that the patient tells her about the ultrasound information. So if she said, Dr. Ashmed told me my baby is very small and my due date is different, no doctor would want to ignore that information. 4:57:58PM

Q. So is that a yes to my question, as to which side do you believe? 4:58:10PM

A. Well, yeah, I guess it is. I think --

Q. Okay.

A. -- that that's the most plausible -- based on my experience, no obstetrician that I've ever run across would want to just ignore meaningful information that the patient is conveying to them. On the other hand, it does happen sometimes that patient remembers some bits of information and not others, and that's just the best that people can do sometimes. 4:58:19PM 4:58:34PM

Q. Do you appreciate, Doctor, at least in Ohio, that whether whose version is correct or truthful, that's up to the trier of fact, the jury, and not you; do you understand that?

MR. MALONE: Well -- well, objection -- 4:58:45PM

MS. REID: You just asked him a question.

MR. MALONE: -- you're the one that asked him the question. I'm not going to ask him that question at trial. You chose to ask him that question. Now he gives you an answer; he doesn't need a lecture in the 4:58:49PM

law. Just ask another question, please. 4:58:52PM

BY MR. BECKER:

Q. Do -- do -- do you understand the question?

A. Yes, I understand.

Q. Okay. Can we agree, Doctor, at the time of admission to L & D, Dr. Lewis dictated a handwritten admit note to Dr. Evanhouse; she handwrote another note to Dr. Evanhouse, another resident; correct? 4:58:57PM

A. I don't recall exactly how Dr. Evanhouse came to the information that he wrote down in the admit note. I know that it reflected part of her assessment and part of his assessment. 4:59:14PM

Q. Did you read Dr. Evanhouse's deposition?

A. I don't think I did.

MR. MALONE: Huh-uh. 4:59:28PM

BY MR. BECKER:

Q. Do you appreciate that Dr. Evanhouse -- there's -- there's an entry in the chart by Dr. -- a Dr. Evanhouse; do you appreciate that?

A. Yes. 4:59:43PM

Q. Do you acknowledge that Dr. Evanhouse contained no reference to comments by Gloria about the 7/12/01 ultrasound; you appreciate that?

A. There is nothing in the record about what Gloria Maslanka said about that 7/12 ultrasound, only 4:59:57PM

that it was done, and that the patient had been -- you know, a history had been obtained from her. 5:00:02PM

Q. Did -- in fact, Doctor, the chart says, "7/12/01 ultrasound equals," and there's a blank there; remember that? 5:00:17PM

A. Yes.

Q. Now, the fact that it's a blank, what does that connote to you?

A. That they expected to get the actual ultrasound result by looking at the prenatal records, or by some other means, or perhaps fill it in in the morning when it was possible to go over and obtain it. They were going to put it in -- put the information in later. In other words, it could be important. 5:00:30PM

Q. Okay. Could be important, and it's unknown -- unknown at the time that ultrasound or that history is taken? 5:00:41PM

A. Yes, it is unknown. The only thing they know about it is what the patient herself is able to communicated to them about it. 5:00:58PM

Q. Doctor, have you ever had a patient, and a resident of yours end up -- first of all, was this an induction or augmentation, in this case? In this case?

A. In my opinion, it was augmentation.

Q. Okay. Have you ever had an augmentation of 5:01:22PM

labor in a presumed, 36-weeker by one of your residents, and it turned out to be a 27-weeker? Has that ever happened to you? 5:01:25PM

MR. MALONE: Objection.

THE WITNESS: I can't recall if that has happened. It's -- it has happened before that someone who was presumed to be further along, 35, 36, 37 weeks, was much less far along, and it's determined only after the baby comes out. That happens from time to time -- 5:01:37PM

BY MR. BECKER: 5:01:53PM

Q. Okay.

A. -- through a series of events.

BY MR. MALONE:

Q. Okay. Doctor, there was a -- a Dr. Goodwin that called Dr. Lewis after the delivery. Are you aware of that? 5:02:00PM

A. I heard -- I saw Dr. Lewis's deposition that that was how she learned that the baby, actually, was of lower gestational age.

Q. Okay. And would you expect Dr. Lewis, in that phone conversation, when she receives a call from the delivering physician and say this baby is not as big as you think it is, we've got a very premature baby, would you expect that -- Dr. Lewis to say to Dr. Goodwin, boy, she told me the ultrasound is consistent with the age? 5:02:16PM 5:02:29PM

MR. MALONE: Objection. We're getting into -- 5:02:35PM
BY MR. BECKER:
Q. Wouldn't you expect her to do it?
MR. MALONE: No. We're not going -- I mean, that's pretty speculative, isn't it? She might have 5:02:39PM first said, gee wiz, I'm really sorry that happened, or gee wiz, what a tragedy; or gee wiz, she missed -- I mean, there is a million things she could have -- who the hell knows what she was going to say, Michael? Come on. 5:02:52PM
BY MR. BECKER:
Q. Would -- wouldn't you have expected that?
MR. MALONE: Don't answer that. It's silly.
BY MR. BECKER:
Q. Do you think -- 5:02:57PM
A. I -- I don't know what she would have said.
Q. Okay.
A. She could have said any number of things. It's inappropriate --
Q. Okay. Let me ask you this one, Doctor: Would 5:03:01PM you have expected a case where you end up augmenting labor on a 27-weeker thinking it's a 36-weeker, would you expect that case to be discussed in peer review, or M and M?
MS. REID: Objection. 5:03:15PM

MR. MALONE: Objection. That one shall not be answered. What they do or don't do is absolutely priveledged by statutes in Ohio. Sorry. 5:03:15PM

MR. BECKER: No. I'm sorry, sir, because I think that's a very relevant -- 5:03:22PM

MR. MALONE: Then we disagree.

MR. BECKER: Okay.

MR. MALONE: What do you want to do?

MR. BECKER: You going to direct him not to answer? 5:03:27PM

MR. MALONE: I just did.

BY MR. BECKER:

Q. Is he your counsel, Doctor?

MR. MALONE: No. But I retained him for purposes of this case. 5:03:33PM

BY MR. BECKER:

Q. Doctor, can we agree that sometimes on documentation in -- in a chart can be so egregious, that it reflects substandard medical practice?

A. Yeah. I think there are settings like that, yes. 5:04:03PM

Q. Dr. Razi had a responsibility to oversee this patient; correct?

A. He was the supervising physician.

Q. He had a responsibility to make sure that -- 5:04:15PM

that this junior resident did a good job assessing gestational age? 5:04:18PM

A. He's responsible for all of the care provided by the residents while he's the supervisor.

Q. Do you think Dr. Razi did a good job overseeing and ensuring that Dr. Lewis did a good job assessing gestational age in this case? 5:04:28PM

A. I think within the confines of how supervisor -- how a supervisor works, I think that Dr. Razi acted within the reasonable standard of care. 5:04:47PM

Q. Can we agree, that Dr. Lewis failed to appreciate 1,000-gram estimated fetal weight, either by physical exam or ultrasound?

A. She failed to appreciate the fact that the baby was much smaller than was suspected -- thought to be by gestational age; I agree with that. 5:05:12PM

Q. If -- if -- if the system that Metro was set up that the ultrasound of Dr. Ashmed was supposed to be sent over to L & D, and for some reason someone dropped the ball and it didn't happen, can we agree that it's a system's ailure (sic) -- system's failure by -- by that ultrasound of Dr. Ashmed not getting to L & D? 5:05:31PM

A. If there was a system set up that said, you know, when ultrasound is completed it's supposed to go to labor and delivery and to the clinic, and that was 5:05:51PM

the preestablished system, and it wasn't done, then that -- that was a failure to comply with one's own system. 5:05:51PM

Q. Okay. And that would be a deviation, if that's the way the system was set up? 5:06:08PM

A. No. I -- I -- I think that that -- because you could have a system set up that's way above any standard of care. Most ultrasounds performed in prenatal care in 2001, and probably still today, go only to the doctor who is providing the care for the patient at that time. 5:06:18PM They do not go straight to labor and delivery. So the fact that someone might have a system that's set up that was -- was allowed -- able to do that, doesn't mean, by itself, that they've established a new standard of care for themselves. I think -- conveying the results to the 5:06:32PM person that's providing the care at that time is the standard of care. And, then, from that record, all the information is collected, and it's conveyed to labor and delivery, as we previously have gone over.

Q. Doctor, you have written -- in fact, you've 5:06:49PM quoted Fanaroff in an article, by talking about the morbidity of 1,000-gram infants in your new book. And you state that, roughly, 10 percent -- 11 percent of those between 1,000 and 1500 grams end up with neurologic compromise; correct? 5:07:09PM

A. Approximately. 5:07:11PM

Q. And that means, assuming good obstetrical and neonatal care 1,000 grams to 1500-gram babies, nine times out of ten, they avoid neurologic injury; correct?

A. Yes. 5:07:25PM

Q. Now, I want you to assume this true, Doctor, that Dr. Lewis has testified, that had she known that the gestational age was reassigned, that the ultrasound reflected a much smaller baby, she would not have administered Pitocin. Can you assume that to be true? 5:08:04PM

A. Yes.

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

A. Yes.

Q. You certainly don't engage in augmentation or induction of labor at a -- when you have PPROM at a 27- or 28-weeker; correct? 5:08:16PM

A. Correct.

Q. You engage in what's called "expectant management;" correct?

A. Unless there's evidence of infection or fetal compromise or some other reason to think that you need to deliver the baby. 5:08:29PM

Q. Right. In this case, we can agree, Doctor, there was no evidence of clinical chorio when the mom presented? 5:08:38PM

A. Well, no, I wouldn't agree with that. 5:08:39PM

Q. Clinical chorio. I'm not talking about subclinical chorio. I'm talking about clinical chorio.

A. I don't think you could have made a definite diagnosis of clinical chorioamnionitis. But the mother 5:08:49PM came in, and ruptured membranes, and had regular contractions; that's very commonly associated with clinical chorioamnionitis. So that's a -- you said -- you asked me if there was no evidence. There was certainly evidence. 5:09:04PM

As a matter of fact, probably most people who come in with preterm premature ruptured membranes and regular contractions have infection going on. She didn't have fever, she didn't have tenderness, so I would not feel confident in saying, I'm sure you have an 5:09:15PM infection, or I think it's very likely. I would have said, this is very concerning for infection.

Q. Okay. But you're -- I'm asking you about clinical chorioamnionitis, which by definition is: Maternal fever, fetal tachycardia, a tender uterus, 5:09:29PM foul-smelling amniotic fluid; there was no evidence of clinical chorioamnionitis, by that definition, when the mom came in?

A. Well, I'm just taking issue with the way you're phrasing it because you're saying no evidence. But I 5:09:45PM

would not -- one could not make a definitive diagnosis of clinical chorioamnionitis, but I wouldn't say that there is no evidence. Ruptured membranes and -- if you take the universe of pregnant women who are at this gestational age, let's say 27 weeks, and you take people who rupture their membranes and have regular contractions, they're about a thousand more times likely to have chorioamnionitis than the lady who's in the clinic at 27 weeks. That's the reason that most people rupture membranes and have contractions. 5:09:47PM 5:09:59PM 5:10:16PM

Now, is that going to be enough for me to say, I'm so sure you're infected, that I need to induce your labor? No. I think you -- you wait -- you would want to also have fever or tenderness or a foul-smelling amniotic fluid to go ahead and do the next step. But you're strongly suspicious of the infection. In other words, there is some evidence. But can you make a definitive diagnosis of clinical chorioamnionitis based on the way she presented it? No, I agree you cannot. 5:10:29PM

Q. So when you have a -- a 28-weeker and you manage -- you're -- with PPROM, and you were managing with -- expectantly, you manage with tocolytics, broad-spectrum antibiotics and corticosteroids; correct? 5:10:44PM

A. We measure -- corticosteroids, broad-spectrum antibiotics and sometimes with tocolytics. It depends 5:11:01PM

on the circumstances. We may or may not use them. 5:11:05PM

Q. Okay. If you know that the gestational age is under 30 week -- 30 weeks, you generally manage with tocolytics; correct?

A. We do. A lot of the conscientious doctors don't. It's -- there is no standard of care in that regard, but we do. 5:11:16PM

Q. Well -- well, the -- okay. So if you were managing this mom and you appreciated the true gestational age, you, Dr. Goodwin, would have -- broad-spectrum antibiotics, tocolytics and corticosteroids; correct? 5:11:38PM

A. I probably would have used those three.

Q. Okay. And tell me why you would use those three? Take each one of those, and tell me why you would -- why would you use that drug? Why would you do that? Why would you do that? 5:11:54PM

A. The tocolysis is in hopes of delaying delivery.

Q. Okay.

A. Fully aware that there is no scientific evidence that it -- that it works, but -- but it might work and it should, probably, not be harmful, unless you wait too long after infection is established. The antibiotics is in hopes of prolonging the latent phase, the time to delivery. 5:12:10PM 5:12:22PM

Q. And -- and that's been established by studies? 5:12:24PM

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 patients with preterm premature ruptured membranes not in labor. 5:12:34PM 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 PPROM that's contracting and that is not in labor?

A. I don't say that there's no studies. But I'm 5:12:50PM 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 5:13:03PM 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 5:13:19PM 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

might reduce intraventricular hemorrhage. The data is -- is conflicting on that. That's as much as we know. It's not proven in ruptured membranes that it has those benefits. But it has the membranes -- has the benefits in intact membranes, and there's no real reason why if the pregnancy -- if the patient stays pregnant long enough, that it shouldn't be able to have some benefit in ruptured membranes, so we hope it does. It's not been -- it's not been demonstrated, but we hope it does. 5:13:35PM 5:13:47PM 5:14:01PM

Q. We can establish in this case, this mom, when she came in, she wasn't in labor; correct?

A. No.

Q. By your definition?

A. Well, she had regular uterine contractions. As I said, the definition of labor involves cervical change. 5:14:09PM

Q. You said progressive --

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

THE WITNESS: Yeah. Progressive cervical changes is -- is the definition of labor. But as I said, when I told you that definition, every patient who actually is in labor has to have a period of time where they're contracting before the cervix is changing. 5:14:21PM

And the other problem is, that you can only 5:14:33PM

know the definition after it's happening, because you have to do a couple of exams some hours apart to know for sure. So in the -- in many practical settings, you have to look at the entire clinical setting and make a decision, do you think this is labor or not. 5:14:35PM 5:14:49PM

BY MR. BECKER:

Q. Okay.

A. My assessment looking at this patient -- looking at the fetal heart rate tracing and the contraction tracing, is that the way she presented with a gush of fluid and the contractions like she had, that she was actually in labor. Reasonable people could disagree on that. That's my assessment, if I'm at the bedside caring her in this setting. 5:14:54PM

THE VIDEOGRAPHER: Two minutes of tape left. 5:15:11PM

MR. MALONE: We'll change the tape deck. We'll go into more questions as soon as the tape is changed.

THE VIDEOGRAPHER: We're off the record at 5:15. This is the end of Tape No. 1, of Dr. Goodwin's deposition. 5:15:21PM

(Recess.)

THE VIDEOGRAPHER: We're back on the record at 5:24. This is the start of Tape No. 2 of Dr. Goodwin's deposition.

/// 5:24:48PM

BY MR. BECKER: 5:24:48PM

Q. Doctor, have you ever heard the phrase, when you see on a standing order for admitted L & D patient, "labor precautions"?

A. Yes. 5:24:59PM

Q. What does that mean?

A. Well, that's usually used on -- when you're discharging someone from L & D. You're telling them what to watch out for so they know when to return when they're in labor. 5:25:12PM

Q. If you were actually planning on inducing or augmenting the patient, you wouldn't use that phrase "labor precautions," would you; it wouldn't make sense?

A. I'm -- I'm just not familiar with using it on admission to the hospital. We don't usually include 5:25:23PM that as one of our standard things to do.

Q. You're assuming that there is a gush of fluid, in this case?

A. Yes.

Q. What's the basis for that? 5:25:39PM

A. It's --

Q. Is it charted?

A. No, it's not charted. It was either in deposition or interrogatory or some -- some response that -- I saw somewhere, Dr. Lewis, relate that. I 5:25:53PM

believe that there was a gush of fluid that came out. 5:26:00PM

Q. Okay. If -- if the patient -- if their mem- -- membranes had not ruptured and the patient had labored at 28 weeks, what's the standard of care? Tocolytics?

A. Steroids and tocolytics. 5:26:16PM

Q. Okay.

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

BY MR. BECKER:

Q. Is it successful?

A. If the patient has ruptured membranes -- 5:26:25PM doesn't have ruptured membranes and she's 28 weeks --

Q. Right.

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

Q. Yeah.

A. -- the outcome depends entirely what's 5:26:30PM underlying the labor and, you know, how far dilated she is and so forth. It can be successful, but it all depends on -- you know, some people are going to deliver in six hours and some are going to deliver in six weeks.

Q. What are the -- again, what are the factors you 5:26:52PM look at as to whether the lady without PPROM is going to deliver or not?

A. A lady without PPROM, I would look at the -- the main factors that we look at these days are, whether -- how far the cervix is dilated, that would be 5:27:04PM

one factor. Another would be the length of the cervix, usually by ultrasound or fetal fibronectin testing. Those would be the main tools that one would have to tell you if the patient is likely to stay pregnant for a long period of time or a short period of time. 5:27:09PM 5:27:26PM

Q. Okay. Now, with the PPROM, same tools? Same factors?

A. We discussed this a little bit right at the very beginning. You can't use the fibronectin, and you can't use the transvaginal ultrasound. You can't really use, even, cervical dilatation, because sometimes the person who is dilated by the bag, when they rupture membranes, the cervix then collapses. You don't really even want to do an exam. You just look at the cervix. And if you look at it and it appears closed, it doesn't have the same predictive value in somebody who has rupture of membranes. 5:27:39PM 5:27:53PM

So we are not nearly as good at trying to predict who -- who has ruptured membranes, is going to be pregnant the next day or the next two days. That's something that we are -- don't have nearly the tools that we have for people who have intact membranes. 5:28:07PM

Q. And -- and the standard of care, where the PPROM, but no prenat- -- no labor is, we agreed tocolytics, broad-spectrum antibiotics and corti- -- 5:28:26PM

corti- -- corticosteroids in a 28-weeker; correct? 5:28:30PM

A. If it's a 28-weeker -- I wouldn't say tocolytics are a standard of care, but they're commonly used. We use them, but they're not standard of care. Good doctors around the country don't use them. But 5:28:41PM tocolytic -- or antibiotics is a standard of care. I think that steroids, it's very commonly used, and I think it should be considered a standard of care, yeah.

Q. So with -- hypothetically, if this patient was not in labor and she's got PPROM at 28 weeks, is it 5:29:20PM likely that you're going to be able to buy at least seven days to ten days of additional latency period?

MR. MALONE: Hypothetically.

THE WITNESS: I'd have to look up the exact data on that. Of all patients who come in with preterm 5:29:44PM premature ruptured membranes at 28 weeks, who are not in labor, I -- I just don't remember offhand if they're more likely than not to be pregnant a week later. I really don't honestly remember that.

My sense is that it's -- it -- it might be near 5:30:05PM that number, nearly 50 percent. I really -- I'd have to look up the data on that. The further along that you're in gestation, the less likely you are to be pregnant a week later when your membranes rupture. I -- I just don't remember what the data is at 24, 25, 26, 27, -8, 5:30:18PM

weeks, exactly. 5:30:20PM

BY MR. BECKER:

Q. You don't know, in this case, had they not given -- you can't rule out that, had they not "pitted" this lady and simply given her an IV bolus, you would 5:30:30PM have reduced the uterine irritability, and she could have gone on for weeks? You can't rule that out, can you?

A. No. I can't rule that out. It could be possible. I don't think it's likely, but it's possible. 5:30:41PM

Q. Now, you keep saying this lady was in labor. You define labor as progressive cervical change. I want you to look at the strips up -- and if I'm wrong, I stand corrected. But it's my belief that "pit" was started around 8:00 p.m. I want you to look at the 5:31:00PM strips until mom comes, until the Pitocin is started, and I want to you comment on frequency, the strength of those contractions.

A. Well, the monitor tracing that I have begins at -- 5:31:29PM

Q. Tell me what panel number you have. That might be easier, if you do have a panel number there, Doctor.

MR. MALONE: Page number one, right here.

THE WITNESS: Okay. Yeah, it's -- actually just says page number one. Funny it doesn't actually 5:31:44PM

have a.

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

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

BY MR. BECKER:

Q. Okay. 5:31:53PM

MR. KULWICKI: 18:12?

BY MR. BECKER:

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

A. 6:00 --

Q. -- 6:12 p.m.? 5:32:03PM

A. Yes.

Q. Okay. So tell me when you see her first contraction?

A. Well, there is no contraction tracing at all through -- up to -- through 19:10, there's -- the 5:32:12PM contraction monitor just isn't picking up any -- it's not monitoring. I'm not even sure if it would have been attached at that time.

Q. Okay. Well, wait a minute. I want to make sure that we establish it, from 16:12 one 17:10 -- 5:32:25PM

MR. KULWICKI: 18:12.

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

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

THE WITNESS: Yeah.

/// 5:32:33PM

BY MR. BECKER: 5:32:34PM

Q. I'm sorry. From 6:12 p.m. until -- did you say 7:10 p.m., there's no contractions?

A. It's not -- the monitor isn't on.

Q. Well, there's no contractions recorded on the 5:32:45PM monitor; correct?

A. I -- let's -- this is -- it's not even -- it's probably sitting on the bed. It's not attached to the patient or something or she's moving around.

Q. So we've got no documented contractions by 5:32:56PM fetal monitoring, correct, between 6:12 and 7:10 p.m.; correct?

A. I would say you have no attempt to monitor.

Q. No evidence of contractions, right, on the --

A. No. I mean, it's different. It sounds like -- 5:33:09PM no evidence sounds like someone was trying to monitor, and wasn't getting it. I'm saying that the monitor wasn't on.

Q. Okay. What is the -- what is the -- the notes -- 5:33:19PM

MR. BECKER: You want to take that, Doctor?

THE WITNESS: I apologize, one second.

MR. BECKER: That's okay. We'll go off the record.

THE VIDEOGRAPHER: We're off the record at 5:33:31PM

5:33 p.m. 5:33:34PM

(Recess.)

THE VIDEOGRAPHER: We're back on the record at 5:35.

BY MR. BECKER: 5:35:10PM

Q. Okay. Doctor, you have the chart in front of you. Feel free to utilize, not only the strips, but the clinical chart, the nurses notes as well, in answering some of these questions. It's not a memory contest.

Between 6:12 and 7:10, how were the 5:35:26PM contractions described in the chart by the caregivers, whether nurses or obstetricians?

A. I'd have to look at the nurses notes to see that.

MR. MALONE: Back here. You got to sort of 5:35:47PM pull that out, but that black line -- that's a flow sheet.

THE WITNESS: I don't know that I have notes in that time frame. I'm just trying to find them. The nurses notes that I'm seeing relate to a time around 5:36:20PM 8:00 o'clock.

BY MR. BECKER:

Q. Okay. Let's -- let's go to the -- let's go to the strips from 7:10 until 8:25 or 8:30. Tell me how you interpret the strips; tell me how often there are 5:36:46PM

contractions; the frequency of the contractions; the intensity of the contractions. 5:36:50PM

A. From -- the contraction tracing that I can interpret, looks to me where it began, is at 19:15. That's 7:15 p.m. And in the first ten minutes, you can't tell exactly how often she's contracting. The contractions, you can see on there, might be two or three in ten minutes, and the next ten minutes it appears that she has three or four contractions in a ten-minute period. That's -- I'm looking at ending at 19:31 beginning at 19:20. 5:37:01PM 5:37:31PM

And the next period from 19:31 to 19:41, it's hard to discern contractions. There might be one or two. This is -- the tracing below the base line, so this happens when the patient moves or something. It's hard to interpret that. 19:41 to 19:51, there's three contractions. 5:37:58PM

MR. KULWICKI: Three?

THE WITNESS: Yeah. That's what I see, three contractions. 19:41 to 19:51, there's three contractions. 5:38:16PM

BY MR. BECKER:

Q. What -- what is the increase in the -- in the -- the pressure?

A. Well, this is an indirect measure of pressure, 5:38:25PM

so it's, strictly speaking, not a direct pressure measurement, but it's a ten millimeter of mercury rise or so from baseline. That's 10 to 20, and the two contractions at 19:45 and at 19:46, and at 19:49, and there's contractions -- the -- the amount of rise is very loosely related to the intensity of contractions, because this is not a direct pressure catheter measurement, so -- 5:38:27PM 5:38:47PM

Q. It's not an IUPC?

A. Right. So depending on the contour of the patient's abdomen, the placement of the transducer and so forth, you may get a nice big rise or you might get a lessor of a rise. There is a general association with the intensity of the contractions, but it's -- it's by no means one to one. 5:39:02PM 5:39:17PM

After 19:51, the contractions occur about every two to three minutes. And allowing for -- for variation in the monitor, there are periods where you -- you can't really discern them. And there's periods where they're quite clearly distern- -- discerned. And this is characteristic of patients who have -- who are being monitored in early labor. 5:39:45PM

We've monitored -- I've monitored hundreds of patients in trials of preterm labor drugs, and this is what one sees. If you look at 21:25, for example, this 5:40:00PM

is what happens when someone just readjusts the monitor, and suddenly what were not that clear of contractions are more clear. And it's not that something magical happened between 21:24 and 21:25. It's just the placement of the -- the uterine contraction monitor or the -- 5:40:07PM 5:40:29PM

Q. But I don't want to get into when Pitocin is on board.

A. Yeah, I understand. But I'm just pointing out that you can't -- there's a long time period here when Pitocin is on, you -- you don't see anything. Pitocin is not diminishing the contractions. The contractions were actually going on just the hour before. It's just that you can't monitor them. 5:40:41PM

Q. So how would you characterize the -- the contractions between 7:10 and 8- -- 8:30? Would you say that they are regular, irregular, mild? 5:40:59PM

A. They're regular contractions. They're -- I think the nurses indicate that they're one plus. This is the way many patients present in preterm labor. 5:41:17PM

Q. In one plus, and --

A. Out of three.

Q. -- out of three. And -- and certainly, you've had many patients, Doctor, that have been presented with strips like this, where you've given them, either, IV 5:41:28PM

fluids or tocolytics, and -- and they have -- they have not delivered within 24, 48 hours; true? 5:41:32PM

A. Yes, I have.

Q. Okay. So I -- so I want to understand -- I'm not trying to be cute, Doctor, I just want to understand what it is about these strips that you just described to me. Can we agree, there's -- there's no cervical change from the time monitoring has begun and before Pitocin? 5:42:06PM

A. Yes.

Q. Okay. 5:42:23PM

A. In practical terms, when you have preterm ruptured membranes and you're trying to assess whether someone is in labor, you never have cervical change --

Q. Okay.

A. -- until they're absolutely -- you -- you just don't do exams. That's -- that's below the standard of care. So you have to -- clinically, you make a diagnosis based on, if they're regular uterine contractions in this setting, is this, probably, real labor or not. And in this setting to me, I -- it looks to me like this is somebody who is really getting into labor. Even with cervical change, it's not 100-percent diagnosis. 5:42:29PM 5:42:44PM

Q. Have you written, Doctor, that 60 percent of the time, if you give Pitocin -- or give tocolytics, 5:43:03PM

based simply on the -- the contractions, that the patient likely is not going to be in labor, 60 percent of the time? 5:43:03PM

A. The patients with intact membranes using conventional diagnosis of preterm labor, it's a -- a lot of the patients really are not in labor; that's true. 5:43:10PM

Q. Okay. So whatever I read that you wrote, that was referring to intact membranes?

A. Yes. That's why the studies of tocolytics and intact membranes are very confusing. A lot of patients we think are in labor, turn out not to be, unless you use very strict criteria. 5:43:24PM

Q. Okay. And -- so it's just that you saw some -- some contractions in those two hours, and you feel more likely than not, you wouldn't have been able to stay the onset of active labor for at least 48 hours; that's what you feel? 5:43:43PM

A. Yes. It's not just some contractions. It's, you know, regular contractions are occurring every three -- two to three minutes -- 5:44:00PM

Q. Okay.

A. -- three to four minutes in different parts of that tracing.

Q. And you feel that way, simply, because of your experience, education, but also, the strips as they 5:44:10PM

appear? 5:44:14PM

A. Yeah.

Q. Okay. Anything else besides the strips?

A. The strips, the fact that the patient has ruptured membranes, the overall clinical setting is, to 5:44:24PM me, comports with a patient who usually delivers in a short time frame; that's what I would expect from a patient who presents like this. If I knew she was 28 weeks, I would still try and stop it.

Q. Well, we know you would, Doctor. I just want 5:44:39PM to understand why you say more likely than not. How -- how do you arrive that this baby -- this -- this mom still would have delivered in 48 hours? Is that a study you're referring to?

A. Well, most patients who are in the preterm 5:44:59PM rupture studies who are having regular contractions, don't -- didn't get in the studies. Some, you -- you can't tell 100 percent, so some probably did. So we -- we can't use all that information to guide us in that. Patients who are having regular uterine activity are 5:45:16PM much more likely to deliver than those who don't. That's -- that's intuitive, and it's medically true as well, and she falls into that group.

That's the base -- you know, I've taken care of innumerable patients like this, so my opin- -- opinion 5:45:41PM

in a patient like this -- if somebody comes up to me and says to me, Doctor, I have two patients next to one other; and one is have no contractions, and one is having contractions like this; and you said, Doctor, what is the chances that either one of these two people is going to be pregnant in 48 hours? The chance that the one who is contracting is going to be pregnant is much less than the person who has no uterine activity. 5:45:41PM 5:45:52PM

Q. But -- but -- but the fact that this is a 28-weeker, that increases their chance of extending beyond 28 weeks -- or beyond 48 hours compared to a 30-weeker; correct? 5:46:06PM

A. That would -- difference would be hard to tell. But between 28 weeks and 34 weeks, yeah.

Q. Okay. 5:46:21PM

A. There -- it's -- they have a higher chance of staying pregnant in any given setting. But their chance of staying pregnant is still -- you know, if you have ruptured membranes and regular contractions, you're very likely to deliver in the next 48 hours. 5:46:32PM

Q. Okay. And can you point to me any study that stands for that proposition? Any study, any writing, anything that comes to mind that stands for that proposition, that opinion you're giving in this case?

A. I -- I'd have -- I can't remember exactly a 5:46:50PM

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. 5:46:52PM 5:47:09PM

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? 5:47:22PM 5:47:38PM

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. 5:47:44PM

MR. BECKER: Read the question, back, please. 5:48:31PM

(The previous question was read.) 5:48:31PM

BY MR. BECKER:

Q. So you're taking that presumption, and then you're applying your rule that PPROM's that are in labor don't go 48 hours; correct? You're making a presumption 5:48:38PM this lady would have gone into labor?

A. Yes. Well, I'm -- I'm saying that she was in the early stages of labor. And by definition, when you have somebody with PPROM, you can't confirm that by sterile examination, you -- until they're very far 5:48:50PM advanced, you know, after the fact.

So I'm -- my -- based on my experience and inferring from what's published on patients who are not in labor, I think that more -- it's more likely than that she wouldn't have stayed pregnant for 48 hours. 5:49:10PM However, a lot -- we still hold out hope that somebody could stay pregnant that long, and some patients do, and some patients stay pregnant for weeks.

Q. Right.

A. So -- 5:49:21PM

Q. And by the -- by the admitted deviations that you've given us tonight, the -- the employees at Metro deprived --

MR. MALONE: I think --

/// 5:49:35PM

BY MR. BECKER: 5:49:35PM

Q. -- this mom of an opportunity or a chance to go beyond 48 hours; correct?

MR. MALONE: Objection.

MS. REID: Objection. 5:49:42PM

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

Answer the question, if you can, Doctor. 5:49:48PM

THE WITNESS: From our dialogue and from my interpretation of the record, if the patient had known -- if the caregivers had known she was 28 weeks, they would have attempted to tocolyze her. And that -- to that extent, there would have been some chance of her 5:50:09PM staying pregnant for 48 hours. Not knowing that she was 28 weeks, there was no chance of her -- the reasonable plan, presuming that she was 34 or 36 weeks, was that she should be induced. And I think the -- Dr. Lewis has said that if she knew she was 28, she would have 5:50:30PM attempted to delay her delivery.

BY MR. BECKER:

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, 5:50:42PM

IV antibiotics and corticosteroids? 5:50:45PM

MR. MALONE: Deprived of a chance?

MR. BECKER: Yeah.

MR. MALONE: That is the question?

MR. BECKER: Yeah. 5:50:53PM

MR. MALONE: Deprived?

MR. BECKER: Yup.

MR. MALONE: Her role in this, of course, is being if negated by you. She had no role in this.

THE WITNESS: If you presume that she's 34 to 36 weeks, then there is no point in trying to prolong the pregnancy. So the doctor's made their best assessment, and the conclusion they came to -- Dr. Lewis's assessments made it unreasonable to try to delay delivery. 5:51:00PM 5:51:18PM

BY MR. BECKER:

Q. Right. Doctor, we can agree that -- that had the chart been kept current and updated, as we talked about earlier, more likely than not, assuming Dr. Lewis's testimony is to be believed, she would not have engaged in augmentation of labor; she would have engaged in expected management; correct? 5:51:32PM

MR. MALONE: Objection.

MS. REID: Objection.

THE WITNESS: If Dr. Lewis had -- Dr. Lewis's 5:51:46PM

testimony, as I understand it, that she would have engaged in expected management if she had understood the patient's gestational age more likely to be 28 weeks. 5:51:46PM

BY MR. BECKER:

Q. Right. And we've previously agreed that it's a deviation from Dr. Charada not to have brought that chart up to date, if he was unsure or didn't even have a clue as to what records are sent over to Metro. We previously agreed on that, true? 5:51:54PM

MR. MALONE: Objection. It's not true. 5:52:11PM

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

BY MR. BECKER:

Q. Okay. We'll have to look at --

A. I'd have to look at exactly what we agreed on, because I -- I wouldn't put it in exactly the terms that you've put it. 5:52:19PM

Q. Okay.

A. It depends what he had reason to believe what would be communicated from the information that was -- that he had on that day. 5:52:24PM

BY MR. BECKER:

Q. Well --

MR. KULWICKI: Don't rehash this.

MR. BECKER: Okay. 5:52:35PM

BY MR. BECKER: 5:52:37PM

Q. Where can I go to find a definition of early labor? Your textbook?

A. I don't think early labor has a definition. It's what every human being goes through before they 5:52:53PM have real labor. It's the first phase of labor.

Q. And -- and how do you distinguish early labor from actual labor?

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

Q. Okay. Well, how do you know in retrospect? 5:53:12PM

A. Well --

Q. They go on to have cervical change?

A. They go on to have a baby, or they go on to have definitive cervical change. But in many settings, you can't clinically wait for that, because you -- you 5:53:21PM have to make the diagnosis for various reasons depending on the gestational age and so forth, sometimes, before you can have cervical change.

Q. If this was expected management, as we agreed likely should have been done, had they known the 5:53:51PM gestational age --

MR. MALONE: Objection, Mike. You got to stop throwing that stuff in there. That's just not fair. It's inappropriate. Please ask a straightforward question. "As we agreed, should have, could have, would 5:54:04PM

have," I mean, come on. You want to make a final argument, you're going to be given an opportunity to do that in the courtroom. You're not going to do it with this witness in cross-examination. 5:54:07PM

Wait for a question, please. 5:54:14PM

BY MR. BECKER:

Q. In retrospect, Doctor, for this patient, she received the wrong medication. She received Pitocin, and she should have received betamethasone, among other things; correct? 5:54:40PM

MR. MALONE: Objection.

THE WITNESS: If the physicians had known her true gestational age, they agreed, and Dr. Lewis agrees, that she would have given betamethasone and would not have given Pitocin. And to that extent, I agree with your statement. 5:54:51PM

BY MR. BECKER:

Q. You have written, Doctor, that in- -- inaccurate diagnosis of early preterm labor has serious consequences; true? 5:55:54PM

A. Yes.

Q. Serious consequences?

A. Yes. I'm -- I'm referring to preterm labor with intact membranes, but it's a general -- I believe that statement, yeah. 5:56:06PM

Q. You agree that the diagnosis of early preterm labor is difficult and is accompanied by a high-false positive rate? 5:56:07PM

A. Yes. That's, again, with regard to intact membranes. But it is true. 5:56:21PM

Q. Doctor, 22 percent of women, you did -- you had a study where 22 percent of women presented with symptoms of preterm labor, and most of those women delivered in five weeks after presentation?

A. I could -- I could believe that. I don't remember that, exactly. Again, that would be intact membranes. 5:57:22PM

MR. MALONE: You want to take a break to go through your notes?

MR. BECKER: Yeah, that's fine. 5:58:31PM

THE VIDEOGRAPHER: We're off the record at 5:58.

(Recess.)

THE VIDEOGRAPHER: We're back on the record at 6:07. 6:07:33PM

BY MR. BECKER:

Q. Doctor, you have written a few times that, if there is any question whether a patient is in labor or not, the best thing to do is to give them a few more hours, sit back, look, reassess; correct, in a PPROM 6:07:43PM

patient? 6:07:48PM

A. I don't know if I've written exactly that, but it's -- it's not a bad plan to follow, in general.

Q. Okay. To your knowledge, has any doctor from Metro ever come to Los Angeles and given -- or either 6:07:58PM come here or provided expert testimony in a malpractice claim against your hospital or USC?

A. I wouldn't have any idea.

Q. You have no idea.

Can you have a urinary tract infection and an 6:08:13PM upper respiratory infection without intrauterine infection?

A. Yes.

Q. Okay. And what's keeping urinary tract infection local versus ascending up into the vaginal 6:08:27PM canal?

A. Well, there is a lot of different things. I mean, it's -- it's in the -- it's separated by a number of layers of tissues. So unless a urinary tract infection gets into the blood stream, or unless the 6:08:45PM bacteria that caused the urinary infection are also in the vagina, then the two should stay separate.

Q. Okay. You're making a couple of assumptions for your ultimate opinion in causation in this case. One is, you're assuming there was a gush of fluid; and 6:09:07PM

two is, you're assuming that the mom, between 7:00 o'clock and 8:30, was in early labor; correct? 6:09:11PM

A. In answer to your first question, I -- I'm assuming that she had obvious rupture of membranes.

Q. Okay. 6:09:26PM

A. I recall the phrase "a gush of fluid," I believe from either Dr. Lewis's deposition or one of the interrogatories. But I believe there was clear ruptured membranes, and I'm also assuming -- I'm sorry, the second part was? 6:09:39PM

Q. That she was in preterm early labor in the first two hours.

A. Yes.

Q. Okay. Now, if either one of those assumptions is in error, then would you agree that, more likely than not, she would have likely proceeded with a latency period beyond 48 hours? 6:09:48PM

A. I think if she was spontaneous preterm ruptured membranes at 28 weeks and not in labor, that she would probably have -- be more likely able to be pregnant 48 hours later. 6:10:10PM

Q. And -- and the key is -- you understand that you need, comfortably, 48 hours to have a full affect of steroids on board to reduce the risk of inter- -- IVH as well as the severity of RDS; do you appreciate that? 6:10:26PM

A. Yes. 6:10:31PM

Q. Okay.

MR. KULWICKI: I got some here.

BY MR. BECKER:

Q. Doctor, are you familiar with Allen's article 6:11:05PM
on tocolytic therapy in preterm PPROM? Preterm PROM?

MR. MALONE: Preterm PPROM, what is --

MR. BECKER: No, PPROM.

BY MR. BECKER:

Q. Toco- -- are you familiar with his article? 6:11:14PM

A. I don't remember that by -- by that name. I'd have to look -- look at it.

Q. Can we agree that a physical exam when a patient is admitted to L & D, should that include fundal height? 6:11:37PM

A. I think that's common practice. It's not a standard of care. Some doctors don't do it, but I don't know what percentage do do it, but it's commonly done.

Q. Can we agree, if there is any doubt about -- any doubt about the gestational age of this fetus, 6:11:52PM ultrasound should have been performed?

A. If ultrasound for gestational age is readily available, and the clinician forms the impression that they're not sure of the date, then it's better to perform an ultrasound. I agree with that; an ultrasound 6:12:05PM

to confirm the gestational age. 6:12:09PM

Q. How accurate is ultrasound in estimating gestational age at -- in mid -- second trimester?

A. At 28 weeks, which we ultimately know this patient's gestational age was, it would be accurate within -- that's between two and three weeks, probably closer to two weeks. But the range -- published range would be within two or three weeks. 6:12:23PM

Q. Have you looked at the ultrasound films from 7/12, in this case? 6:12:39PM

A. I -- don't -- I've seen the report. I don't -- I can't recall if I've seen the films.

Q. Do you have any disagreement with Dr. Ashmed's interpretation?

A. No. 6:12:50PM

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

A. I believe that if an ultrasound had been performed to measure the fetus and, again, gestational age, it would have given a more accurate impression than the doctor's had from relying on the last menstrual period and the prenatal record that they had. 6:13:12PM

Q. Should this mom have also received antibiotics 6:13:51PM

for Group B Strep at -- during the -- in L & D? 6:13:54PM

A. For Group 2, this mom, I believe, should have received antibiotics to prevent Group B Strep transmission in labor and delivery.

Q. Was it deviation to withhold antibiotics in this case? 6:14:06PM

A. Yes. I mean, even if you think somebody is 36 weeks, you should still give the antibiotics. I believe that is a deviation from the standard of care. I saw where they were ordered, but, apparently, not given. 6:14:21PM

Q. The fact that this mom was charted as being one-centimeter by an exam, is that influencing in your opinion, in any way, as to whether or not she likely was in early preterm labor?

A. A -- if she was charted as being four centimeters, I'd say for sure she is. And -- but if -- if she's charted at one centimeter, she still could be in early preterm labor. 6:14:46PM

Q. Okay.

A. And I'm basing that -- so -- it -- it -- it doesn't put me off the track. It -- it would be more -- I'd be more certain if she was further dilated. But even the fact that she's one centimeter, could be consistent with someone who is in labor, especially with ruptured membranes. 6:14:54PM 6:15:12PM

Q. Now, with multips, is it not unusual to see them in one centimeter when they come in? 6:15:13PM

A. Could be.

Q. Yeah. And that doesn't mean just because you see a multip at one centimeter, means they're in preterm labor, does it? 6:15:25PM

A. Not necessarily, no.

Q. We're almost done.

Now, Doctor, when this mom was admitted, did the plan -- feel free to look at the plan on 7/31/01, 20:38. 6:16:47PM

A. Yes.

MR. MALONE: These are the plans down here.

THE WITNESS: I'm looking at 7/31/01, 20:38.

BY MR. BECKER: 6:17:30PM

Q. Yeah. Under impression, you see at the bottom it says "impression," it also says "plan."

A. Yes.

Q. Okay. And do you see any indication on that plan to either induce or augment labor? 6:17:41PM

A. No.

Q. In fact, contrarily, it says, "Labor precautions." Does that suggest to you to look for signs of labor?

A. It's -- it means to me, at this time, they're 6:18:01PM

trying to assess, is this labor? What's going on? 6:18:04PM

MR. BECKER: Anything else?

BY MR. BECKER:

Q. Do you find anywhere in that chart, where there -- there's a change of plan to start augmenting labor? 6:18:36PM

A. No. I -- I don't see it clearly stated that -- where the change of plan is indicated.

Q. Do you offer the responsibility that Pitocin was inadvertently placed on the patient? 6:19:12PM

A. No. If you think somebody is 36 weeks, you should give Pitocin. You have to give Pitocin, if they have ruptured membranes and you think they're 36 weeks. It's just a question of whether you do it immediately or whether you -- you can wait and see if they have spontaneous labor on their own, or you can give it promptly. 6:19:27PM

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

A. This is just --

Q. -- before she left triage? 6:19:43PM

A. This is a -- a change in practice that's gone on over years. It used to be that you would give a patient like this six hours to see if they labored on their own. Gradually, there's been less and less tolerance for waiting, because the -- if you think a 6:19:58PM

patient is 36 weeks, the downside of waiting is that they can sometimes develop an overwhelming infection. The downside of giving it early is, virtually, nothing, and so there's been more and more of a tendency to say, as soon as we confirm ruptured membranes, to go ahead and start Pitocin. 6:20:02PM 6:20:15PM

Q. Doctor, we can agree, just to wrap up, that something or someone at Metro would be responsible for Dr. Lewis not having the results of Dr. Ashmed's ultrasound at the time she rendered care to this mom; correct? 6:20:31PM

MR. MALONE: Objection.

THE WITNESS: I would say "something" is responsible in the sense that she -- the system that was in place, similar to most systems in most hospitals in the country, doesn't allow for immediate conveyance of all the information to the doctor's on labor and delivery. 6:20:45PM

BY MR. BECKER:

Q. This is either a system's failure by MetroHealth of not having that system in place, or a failure by Dr. Charada of not updating the chart so that information could be at hand; correct? 6:20:56PM

MR. MALONE: Objection.

THE WITNESS: This is what would have happened 6:21:14PM

in most hospitals in the country, as far as the chart being available and the ultrasound being available, in 2001, to my knowledge. Most hospitals would not have a recent ultrasound result or lab results sent over to labor and delivery at this time in gestation. And that -- that's -- that's the state of -- the way information is communicated. It's not ideal. 6:21:16PM 6:21:31PM

BY MR. BECKER:

Q. Well, if the hospital is not going to send it over, then, we've previously agreed, Dr. Charada has a responsibility to -- to so indicate in the chart the discrepancy of dates, so a subsequent caregiver can provide better care? 6:21:44PM

A. Yes.

Q. All right. 6:22:00PM

A. And then when -- when that is sent over, that person will have that information.

MR. BECKER: I'm -- I'm done.

THE VIDEOGRAPHER: This concludes the January 23rd, 2007, deposition of Dr. Goodwin. 6:22:09PM

We're off the record at 6:22, and this is the end of Tape No. 2.

(The deposition was concluded at 6:22 p.m.)

--o0o--

Please be advised the foregoing deposition was read, and I state there are:

(Check one)

_____ NO CORRECTIONS

_____ CORRECTIONS ATTACHED

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T. MURPHY GOODWIN, M.D.

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Date Signed

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DEPOSITION OF: T. MURPHY GOODWIN, M.D.

CASE: MASLANKA VS. METROHEALTH

DATE OF DEPOSITION: JANUARY 23, 2007

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STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN BERNARDINO)

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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